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The Code of Federal Regulations is sold by the Superintendent of Documents.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 58

[TD 10037]

RIN 1545-BQ59

Excise Tax on Repurchase of Corporate Stock; Correction

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final rule; correcting amendments.

SUMMARY: This document includes corrections to final regulations (TD 10037) published in the **Federal Register** (90 FR 53144) on Monday, November 24, 2025, providing guidance regarding the application of the excise tax on repurchases of corporate stock made after December 31, 2022.

DATES:

Effective date: These corrections are effective on February 11, 2026.

Applicability date: For dates of applicability, see §§ 1.1275-6(f)(12)(iii)(B), 58.4501-6, 58.4501-7(r), and 58.6011-1(d).

FOR FURTHER INFORMATION CONTACT: Concerning § 58.4501-7, Brittany N. Dobi of the Office of Associate Chief Counsel (International) at (202) 317-5469 (not a toll-free number). For all other issues, Kailee H. Hock of the Office of Associate Chief Counsel (Corporate) at (202) 317-3181 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

The final regulations (TD 10037) subject to these corrections are issued under sections 1275, 4501, and 6011 of the Internal Revenue Code.

List of Subjects in 26 CFR Part 58

Excise taxes, Stocks, Reporting and recordkeeping requirements.

Correction to the Regulations

Accordingly, 26 CFR part 58 is corrected by making the following correcting amendments:

PART 58—STOCK REPURCHASE EXCISE TAX

■ **Paragraph 1.** The authority citation for part 58 continues to read in part as follows:

Authority: 26 U.S.C. 4501(f) and 7805.

■ **Par. 2.** Section 58.4501-4 is amended by revising paragraph (f)(3)(i) to read as follows:

§ 58.4501-4 Application of netting rule.

* * * * *

(f) * * *

(3) * * *

(i) Any stock issued by a recapitalizing corporation as part of a transaction qualifying as an E reorganization, but only to the extent such stock was issued in exchange for other stock of the recapitalizing corporation.

* * * * *

■ **Par. 3.** Section 58.4501-5 is amended by revising paragraph (b)(20)(ii) to read as follows:

§ 58.4501-5 Examples.

* * * * *

(b) * * *

(20) * * *

(ii) **Analysis.** Corporation X reduces its gross repurchase amount by an amount equal to the sum of the fair market values of the different class of stock at the time the stock is contributed to the employer-sponsored retirement plan (\$1,000x + \$500x = \$1,500x). Corporation X's stock repurchase excise tax base for its 2025 taxable year is \$0 (\$1,200x repurchase – \$1,500x exception). The \$300x excess of the contributions qualifying for the exception under § 58.4501-3(d) over the gross repurchase amount (\$1,500x exception – \$1,200x gross repurchase amount) may not be carried forward or backward to preceding or succeeding

taxable years of Corporation X. See § 58.4501-2(c)(2)(ii).

* * * * *

Oluwafunmilayo A. Taylor,

Chief, Publications and Regulations Section, Associate Chief Counsel (Procedure and Administration).

[FR Doc. 2026-02748 Filed 2-10-26; 8:45 am]

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DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG-2025-0999]

RIN 1625-AA09

Drawbridge Operation Regulation; Passaic River, Between the City of Newark and Town of Kearny, NJ

AGENCY: Coast Guard, DHS.

ACTION: Final rule.

SUMMARY: The Coast Guard is modifying the operating regulation that governs the Point No Point Railroad Bridge across the Passaic River, mile 2.6, between the City of Newark and Town of Kearny, NJ. The change in the regulation will allow the bridge to be remotely operated from the Conrail North Jersey Dispatch Center in Mount Laurel, NJ. This change will alter the operating schedule of the bridge to open on signal and no longer require a four-hour advance notice.

DATES: This rule is effective March 13, 2026.

ADDRESSES: To view documents mentioned in this preamble as being available in the docket, go to <https://www.regulations.gov>. Type the docket number USCG-2025-0999 in the "SEARCH" box and click "SEARCH". In the Document Type column, select "Supporting & Related Material."

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Mr. Gregory P. Hitchen, Northeast Coast Guard District (dpb), the Coast Guard; telephone 571-607-8154, email Gregory.P.Hitchen@uscg.mil.

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

[Delete/add any abbreviations not used/used in this document]

CFR Code of Federal Regulations
 DHS Department of Homeland Security
 FR Federal Register
 OMB Office of Management and Budget
 NPRM Notice of Proposed Rulemaking
 (Advance, Supplemental)
 § Section
 U.S.C. United States Code

II. Background Information and Regulatory History

On December 1, 2025, the Coast Guard published a Notice of Proposed Rulemaking entitled “Drawbridge Operation Regulation: Passaic River, Between the City of Newark and Town of Kearny, NJ” in the **Federal Register** (90 FR 55063). There we stated why we issued the NPRM and invited comments on our proposed regulatory action related to this regulatory change. During the comment period that ended December 31, 2025, we received one comment and that comment is addressed in Section IV of this Final Rule.

III. Legal Authority and Need for Rule

The Coast Guard is issuing this rule under authority 33 U.S.C. 499. The Point No Point Railroad Bridge across the Passaic River, between the City of Newark and Town of Kearny, NJ, mile 2.6, owned and operated by Conrail, has a vertical clearance of 20 feet above mean high water when closed and is unlimited when open.

This regulation will allow the bridge to be remotely operated from the Conrail North Jersey Dispatch Center in Mount Laurel, NJ. The current operating schedule is published in 33 CFR 117.739(c). With the implementation of remote operation of the bridge, the operating schedule will change to allow the bridge to open on signal versus requiring a four-hour advance notice. There are 30 daily train transits that cross the bridge and an average of one bridge opening every six months for vessel transits. The bridge is normally maintained in the closed position due to the average daily number of trains crossing the bridge. The Passaic River has limited commercial and recreational vessel traffic. Most commercial traffic supports marine construction projects in the waterway.

This rule will improve the efficiency of bridge openings. Currently the Conrail train dispatcher in Mount Laurel NJ must dispatch bridge operating personnel to open the Point No Point Railroad Bridge. Remote operations will allow the Conrail train dispatcher to open the bridge on signal.

IV. Discussion of Comments, Changes and the Final Rule

One comment was received that raised safety concerns regarding the remote operation of movable bridges over navigable waterways. The commenter urged the Coast Guard to work with the maritime industry, bridge owners and operators, and other stakeholders as appropriate to establish safety standards for remote controlled bridge operations.

In response to this comment, the Coast Guard amended the regulatory text to codify existing requirements to locally operate the bridge if the remote system malfunctions.

The bridge owner, Conrail, submitted a comprehensive remote operation application in accordance with the Coast Guard’s Bridge Remote/Automated Operation Request Guide. The Request Guide was developed to meet guidelines promulgated by the American Association of State Highway and Transportation Officials, and the National Institute of Standards and Technology, for remotely operated bridges. Both Conrail and the Coast Guard conducted outreach to local stakeholders regarding procedures and protocols for remote operations. Upon reviewing remote operation application, the Coast Guard assessed that the remote operation system is designed to provide equal or greater capabilities compared to the on-site bridge tender, and that the remote operation meets the reasonable needs for existing and prospective navigation on the waterway.

V. Regulatory Analyses

We developed this rule after considering numerous statutes and Executive Orders related to rulemaking. Below we summarize our analyses based on a number of these statutes and Executive Orders.

A. Impact on Small Entities

The Regulatory Flexibility Act of 1980, 5 U.S.C. 601–612, as amended, requires federal agencies to consider the potential impact of regulations on small entities during rulemaking. The term “small entities” comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. The Coast Guard received no comments from the Small Business Administration on this rule. The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities for the following reasons. (1) vessels

will be able to obtain bridge openings on signal versus a four-hour advance notice, (2) the remote operation system is designed to provide equal or greater capabilities compared to the on-site bridge tender, and (3) the bridge owner will be capable of restoring on-site operation of the bridge within 60 minutes if the remote operation system fails.

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this rule. If the rule will affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section.

Small businesses may send comments on the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency’s responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

B. Collection of Information

This rule calls for no new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

C. Federalism and Indian Tribal Government

A rule has implications for federalism under Executive Order 13132, Federalism, if it has 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. We have analyzed this rule under that Order and have determined that it is consistent with the fundamental federalism principles and preemption requirements described in Executive Order 13132.

Also, this rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does 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.

D. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of \$100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

E. Environment

We have analyzed this rule under Department of Homeland Security Management Directive 023–01, Rev. 1, associated implementing instructions, and Environmental Planning Policy COMDTINST 5090.1 (series) which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f). The Coast Guard has determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule promulgates the operating regulations or procedures for drawbridges and is categorically excluded from further

review, under paragraph L49, of Appendix A, Table 1 of DHS Instruction Manual 023–01–001–01, Rev. 1.

Neither a Record of Environmental Consideration nor a Memorandum for the Record are required for this rule.

List of Subjects in 33 CFR Part 117

Bridges.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 117 as follows:

PART 117—DRAWBRIDGE OPERATION REGULATIONS

■ 1. The authority citation for part 117 continues to read as follows:

Authority: 33 U.S.C. 499; 33 CFR 1.05–1; and DHS Delegation No. 00170.1. Revision No. 1.04.

■ 2. Revise 117.739(c) to read as follows:

§ 117.739 Passaic River.

* * * * *

(c) The draw of CONRAIL's Point-No-Point Railroad Bridge, mile 2.6, between the City of Newark and the Town of Kearny, NJ, shall be operated from a remote location at all times, except when it is tended locally. The bridge shall open on signal once notice is given. After the signal to open is given, the opening may be delayed no more than ten minutes.

(1) Closed circuit television cameras shall be operated and maintained at the bridge site to enable the remotely

located bridge tender to have a full view of both vessel traffic and the bridge.

(2) Radiotelephone Channel 13/16 VHF–FM shall be maintained and utilized to facilitate communication in both remote and local control locations. A push-to-talk (PTT) will be maintained on VHF–FM channel 13. Vessels may push the PTT button five times while on VHF–FM channel 13 and the remotely located bridge tender will receive and respond to the request and commence opening of the bridge.

(3) The bridge shall also be equipped with directional microphones and horns to receive and deliver signals to vessels.

(4) A telephone number will be maintained and posted for mariners to directly contact the remotely located bridge tender.

(5) Whenever the remote-control system equipment is partially disabled or fails for any reason, the bridge shall be physically tended and operated by local control as soon as possible, but no more than 60 minutes after malfunction or disability of the remote system. Mechanical bypass and override capability of the remote system shall be provided and maintained.

* * * * *

M.E. Platt,

Rear Admiral, U.S. Coast Guard, Commander, Northeast Guard District.

[FR Doc. 2026–02690 Filed 2–10–26; 8:45 am]

BILLING CODE 9110–04–P

Proposed Rules

Federal Register

Vol. 91, No. 28

Wednesday, February 11, 2026

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.

FEDERAL DEPOSIT INSURANCE CORPORATION

12 CFR Part 303

RIN 3064–AG20

Approval Requirements for Issuance of Payment Stablecoins by Subsidiaries of FDIC-Supervised Insured Depository Institutions; Extension of Comment Period

AGENCY: Federal Deposit Insurance Corporation.

ACTION: Notice of proposed rulemaking; extension of comment period.

SUMMARY: On December 19, 2025, the Federal Deposit Insurance Corporation (FDIC) published in the **Federal Register** a notice of proposed rulemaking that would establish procedures to be followed by an insured State nonmember bank or State savings association (each, an FDIC-supervised institution) that seeks to obtain FDIC approval to issue payment stablecoins through a subsidiary pursuant to the Guiding and Establishing National Innovation for U.S. Stablecoins Act (GENIUS Act). The proposed rule provided for a 60-day comment period, which will close on February 17, 2026. The FDIC has determined that an extension of the comment period until May 18, 2026, is appropriate. This action will allow interested parties additional time to analyze the proposal and prepare comments.

DATES: The comment period for the document published at 90 FR 59409 (December 19, 2025) is extended. Comments must be received on or before May 18, 2026.

ADDRESSES: You may submit comments, identified by RIN 3064–AG20, by any of the following methods:

- **Agency Website:** <https://www.fdic.gov/resources/regulations/federal-register-publications>. Follow instructions for submitting comments on the agency website.

- **Email:** comments@fdic.gov. Include RIN 3064–AG20 in the subject line of the message.

- **Mail:** Jennifer M. Jones, Deputy Executive Secretary, Attention: Comments—RIN 3064–AG20, Federal Deposit Insurance Corporation, 550 17th Street NW, Washington, DC 20429.

- **Hand Delivery:** Comments may be hand-delivered to the guard station at the rear of the 550 17th Street NW Building (located on F Street) on business days between 7 a.m. and 5 p.m.

- **Public Inspection:** Comments received, including any personal information provided, may be posted without change to <https://www.fdic.gov/resources/regulations/federal-register-publications>. Commenters should submit only information that the commenter wishes to make available publicly. The FDIC may review, redact, or refrain from posting all or any portion of any comment that it may deem to be inappropriate for publication, such as irrelevant or obscene material. The FDIC may post only a single representative example of identical or substantially identical comments, and in such cases will generally identify the number of identical or substantially identical comments represented by the posted example. All comments that have been redacted, as well as those that have not been posted, that contain comments on the merits of the notice will be retained in the public comment file and will be considered as required under all applicable laws. All comments may be accessible under the Freedom of Information Act.

FOR FURTHER INFORMATION CONTACT:

With respect to the comment period extension: Chantal Hernandez, Counsel, (202) 898–7388, chhernandez@fdic.gov.

With respect to the notice of proposed rulemaking: Alfred L. Seivold, Acting Senior Deputy Director, (415) 808–8248, aseivold@fdic.gov, Division of Complex Institution Supervision and Resolution; Sandra Macias, Acting Associate Director, (202) 898–3642, smacias@fdic.gov, Division of Risk Management Supervision; Nicholas Simons, Counsel, (202) 898–6785, nsimons@fdic.gov, Chantal Hernandez, Counsel, (202) 898–7388, chhernandez@fdic.gov, Eugene Frenkel, Fin-Tech Counsel, (202) 898–3578, yfrenkel@fdic.gov, Legal Division.

SUPPLEMENTARY INFORMATION:

On December 19, 2025, the FDIC published in the **Federal Register** (90 FR 59409) a

notice of a proposed rule that would establish procedures for FDIC-supervised institutions seeking FDIC approval to issue payment stablecoins through a subsidiary pursuant to the GENIUS Act.¹ The proposed rule stated that the comment period would close on February 17, 2025. To provide additional time for the public to prepare comments to address the matters raised by the proposed rule, the FDIC is extending the comment period for the proposed rule from February 17, 2026, to May 18, 2026.

Federal Deposit Insurance Corporation.

Dated at Washington, DC, on February 6, 2026.

Jennifer M. Jones,

Deputy Executive Secretary.

[FR Doc. 2026–02665 Filed 2–10–26; 8:45 am]

BILLING CODE 6714–01–P

NATIONAL CREDIT UNION ADMINISTRATION

12 CFR Part 701

RIN 3133–AF78

Chartering and Field of Membership for Federal Credit Unions—Interpretive Rulings and Policy Statements

AGENCY: National Credit Union Administration (NCUA).

ACTION: Proposed rule.

SUMMARY: The NCUA Board proposes to rescind its Interpretative Ruling and Policy Statement 06–1 (IRPS 06–1). Rescinding IRPS 06–1 would ease the compliance burden on Federal credit unions (FCUs) by limiting the number of sources that FCUs must check to ensure compliance with applicable chartering and field of membership (FOM) requirements.

DATES: Comments must be received on or before April 13, 2026.

ADDRESSES: Comments may be submitted in one of the following ways. (Please send comments by one method only):

- **Federal eRulemaking Portal:** <https://www.regulations.gov/>. The docket number for the proposed IRPS rescission is NCUA–2026–0265. Follow the “Submit a comment” instructions. If you are reading this document on

¹ Public Law 119–27, 139 Stat. 419 (codified at 12 U.S.C. 5901–5916).

[federalregister.gov](https://www.federalregister.gov), you may use the green “SUBMIT A PUBLIC COMMENT” button beneath this rulemaking’s title to submit a comment to the [regulations.gov](https://www.regulations.gov) docket. A plain language summary of the proposed rescission is also available on the docket website.

- **Mail:** Address to Melane Conyers-Ausbrooks, Secretary of the Board, National Credit Union Administration, 1775 Duke Street, Alexandria, Virginia 22314–3428.

- **Hand Delivery/Courier:** Same as mailing address.

Mailed and hand-delivered comments must be received by the close of the comment period.

Public inspection: Please follow the search instructions on <https://www.regulations.gov> to view the public comments. Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are public records; they are publicly displayed exactly as received, and will not be deleted, modified, or redacted. Comments may be submitted anonymously. If you are unable to access public comments on the internet, you may contact the NCUA for alternative access by calling (703) 518–6540 or emailing OGCMail@ncua.gov.

FOR FURTHER INFORMATION CONTACT:

Keisha Brooks, Attorney-Advisor, Office of General Counsel, at (703) 518–6540 or at 1775 Duke Street, Alexandria, VA 22314.

SUPPLEMENTARY INFORMATION:

I. Introduction

A. Background

Since 1979, the NCUA Board (Board) has issued interpretive rulings and policy statements (IRPS) to address various generally applicable interpretive and policy matters in the **Federal Register**. The first NCUA IRPS was published in April 1979 to set forth the agency’s policy on how existing credit union service corporations could comply with the NCUA’s new credit union service organizations regulation.¹ The topics covered by IRPS have ranged from interpretations on FCU share accounts to guidelines for compliance with the federal Bank Bribery Act. In issuing IRPS, the Board has often, but not always, used notice-and-comment procedures comparable to those it uses for codified regulations. While the IRPS are not codified in the Code of Federal Regulations (CFR), the NCUA does make the currently effective IRPS available on

its public website at <https://ncua.gov/regulation-supervision/rules-regulations/interpretive-rulings-policy-statements>.

B. Legal Authority

Under the Federal Credit Union Act (the FCU Act), the NCUA is the chartering and supervisory authority for FCUs and the Federal supervisory authority for federally insured credit unions (FICUs).² The FCU Act grants the Board broad general rulemaking authority over FCUs and to govern their chartering and field of membership within the confines of the FCU Act.³ Section 120 of the FCU Act is a general grant of regulatory authority and authorizes the NCUA Board to prescribe rules and regulations for the administration of the FCU Act.⁴

The NCUA Board is issuing this proposed rule pursuant to its rulemaking authority under Section 109 of the FCU Act.⁵ Section 109 of the FCU Act establishes the chartering and field of membership (FOM) framework for FCUs.⁶ Section 109(d)(3) directs the Board to issue guidelines or regulations, after notice and opportunity for comment, setting forth the criteria that the Board will apply in determining under this subsection whether an additional group may be included within the FOM category of an existing multiple common bond FCU.⁷ Sections 109(a) and 109(f)(2)(E) reference more general rulemaking authority with respect to associational groups and FCU FOM.⁸ Pursuant to its authority under the FCU Act, the Board implements these statutory requirements through its Chartering and Field of Membership Manual, incorporated as Appendix B to part 701 of its regulations (Chartering Manual).⁹

II. Proposed Rule

In 1989, the Board issued its Chartering and Field of Membership Policy (IRPS 89–1), which consolidated FOM guidance.¹⁰ The Board also incorporated IRPS 89–1 by reference into § 701.1 of the NCUA’s regulations.¹¹ Over the years, the Board

periodically updated the Chartering Manual through IRPS and amended § 701.1 to reference the updated IRPS.¹² While copies of the IRPS were available to the public, the text of the IRPS did not appear in the CFR.¹³

In 2008, after notice and consideration of public comment, the Board issued a final rule publishing IRPS 08–2 as Appendix B to part 701.¹⁴ In 2010, the Board amended § 701.1 to remove references to IRPS 08–2 and establish Appendix B as the Chartering Manual.¹⁵ Accordingly, the Chartering Manual (as published in Appendix B to part 701) sets forth the NCUA’s current FOM policies and procedures.¹⁶ Because the current FOM rules are stated in the Chartering Manual, IRPS 06–1 is no longer necessary.

The Board proposes rescinding IRPS 06–1. In 2006, after a comprehensive review of its chartering policies and based upon the NCUA’s experience addressing field of membership issues, the Board issued IRPS 06–1 as a final rule amending its field of membership rules to limit underserved area additions to multiple common bond credit unions and to revise facility requirements for underserved areas.¹⁷ The current requirements for service to underserved areas are stated in Chapter 3 of the Chartering Manual.¹⁸ This proposed rescission would not add, remove, clarify, or otherwise change the substantive requirements already established in the FCU Act and the Chartering Manual.

The NCUA invites the public to review IRPS 06–1 and solicits comment on any issue, concern, or suggestion that the public may have regarding the proposed rescission. The NCUA seeks comments on any and all relevant issues concerning the proposed rescission. Since a copy of IRPS 06–1 is available to all FICUs on the NCUA’s public website, the IRPS has not been set out in full text in this proposal.¹⁹

¹² See IRPS 99–1, 63 FR 71998 (Dec. 30, 1998), as amended by IRPS 00–1, 65 FR 64512 (October 27, 2000) and IRPS 02–2, 67 FR 20013 (Apr. 24, 2002).

¹³ See e.g., IRPS 03–1, 68 FR 18334 (Apr. 15, 2003), as amended by IRPS 06–1, 71 FR 36667 (June 28, 2006).

¹⁴ 73 FR 73392, 73301 (Dec. 2, 2008).

¹⁵ 75 FR 36263 (June 25, 2010).

¹⁶ See 12 CFR part 701, App. B.

¹⁷ See 71 FR 36667 (June 28, 2006).

¹⁸ See 12 CFR part 701, App. B. Ch. 3, § III.

¹⁹ NCUA, Interpretive Rulings and Policy Statements, <https://ncua.gov/regulation-supervision/rules-regulations/interpretive-rulings-policy-statements> (page last visited October 1, 2025).

¹ 44 FR 21762 (Apr. 12, 1979).

² 12 U.S.C. 1752–1775.

³ 12 U.S.C. 1751, 1766(a), 1787(b)(1), 1789(a)(11).

⁴ 12 U.S.C. 1766(a).

⁵ 12 U.S.C. 1751 *et seq.*

⁶ 12 U.S.C. 1753(5), 1754, 1759.

⁷ 12 U.S.C. 1759.

⁸ 12 U.S.C. 1759.

⁹ 12 CFR part 701, App. B. The Chartering Manual addresses all aspects of chartering FCUs. In that respect, it is similar to the regulations of the Office of the Comptroller of the Currency applicable to the chartering of national banks or federal savings associations. 12 CFR part 5.

¹⁰ 54 FR 31165 (July 27, 1989).

¹¹ 12 CFR 701.1.

III. Regulatory Procedures

A. Providing Accountability Through Transparency Act of 2023

The Providing Accountability Through Transparency Act of 2023 (5 U.S.C. 553(b)(4)) requires that a notice of proposed rulemaking include the internet address of a summary of not more than 100 words in length of a proposed rule, in plain language, that shall be posted on the internet website under section 206(d) of the E-Government Act of 2002 (44 U.S.C. 3501 note) (commonly known as *regulations.gov*). The Act, under its terms, applies to notices of proposed rulemaking and does not expressly include other types of documents that the Board publishes voluntarily for public comment, such as notices and interim-final rules that request comment despite invoking “good cause” to forgo such notice and public procedure. The Board, however, has elected to address the Act’s requirement in these types of documents in the interests of administrative consistency and transparency.

In summary, the NCUA Board proposes to rescind its IRPS 06–1. Rescinding IRPS 06–1 would ease the compliance burden on FCUs and provide more valuable guidance by limiting the number of sources that FCUs must check to ensure compliance with applicable chartering and FOM requirements.

The proposal and the required summary can be found at <https://www.regulations.gov>.

B. Executive Orders 12866, 13563, and 14192

Pursuant to Executive Order 12866 (“Regulatory Planning and Review”), as amended by Executive Order 14215, a determination must be made whether a regulatory action is significant and therefore subject to review by the Office of Management and Budget (OMB) in accordance with the requirements of the Executive Order.²⁰ Executive Order 13563 (“Improving Regulation and Regulatory Review”) supplements and reaffirms the principles, structures, and definitions governing contemporary regulatory review established in Executive Order 12866.²¹ This proposed rule was drafted and reviewed in accordance with Executive Order 12866 and Executive Order 13563. OMB has determined that this proposed rule is not a “significant regulatory action” as defined in section 3(f)(1) of Executive Order 12866. Further, the proposal is

consistent with Executive Order 13563. The rescission should reduce confusion by focusing FCUs principally on applicable statutes and codified regulations.

Executive Order 14192 (“Unleashing Prosperity Through Deregulation”) requires that any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations.²² This proposed rule is expected to be a deregulatory action for purposes of Executive Order 14192.

C. Regulatory Flexibility Act

The Regulatory Flexibility Act²³ generally requires an agency to conduct a regulatory flexibility analysis of any rule subject to notice and comment rulemaking requirements, unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities. If the agency makes such a certification, it shall publish the certification at the time of publication of either the proposed rule or the final rule, along with a statement providing the factual basis for such certification.²⁴ For purposes of this analysis, the NCUA considers small credit unions to be those having under \$100 million in assets.²⁵ The Board fully considered the potential economic impacts of the regulatory amendments on small credit unions.

As discussed in this preamble, the proposed rescission is intended to ease the compliance burden on FCUs and provide more valuable guidance by limiting the number of sources that FCUs of all sizes must check to ensure compliance with laws and regulations. The rescission should also reduce confusion by focusing FCUs principally on applicable statutes and codified regulations. The proposed rescission would not impose any new requirements that would result in FCUs (irrespective of size) incurring an economic cost.

To the extent the proposed rescission has any economic impact it will be indirect, by reducing the staff time and other resources FCUs currently devote to checking potentially duplicative sources to ensure compliance with existing requirements codified in the Chartering Manual.

Accordingly, the NCUA certifies the proposed rule would not have a significant economic impact on a

substantial number of small credit unions.

D. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (PRA) generally provides that an agency may not conduct or sponsor, and not withstanding any other provision of law, a person is not required to respond to, a collection of information, unless it displays a currently valid Office of Management and Budget (OMB) control number.

The PRA applies to rulemakings in which an agency creates a new or amends existing information collection requirements. For purposes of the PRA, an information-collection requirement may take the form of a reporting, recordkeeping, or a third-party disclosure requirement. The NCUA has determined that the changes in the IRPS do not create a new information collection or revise an existing information collection as defined by the PRA.

E. Executive Order 13132 on Federalism

Executive Order 13132 encourages certain regulatory agencies to consider the impact of their actions on state and local interests. The NCUA, an agency as defined in 44 U.S.C. 3502(5), complies with the executive order to adhere to fundamental federalism principles. This proposed rescission would only affect FCUs. The proposed rescission would mainly clarify the existing regulations and guidance applicable solely to FCUs and are not intended to affect the division of responsibilities between the NCUA and state regulatory authorities with oversight of federally insured, state-chartered credit unions. The rulemaking would therefore not have direct effect on the states, the relationship between the national government and the states, or on the distribution of power and responsibilities among the various levels of government.

F. Assessment of Federal Regulations and Policies on Families

The NCUA has determined that this proposed rule would not affect family well-being within the meaning of section 654 of the Treasury and General Government Appropriations Act, 1999.²⁶ The proposed rescission relates only to duplicative chartering and field of membership requirements for FCUs, and any effect on family well-being is expected to be indirect.

²² 90 FR 9065 (Feb. 6, 2025).

²³ 5 U.S.C. 601 *et seq.*

²⁴ 5 U.S.C. 605(b).

²⁵ 80 FR 57512 (Sept. 24, 2015).

²⁶ Public Law 105–277, 112 Stat. 2681 (1998).

²⁰ 58 FR 51735 (Oct. 4, 1993).

²¹ 76 FR 3821 (Jan. 21, 2011).

List of Subjects in 12 CFR Part 701

Advertising, Aged, Civil rights, Credit, Credit unions, Fair housing, Individuals with disabilities, Insurance, Marital status discrimination, Mortgages, Religious discrimination, Reporting and recordkeeping requirements, Sex discrimination, Signs and symbols, Surety bonds.

By the National Credit Union Administration Board, this 9th day of February, 2026.

Melane Conyers-Ausbrooks,

Secretary of the Board.

[FR Doc. 2026-02765 Filed 2-10-26; 8:45 am]

BILLING CODE 7535-01-P

NATIONAL CREDIT UNION ADMINISTRATION

12 CFR Part 708a

RIN 3133-AG01

Bank Conversions and Mergers, Subpart A—Conversion of Insured Credit Unions to Mutual Savings Banks

AGENCY: National Credit Union Administration (NCUA)

ACTION: Proposed rule.

SUMMARY: The NCUA Board (Board) is proposing to amend its regulations governing the conversion of insured credit unions into banks. The NCUA Board proposes to eliminate certain prescriptive procedural, disclosure, and communication requirements. This action reduces unnecessary regulatory burdens and provides credit union boards of directors with greater flexibility to exercise their business judgment. The intended effect of these changes is to simplify compliance for credit unions, reduce administrative costs, and modernize the conversion process, while ensuring members receive clear and effective disclosures.

DATES: Comments must be received on or before April 13, 2026.

ADDRESSES: Comments may be submitted in one of the following ways. (Please send comments by one method only):

- *Federal eRulemaking Portal:* <https://www.regulations.gov>. The docket number for this proposed rule is NCUA-2026-0266. Follow the “Submit a comment” instructions. If you are reading this document on [federalregister.gov](https://www.federalregister.gov), you may use the green “SUBMIT A PUBLIC COMMENT” button beneath this rulemaking’s title to submit a comment to the [regulations.gov](https://www.regulations.gov) docket. A plain language summary of the proposed rule is also available on the docket website.

- *Mail:* Address to Melane Conyers-Ausbrooks, Secretary of the Board, National Credit Union Administration, 1775 Duke Street, Alexandria, Virginia 22314-3428.

- *Hand Delivery/Courier:* Same as mailing address.

Mailed and hand-delivered comments must be received by the close of the comment period.

Public inspection: Please follow the search instructions on <https://www.regulations.gov> to view the public comments. Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are public records; they are publicly displayed exactly as received and will not be deleted, modified, or redacted. Comments may be submitted anonymously. If you are unable to access public comments on the internet, you may contact the NCUA for alternative access by calling (703) 518-6540 or emailing OGCMail@ncua.gov.

FOR FURTHER INFORMATION CONTACT: Ariel Woodard-Stephens, Staff Attorney, Office of General Counsel, National Credit Union Administration, at 1775 Duke Street, Alexandria, Virginia, 22314 or by telephone at (703) 518-6540.

SUPPLEMENTARY INFORMATION:

I. Introduction

The Board proposes to amend its regulations at subpart A of 12 CFR part 708a, which governs bank conversions and mergers. The primary purpose of this proposed rule is to partially or wholly eliminate several sections within subpart A “Conversion of Insured Credit Unions to Mutual Savings Banks”. Under the authority of the Federal Credit Union Act (FCU Act), the regulations at part 708a establish a procedural framework for transactions that fundamentally alter a credit union’s charter or structure.

A. Background

The Board established regulations at 12 CFR part 708a, subpart A, in a final rule published in the **Federal Register** on December 22, 2006. 71 FR 77167. The original purpose of this subpart was to govern the process by which a federally insured credit union may convert to a mutual savings bank. Section 708a.101 provides the definitions for this part, including the term “clear and conspicuous”, a term used as a standard for the subsequent notice requirements in both subpart A and subpart C. Section 708a.103 provides credit union boards with

specific media to use for notice requirements before voting on a proposal to convert. Section 708a.104 imposes specific disclosure requirements that a credit union board must follow after complying with § 708a.103. Finally, § 708a.113 provides a set of non-binding voting guidelines to assist credit unions in conducting a fair and legal member vote, with suggestions covering state law applicability, member eligibility, and the use of voting incentives.

B. Legal Authority

The FCU Act grants the Board a broad mandate to issue regulations governing both federal credit unions and federally insured state-chartered credit unions. Section 120 of the FCU Act is a general grant of regulatory authority, and it authorizes the Board to prescribe rules and regulations for the administration of the FCU Act. Section 209 of the FCU Act is a plenary grant of regulatory authority to the NCUA to issue regulations necessary or appropriate to carry out its role as share insurer for all insured credit unions. Finally, the Board is required to issue regulations regarding the conversion of insured credit unions to mutual savings banks. 12 U.S.C. 1785(b)(2)(G).

II. Proposed Rule

A. Proposed Amendments To Reduce Regulatory Burden

The Board is proposing several amendments to subpart A of 12 CFR part 708a to reduce unnecessary regulatory burdens.

The Board proposes to eliminate several provisions that are overly prescriptive and impose burdens on a credit union’s board of directors during the initial phases of conversions. These changes are intended to restore the board’s role in exercising its fiduciary duties and business judgment while still ensuring that members receive clear and effective disclosures to make informed decisions.

The Board proposes to remove § 708a.101’s “clear and conspicuous” definition. This definition mandates specific formatting, such as bold type and a minimum 12-point font size. The Board believes this overly prescriptive definition is unnecessary and can hinder effective communication. It locks credit unions into a rigid standard that may not be optimal across different media, such as print and digital formats, and prevents them from using design principles that could more effectively draw member attention to key disclosures. While the FCU Act requires member notice, it is silent on specific

formatting. Removing this definition will allow credit unions the flexibility to design disclosures that are effective and clear for their members. The Board preliminarily believes this definition may be unnecessary and burdensome but requests public comment on this determination.

Section 708a.103(a)(1) requires newspaper notice of the proposed conversion, and that the notice be posted in the lobby of the credit union's home office and on the home page of the website in a "clear and conspicuous" fashion. The Board proposes to revise the subparagraph (a)(1) requirements. The requirement to publish notice in a newspaper may no longer be one of the more effective tools for communicating with members in the digital age and may impose unnecessary costs. The Board preliminarily believes these requirements are unduly burdensome and overly prescriptive. The Board requests public comment on these changes.

Section 708a.104 governs disclosures and communications to members following the credit union board of director vote on a proposed conversion. Subparagraph (d)(2) and paragraph (e) both provide prescriptive and detailed requirements that the Board now believes may be unduly burdensome. Subparagraph (d)(2) defines typographical requirements, which the Board proposes to remove. Subparagraph (e) currently requires communications to be written "in a manner that is simple and easy to understand. Simple and easy to understand means the communications are written in plain language . . ." This proposal would remove the last sentence providing examples. The definition of "plain language" provides a sufficient description. The Board requests public comment on these changes to reserve communication requirements for the discretion of credit union boards of directors.

Under § 708a.104(f), a member may ask a converting credit union's board to mail or email conversion-related materials to other members who are eligible to vote on the conversion. The credit union board must send the materials if the request is timely and the materials meet criteria specified in the regulation. The Board proposes to remove subparagraph (f)(5) regarding submission of member materials to the Regional Director within 7 days of receipt of the member request if the credit union believes the member request to be improper. The Board believes credit union management officials can determine when to consult a Regional Director, again reserving

communication requirements for the discretion of credit union boards of directors. The Board requests public comment on its proposal to remove this direction from subparagraph (f). Similarly, in subparagraph (f)(8), the Board proposes to remove direction for credit unions to send improper member materials to regional directors, the Board believes credit union management officials can determine improper submissions. The Board requests comments on these proposed changes.

B. Elimination of Non-Regulatory Guidance in Conversions

The Board's last proposal in this rulemaking is to remove non-regulatory guidance from § 708a.113's "Voting Guidelines" as it is non-binding and likely better suited as non-regulatory guidance. This section does not establish any mandatory requirements; rather, it explicitly states that its contents are "guidelines as suggestions to help a credit union obtain a fair and legal vote." It offers advice on matters such as the applicability of state law, determining voter eligibility, and scheduling meetings. While such guidance can be helpful, including it within the Code of Federal Regulations is inconsistent with the principles of good regulatory practice. Regulations should contain binding legal obligations, not suggestions.

Credit unions will still be required to conduct votes on conversions consistent with applicable law and regulation. However, the presence of non-binding guidance within a body of mandatory rules creates confusion for regulated entities, blurring the line between what is required and what is merely recommended. Removing this section will streamline the regulatory text and help credit unions to understand their legal duties. This action is supported by the fact that the provision itself acknowledges its advisory nature and, as such, it is not statutorily required to be included in the regulation. The Board seeks public comment on the proposed removal of § 708a.113. Specifically, the Board asks whether removing these non-binding guidelines from the regulation would improve clarity and whether providing this information through other, non-regulatory channels is necessary. The Board would remind credit unions they are still required to conduct votes on conversions consistent with applicable law and regulation.

III. Regulatory Procedures

A. Providing Accountability Through Transparency Act of 2023

The Providing Accountability Through Transparency Act of 2023 (5 U.S.C. 553(b)(4)) requires that a notice of proposed rulemaking include the internet address of a summary of not more than 100 words in length of a proposed rule, in plain language, that shall be posted on the internet website under section 206(d) of the E-Government Act of 2002 (44 U.S.C. 3501 note) (commonly known as *regulations.gov*). In summary, the Board proposes to eliminate certain prescriptive procedural, disclosure, and communication requirements. This action is necessary to reduce unnecessary regulatory burdens and provide credit union boards of directors with greater flexibility to exercise their business judgment. The intended effect of these changes is to simplify compliance for credit unions, reduce administrative costs, and modernize the conversion process, while ensuring members receive clear and effective disclosures. The proposal and the required summary can be found at <https://www.regulations.gov>.

B. Executive Order 12866, 13563, and 14192

Executive Order 14192 ("Unleashing Prosperity Through Deregulation") requires that any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations.¹ This proposed rule, if finalized as proposed, is not expected to be an Executive Order 14192 regulatory action. Pursuant to Executive Order 12866 ("Regulatory Planning and Review"), a determination must be made whether a regulatory action is significant and therefore subject to review by the Office of Management and Budget (OMB) in accordance with the requirements of the executive order.² Executive Order 13563 ("Improving Regulation and Regulatory Review") supplements and reaffirms the principles, structures, and definitions governing contemporary regulatory review established in Executive Order 12866.³

This proposed rule was drafted and reviewed in accordance with Executive Order 12866 and Executive Order 13563. Analysis by the NCUA indicates the proposed amendments to modernize

¹ 90 FR 9065 (Feb. 6, 2025).

² 58 FR 51735 (Oct. 4, 1993).

³ 76 FR 3821 (Jan. 21, 2011).

the conversion process do not collectively qualify as a “significant regulatory action” under E.O. 12866. The NCUA expects the proposed rule to produce only modest cost savings (at best). Moreover, the aggregate impact on the credit-union sector, market for depository-institution services, and macro-economy should prove modest. Based on DCE analysis, the NCUA expects this proposed rule, if adopted, to marginally reduce the transactions costs of conversions. OMB has determined that this proposed rule is not a “significant regulatory action” as defined in section 3(f) of Executive Order 12866.

C. The Regulatory Flexibility Act

The Regulatory Flexibility Act⁴ generally requires an agency to conduct a regulatory flexibility analysis of any rule subject to notice and comment rulemaking requirements, unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities. If the agency makes such a certification, it shall publish the certification at the time of publication of either the proposed rule or the final rule, along with a statement providing the factual basis for such certification.⁵ For purposes of this analysis, the NCUA considers small credit unions to be those having under \$100 million in assets.⁶ The Board fully considered the potential economic impacts of the regulatory amendments on small credit unions. Analysis by the NCUA indicates that, if finalized, these proposed amendments will not adversely and disproportionately burden small FICUs under the RFA.

Accordingly, the NCUA certifies the proposed rule would not have a significant economic impact on a substantial number of small credit unions.

D. The Paperwork Reduction Act of 1995

The Paperwork Reduction Act of 1995 (PRA) generally provides that an agency may not conduct or sponsor, and not withholding any other provision of law, a person is not required to respond to, a collection of information, unless it displays a currently valid OMB control number.⁷ For purposes of the PRA, an information-collection requirement may take the form of a reporting, recordkeeping, or a third-party disclosure requirement. This rule does

not propose to revise an existing information collection.

E. Executive Order 13132 on Federalism

Executive Order 13132 encourages certain regulatory agencies to consider the impact of their actions on state and local interests. The NCUA, an agency as defined in 44 U.S.C. 3502(5), complies with the executive order to adhere to fundamental federalism principles. The proposed rule does not have substantial direct effects 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. The proposed rule would remove targeted prescriptive requirements that apply to converting federally insured credit unions, including federally insured, state-chartered credit unions. The proposal would not change the fundamental requirement to notify members or impose new requirements on state-chartered credit unions or state regulatory agencies. The NCUA has therefore determined that this proposed rule will not constitute a policy that has federalism implications for purposes of the executive order.

F. Assessment of Federal Regulations and Policies on Families

The NCUA has determined that this rule will not affect family well-being within the meaning of § 654 of the Treasury and General Government Appropriations Act.⁸ The proposed rule would apply to notices provided to consumers but is not intended to change fundamental member rights. Therefore, any effect on family well-being, including financial well-being, is expected to be indirect, at most.

List of Subjects in 12 CFR Part 708a

Bank deposit insurance, credit unions, Reporting and recordkeeping requirements.

By the National Credit Union Administration Board, this 9th day of February, 2026.

Melane Conyers-Ausbrooks,
Secretary of the Board.

For the reasons set forth in the preamble, the NCUA Board proposes to amend 12 CFR part 708a as follows:

PART 708a—Bank Conversions and Mergers

■ 1. The authority citation for part 708a continues to read as follows:

Authority: 12 U.S.C. 1766, 1785(b), and 1785(c).

§ 708a.101. [Amended]

■ 2. Amend § 708a.101 by removing “*Clear and conspicuous* means text in bold type in a font size at least one size larger than any other text used in the document (exclusive of headings), but in no event smaller than 12 point.”

§ 708a.103. [Amended]

■ 3. Revise and publish § 708a.103(a)(1) as:

No later than 30 days before a board of directors votes on a proposal to convert, it must publish a notice in a clear and conspicuous fashion in the lobby of the credit union’s home and branch offices and on the credit union’s website, and a member’s home banking landing page, if it has one. If the notice is not on the home page of the website, the home page must have a clear and conspicuous link to the notice, visible on a standard monitor without scrolling, to the notice.

§ 708a.104. [Amended]

■ 4. Revise § 708a.104 by:
■ a. Removing and reserving paragraph (d)(2);
■ b. Removing the last sentence of paragraph (e);
■ c. Removing paragraph (f)(5);
■ d. Redesignating subparagraph (f)(6) through (10) as subparagraph (f)(5) through (9) respectively; and
■ e. In newly redesignated subparagraph (f)(7), delete the third sentence.

The revisions read as follows:

§ 708a.104 Disclosures and communications to members.

* * * * *

(d)

(1) * * *

(2) [Removed and Reserved]

(e) All written communications from a converting credit union to its members regarding the conversion must be written in a manner that is simple and easy to understand. Simple and easy to understand means the communications are written in plain language designed to be understood by ordinary consumers, and use clear and concise sentences, paragraphs, and sections.

(f)

(1) * * *

(2) * * *

(3) * * *

(4) * * *

(5) A credit union must ensure that its members receive all materials that meet the requirements of on or before the date the members receive the 30-day notice and associated ballot. If a credit union cannot meet this delivery requirement, it must postpone mailing the 30-day notice until it can deliver the member materials. If a credit union postpones

⁴ 5 U.S.C. 601 *et seq.*

⁵ 5 U.S.C. 605(b).

⁶ 80 FR 57512 (Sept. 24, 2015).

⁷ 44 U.S.C. 3501–3520; 5 CFR part 1320.

⁸ Public Law 105–277, 112 Stat. 2681 (1998).

the mailing of the 30-day notice, it must also postpone the special meeting by the same number of days. When the credit union has completed the delivery, it must inform the requesting member that the delivery was completed and provide the number of recipients.

(6) The term “appropriate advance payment” means:

(i) For requests to mail materials to all eligible voters, a payment in the amount of 150 percent of the first class postage rate times the number of mailings, and

(ii) For requests to email materials only to members that have agreed to accept electronic communications, a payment in the amount of 200 dollars.

(7) If a credit union posts conversion-related information or material on its website, then it must simultaneously make a portion of its website available free of charge to its members to post and share their opinions on the conversion. A link to the portion of the website available to members to post their views on the conversion must be marked “Members: Share your views on the proposed conversion and see other members views” and the link must also be visible on all pages on which the credit union posts its own conversion-related information or material, as well as on the credit union’s homepage. The credit union may also post a content-neutral disclaimer using language similar to the language in paragraph (f)(3)(i) of this section.

(8) A converting credit union must inform members with the 90-day notice that if they wish to provide their opinions about the proposed conversion to other members, they can submit their opinions in writing to the credit union no later than 35 days from the date of the notice and the credit union will forward those opinions to other members. The 90-day notice will provide a contact at the credit union for delivery of communications, will explain that members must agree to reimburse the credit union’s costs of transmitting the communication including providing an advance payment, and will refer members to this section of NCUA’s regulations for further information about the communication process. The credit union, at its option, may include additional factual information about the communication process with its 90-day notice.

(9) A group of members may make a joint request that the credit union send its materials to other members. For purposes of paragraphs (f)(2) and (f)(3) of this section, the credit union will use the name provided by the group.

§ 708a.113 [Removed]

■ 5. Remove § 708a.113.

[FR Doc. 2026–02763 Filed 2–10–26; 8:45 am]

BILLING CODE P

NATIONAL CREDIT UNION ADMINISTRATION

12 CFR Part 708b

RIN 3133–AG03

Mergers of Insured Credit Unions Into Other Credit Unions; Voluntary Termination or Conversion of Insured Status

AGENCY: National Credit Union Administration (NCUA).

ACTION: Proposed rule.

SUMMARY: The NCUA Board (Board) proposes to amend its regulations governing the voluntary termination of federal share insurance to streamline member communication requirements. This action is necessary to reduce regulatory burden by eliminating overly prescriptive formatting rules for the mandatory disclosure statement that credit unions must provide to members. The intended effect is to simplify compliance and provide credit unions with greater flexibility in designing effective communications, while still ensuring that members receive clear and prominent notice of a proposed termination of federal insurance.

DATES: Comments must be received on or before April 13, 2026.

ADDRESSES: Comments may be submitted in one of the following ways. (*Please send comments by one method only*):

- **Federal eRulemaking Portal:** <https://www.regulations.gov>. The docket number for this proposed rule is NCUA–2026–0267. Follow the “Submit a comment” instructions. If you are reading this document on [federalregister.gov](https://www.federalregister.gov), you may use the green “SUBMIT A PUBLIC COMMENT” button beneath this rulemaking’s title to submit a comment to the [regulations.gov](https://www.regulations.gov) docket. A plain language summary of the proposed rule is also available on the docket website.

- **Mail:** Address to Melane Conyers-Ausbrooks, Secretary of the Board, National Credit Union Administration, 1775 Duke Street, Alexandria, Virginia 22314–3428.

- **Hand Delivery/Courier:** Same as mailing address.

Mailed and hand-delivered comments must be received by the close of the comment period.

Public inspection: Please follow the search instructions on [https://](https://www.regulations.gov)

www.regulations.gov to view the public comments. Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are public records; they are publicly displayed exactly as received and will not be deleted, modified, or redacted. Comments may be submitted anonymously. If you are unable to access public comments on the internet, you may contact the NCUA for alternative access by calling (703) 518–6540 or emailing OGCMail@ncua.gov.

FOR FURTHER INFORMATION CONTACT:

Ariel Woodard-Stephens, Staff Attorney, Office of General Counsel, National Credit Union Administration, at (703) 518–6540 or at 1775 Duke Street, Alexandria, Virginia 22314.

SUPPLEMENTARY INFORMATION:

I. Introduction

A. Background

Under its authority in the Federal Credit Union Act (FCU Act), 12 U.S.C. 1766, the Board issues regulations governing mergers and changes in insured status. NCUA regulations part 708b governs mergers of insured credit unions and the voluntary termination or conversion of insured status, and is comprised of subparts A and B. Subpart A prescribes the process for merging one or more credit unions, while subpart B prescribes the procedures and detailed notice requirements for a federally insured credit union (FICU) to voluntarily terminate its federal share insurance or convert to nonfederal insurance.

The primary purpose of these subparts was to ensure credit union members are fully and accurately informed ahead of proposed mergers and before voting on whether to convert from federal insurance to nonfederal insurance. The regulations are intended to provide members with adequate notice and time to respond to proposed mergers and the necessary protections and disclosures to make an informed decision about their insured funds. The Board is proposing targeted amendments to its regulations at §§ 708b.106(d)–(e), 708b.206(b)(2), and 708b.206(c)(2), which govern member-to-member (MTM) communications and share insurance communications to streamline requirements while maintaining essential member protections.

B. Legal Authority

The FCU Act grants the Board a broad mandate to issue regulations governing

both insured federal and state-chartered credit unions. Section 120 of the FCU Act is a general grant of regulatory authority, and it authorizes the Board to prescribe rules and regulations for the administration of the FCU Act. Section 209 of the FCU Act is a plenary grant of regulatory authority to the NCUA to issue the regulations necessary or appropriate to carry out its role as share insurer for all insured credit unions.

II. Proposed Rule

A. § 708b.106

Section 708b.106 requires notice of the vote on a proposed merger at least 45 calendar days before the member meeting takes place, and describes what the member communication package must include. Paragraph (d) established a mechanism for MTM communications. These requirements are meant to ensure reasonable MTM communication in advance of a proposed merger. The Board believes the goal of ensuring reasonable member notice of mergers is achieved through the provisions of paragraphs (a) through (c) and seeks to remove requirements in paragraphs (d) and (e). These two provisions define a mechanism for members to submit comments to the NCUA about the merger, and for the NCUA to post member comments received in response to the member notification on a website accessible to credit union members. In 2024, only 34 of the 143 mergers received a comment.¹ Given its infrequent public use, the Board proposes to discontinue the requirement as described in § 708b.106(d) and (e).

As the Board proposes to remove its requirement to post member comments, criteria for the posting of said comments in paragraph (e) are no longer necessary and would also be removed. The Board requests public comments on these proposed changes.

B. § 708b.206

On December 28, 2010, the Board issued a final rule that, among other things, amended certain procedures applicable to share insurance conversions to better protect the integrity of the member voting process.² The NCUA regulations at § 708b.206 set forth specific provisions governing member communications about any impending vote. The Board revised the specific disclosure language required by section 708b.206(b) to ensure members received a more explicit warning about

the loss of the federal guarantee. To ensure members receive clear and accurate information, sections 708b.206(b) and (c) mandate that every communication concerning an insurance conversion or termination, respectively, must contain a conspicuous statement.

This required statement informs members that their accounts are currently insured by the NCUA, a federal agency, and that this insurance is backed by the full faith and credit of the United States government. The statement further clarifies that, if the credit union converts to private insurance or terminates its federal insurance and then fails, the federal government does not guarantee the member will get its money back. The regulations require this disclosure to be prominent, mandating that it appear on the first page of the communication and be printed in capital letters, bolded, offset by a border, and in a font size at least one size larger than other text.

This proposal focuses on eliminating overly prescriptive formatting mandates that may impose unnecessary burdens on credit unions. Section 206 of the FCU Act³ requires credit unions to provide members with “prompt and reasonable notice” of a vote on insurance termination. The Board has preliminarily determined that the prescriptive provisions within this part are unnecessarily burdensome. By removing these prescriptive elements, the regulation will be better aligned with the statutory focus on the substantive goal of effective notice. The requirement for a “conspicuous” statement is a sufficient guideline for credit unions to follow, ensuring critical information reaches members without imposing excessive and statutorily unsupported formatting rules. The Board invites public comment on this proposed change. Specifically, the Board seeks feedback on whether the remaining requirement for the disclosure to be “conspicuous” and earlier clarification that the conspicuous statement must appear on the first page of the communication where conversion is discussed are sufficient to ensure members receive prominent and effective notice regarding the termination of federal insurance. Commenters are also invited to suggest alternative approaches that could achieve this objective without being overly prescriptive.

The Board also proposes to amend § 708b.206(c)(2) by removing the specific formatting requirements for the mandatory disclosure statement in

communications about the termination of federal share insurance. Currently, this provision requires the disclosure to be in capital letters, bolded, offset by a border, and at least one font size larger than other text. While the Board remains committed to ensuring members receive clear and prominent notice about the significant consequences of terminating federal insurance, it has preliminarily determined that these rigid formatting rules are unnecessarily prescriptive.

The Board believes that the core goal of this provision is ensuring the disclosure is genuinely conspicuous and effectively communicates the loss of the federal guarantee, rather than adherence to a specific typographical checklist. The Board believes removing these prescriptive requirements and earlier clarification that the statement must appear on the first page of the communication where conversion is discussed does not undermine member protection but will lift undue operational burdens, including on communication design. The Board invites public comment on this proposed change. Specifically, the Board seeks feedback on whether the remaining requirement for the disclosure to be “conspicuous” is sufficient to ensure members receive prominent and effective notice when federal insurance will be terminated. Commenters are also invited to suggest alternative approaches that could achieve this objective without being overly prescriptive.

III. Regulatory Procedures

A. Providing Accountability Through Transparency Act of 2023

The Providing Accountability Through Transparency Act of 2023⁴ requires that a notice of proposed rulemaking include the internet address of a summary of not more than 100 words in length of a proposed rule, in plain language, that shall be posted on the internet website under section 206(d) of the E-Government Act of 2002⁵ (commonly known as *regulations.gov*).

In summary, this rule proposes to amend regulations governing the voluntary termination of federal share insurance to streamline member communication requirements. The intended effect is to simplify compliance and provide credit unions with greater flexibility in designing effective communications, while still ensuring that members receive clear and

¹ See <https://ncua.gov/support-services/credit-union-resources-expansion/credit-union-merger-resources/comments-proposed-credit-union-mergers>.

² 75 FR 81378.

³ 12 U.S.C. 1786.

⁴ 5 U.S.C. 553(b)(4).

⁵ 44 U.S.C. 3501 note.

prominent notice of a proposed termination of federal insurance.

The proposal and the required summary can be found at <https://www.regulations.gov>.

B. Executive Order 12866, 13563, and 14192

Pursuant to Executive Order 12866 (“Regulatory Planning and Review”), a determination must be made whether a regulatory action is significant and therefore subject to review by the Office of Management and Budget (OMB) in accordance with the requirements of the Executive Order.⁶ Executive Order 13563 (“Improving Regulation and Regulatory Review”) supplements and reaffirms the principles, structures, and definitions governing contemporary regulatory review established in Executive Order 12866.⁷

OMB has determined that this proposed rule is not a “significant regulatory action” as defined in section 3(f)(1) of Executive Order 12866.

Analysis by the NCUA indicates these proposed changes collectively do not qualify as a “significant regulatory action” under Executive Order 12866. This rule proposes to amend two regulations that govern communication about pending credit-union mergers, specifically (i) a directive requiring the NCUA to post merger-related comments received from members of participating FICUs and (ii) a mandate prescribing the content/style of every FICU communication with members about the loss of federal insurance. Both amendments are designed to relax these dictates to trim merger costs.

A majority of voting members must approve a voluntary credit-union merger. Before that vote, any member (or collection of members) of a merging FICU may send comments to the NCUA. Section 708b.106(d) in Subpart A requires the agency to post these comments on a website accessible to all members.⁸ However, since adoption of this rule in October 2018, comment volume has been low. In 2024, for example, the NCUA received member feedback on only 24 percent of mergers.⁹ The paucity of comments

strongly suggests affected parties have put little value on agency efforts to circulate their views. Accordingly, the proposed rule eliminates all mention of such posting in § 708.106.

The Board expects this proposed rule, if adopted, would marginally reduce the transactions costs of mergers for both the agency and participating FICUs. That said, in recent years, the annual number of unassisted mergers involving at least one FICU has been relatively low. In 2024, there were 138; from 2020 through 2024 that number ranged from 138 to 162.¹⁰ Moreover, mergers between privately insured credit unions and FICUs are rare—particularly ones that threaten some members with loss of federal coverage. Indeed, fewer than 130 U.S. credit unions currently operate with private insurance. For this reason, the NCUA expects the proposed rule to produce only modest cost savings (at best). Finally, the aggregate impact on the credit-union sector, market for depository-institution services, and macro-economy should prove modest as well.

Executive Order 14192 (“Unleashing Prosperity Through Deregulation”) requires that any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations.¹¹ This proposed rule, if finalized as proposed, is not expected to be a deregulatory action for purposes of Executive Order 14192.

C. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) generally requires an agency to conduct a regulatory flexibility analysis of any rule subject to notice and comment rulemaking requirements, unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities.¹² If the agency makes such a certification, it shall publish the certification at the time of publication of either the proposed rule or the final rule, along with a statement providing the factual basis for such certification.¹³ For purposes of this analysis, the NCUA considers small credit unions to be those having under \$100 million in assets.¹⁴ The Board fully considered the potential economic impacts of the regulatory amendments on small credit unions. Small credit unions should

enjoy a small benefit in mergers because of their limited resources for communicating with members. Ultimately, analysis by the NCUA indicates the proposed amendments to modernize the conversion process should not adversely or disproportionately affect small credit unions.

D. The Paperwork Reduction Act of 1995

The Paperwork Reduction Act of 1995 (PRA) generally provides that an agency may not conduct or sponsor, and not withstanding any other provision of law, a person is not required to respond to, a collection of information, unless it displays a currently valid Office of Management and Budget control number.¹⁵ The PRA applies to rulemakings in which an agency creates a new or revises existing information collection requirements. For purposes of the PRA, an information-collection requirement may take the form of a reporting, recordkeeping, or a third-party disclosure requirement. The NCUA has determined that the changes addressed in this notice do not create a new information collection or revise an existing information collection as defined by the PRA.

E. Executive Order 13132 on Federalism

Executive Order 13132 encourages certain agencies to consider the impact of their actions on state and local interests. The NCUA, an agency as defined in 44 U.S.C. 3502(5), complies with the executive order to adhere to fundamental federalism principles. The proposed rule does not have substantial direct effects 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. The proposed rule would remove targeted prescriptive requirements that apply to converting federally insured credit unions, including federally insured, state-chartered credit unions. But the proposal would not change the fundamental requirements of member notice or impose new requirements on state-chartered credit unions or state regulatory agencies. The NCUA has therefore determined that this proposed rule will not constitute a policy that has federalism implications for purposes of the executive order.

⁶ 58 FR 51735 (Oct. 4, 1993).

⁷ 76 FR 3821 (Jan. 21, 2011).

⁸ Section 708b.106(e) gives the NCUA discretion to refrain from publishing certain types of comments such as those that misrepresent/omit key facts, involve personal claims/grievances, address matters unrelated to the merger, etc.

⁹ As part of regulatory reform efforts begun in 2017 (and consistent with the spirit of Executive Order 14219), the NCUA is working to identify redundant, confusing, outdated, low value, or unnecessarily onerous regulations. This review flagged both Sections 708b.106 and 206 for amendment.

¹⁰ For perspective, the number of FICUs at year-end 2024 was 4,455.

¹¹ 90 FR 9065 (Feb. 6, 2025).

¹² 5 U.S.C. 601 *et seq.*

¹³ 5 U.S.C. 605(b).

¹⁴ 80 FR 57512 (Sept. 24, 2015).

¹⁵ 44 U.S.C. 3501–3520; 5 CFR part 1320.

F. Assessment of Federal Regulations and Policies on Families

The NCUA has determined that this rule will not affect family well-being within the meaning of § 654 of the Treasury and General Government Appropriations Act.¹⁶ The proposed rule would apply to notices provided to consumers but is not intended to change fundamental member rights. Therefore, any effect on family well-being, including financial well-being, is expected to be indirect, at most.

List of Subjects in 12 CFR Part 708b

Bank deposit insurance, Credit unions, Reporting and recordkeeping requirements.

By the National Credit Union Administration Board, this 9th day of February, 2026.

Melane Conyers-Ausbrooks,
Secretary of the Board.

For the reasons stated in the preamble, the NCUA Board proposes to amend 12 CFR part 708b to read as follows:

PART 708b—MERGERS OF INSURED CREDIT UNIONS INTO OTHER CREDIT UNIONS; VOLUNTARY TERMINATION OR CONVERSION OF INSURED STATUS

The authority citation for part 708b continues to read as follows:

Authority: 12 U.S.C. 1752(7), 1766, 1785, 1786, 1789.

§ 708b.106 [Amended]

- 1. Revise § 708b.106 by:
 - a. Removing the last sentence of paragraph (d);
 - b. Removing paragraph (e); and
 - c. Redesignating paragraphs (f) through (g) as paragraphs (e) through (f) respectively.
- 2. Revise and republish § 708b.206 to read as follows:

§ 708b.206 Share insurance communications to members.

* * * * *

(b) Every share insurance communication must contain the following conspicuous statement on the first page of the communication where conversion is discussed: “IF YOU ARE A MEMBER OF THIS CREDIT UNION, YOUR ACCOUNTS ARE CURRENTLY INSURED BY THE NATIONAL CREDIT UNION ADMINISTRATION, A FEDERAL AGENCY. THIS FEDERAL INSURANCE IS BACKED BY THE FULL FAITH AND CREDIT OF THE UNITED STATES GOVERNMENT. IF THE CREDIT UNION CONVERTS TO

PRIVATE INSURANCE WITH [insert name of private share insurer] AND THE CREDIT UNION FAILS, THE FEDERAL GOVERNMENT DOES NOT GUARANTEE THAT YOU WILL GET YOUR MONEY BACK.” If the communication is on an internet website posting, the credit union must make reasonable efforts to make it visible without scrolling.

(c) Every share insurance communication about share insurance termination must contain the following conspicuous statement on the first page of the communication where termination is discussed: “IF YOU ARE A MEMBER OF THIS CREDIT UNION, YOUR ACCOUNTS ARE CURRENTLY INSURED BY THE NATIONAL CREDIT UNION ADMINISTRATION, A FEDERAL AGENCY. THIS FEDERAL INSURANCE IS BACKED BY THE FULL FAITH AND CREDIT OF THE UNITED STATES GOVERNMENT. IF THE CREDIT UNION TERMINATES ITS FEDERAL INSURANCE AND THE CREDIT UNION FAILS, THE FEDERAL GOVERNMENT DOES NOT GUARANTEE THAT YOU WILL GET YOUR MONEY BACK.” If the communication is on an internet website posting, the credit union must make reasonable efforts to make it visible without scrolling.

* * * * *

[FR Doc. 2026–02764 Filed 2–10–26; 8:45 am]

BILLING CODE 7535–01–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2026–0745; Project Identifier AD–2025–01574–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 757–200 and –200CB series airplanes. This proposed AD was prompted by an evaluation of the design approval holder (DAH) indicating that the inner skin of the lap splices, at the lower fastener row, is subject to widespread fatigue damage (WFD). This proposed AD would require an inspection or a maintenance records check for any

existing repair of certain fuselage skin panels, 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 March 30, 2026.

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](https://www.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](https://www.regulations.gov) under Docket No. FAA–2026–0745; 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 Westminister 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](https://www.regulations.gov) under Docket No. FAA–2026–0745.

FOR FURTHER INFORMATION CONTACT: Wayne Ha, Aviation Safety Engineer, FAA, 2200 South 216th St., Des Moines, WA 98198; phone: 562–627–5238; email: wayne.ha@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–2026–0745; Project Identifier AD–2025–01574–T” at the beginning of your comments. The most helpful comments reference a specific

¹⁶ Public Law 105–277, 112 Stat. 2681 (1998).

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](https://www.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 Wayne Ha, Aviation Safety Engineer, FAA, 2200 South 216th St., Des Moines, WA 98198; phone: 562-627-5238; email: wayne.ha@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

Fatigue damage can occur locally, in small areas or structural design details, or globally, in widespread areas. Multiple-site damage is widespread damage that occurs in a large structural element such as a single rivet line of a lap splice joining two large skin panels. Widespread damage can also occur in multiple elements such as adjacent frames or stringers. Multiple-site damage and multiple-element damage cracks are typically too small initially to be reliably detected with normal inspection methods. Without intervention, these cracks will grow and eventually compromise the structural integrity of the airplane. This condition is known as WFD. It is associated with general degradation of large areas of

structure with similar structural details and stress levels. As an airplane ages, WFD will likely occur, and will certainly occur if the airplane is operated long enough without any intervention.

An FAA final rule ("Aging Airplane Program: Widespread Fatigue Damage;" 75 FR 69746, November 15, 2010) became effective on January 14, 2011, and amended 14 CFR parts 25, 26, 121, and 129 (commonly known as the WFD rule). The WFD rule requires certain actions to prevent structural failure due to WFD throughout the operational life of certain existing transport category airplanes and all these airplanes that will be certificated in the future. DAHs of existing and future airplanes subject to the WFD rule are required to establish a limit of validity (LOV) of the engineering data that supports the structural maintenance program. Operators affected by the WFD rule may not fly an airplane beyond its LOV, unless an extended LOV is approved.

The WFD rule does not require identifying and developing maintenance actions if the DAHs can show that such actions are not necessary to prevent WFD before the airplane reaches the LOV. Many LOVs, however, do depend on accomplishment of future maintenance actions. As stated in the WFD rule, any maintenance actions necessary to reach the LOV will be mandated by airworthiness directives through separate rulemaking actions.

In the context of WFD, this action is necessary to enable DAHs to propose LOVs that allow operators the longest operational lives for their airplanes and still ensure that WFD will not occur. This approach allows for an implementation strategy that provides flexibility to DAHs in determining the timing of service information development (with FAA approval), while providing operators with certainty regarding the LOV applicable to their airplanes.

The FAA has received an evaluation by the DAH indicating that the inner skin of the lap splices, at the lower fastener row, is subject to WFD. The inner skin in the lap splice lower fastener row at various fuselage lap splice locations in Sections 43 and 46 is susceptible to scratches, which may develop into cracks and potentially interact with multi-site damage. The unsafe condition, if not addressed, could result in accelerated crack growth rate, which may result in the inability of a principal structural element to sustain limit load and lead to a decompression event.

For airplanes with 60,000 total flight cycles or more, existing inspections alone at the S-14 lap splices are inadequate to ensure the safety of the fleet. The on-condition actions (*i.e.*, the modification or replacement) specified in Boeing Alert Requirements Bulletin 757-53A0109 RB, dated September 25, 2025, provide final mitigating action to the airplane level safety issue for those airplanes.

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 757-53A0109 RB, dated September 25, 2025. This material specifies procedures for a general visual inspection (GVI) or a maintenance records check for any existing repair of the fuselage skin panels between stringers S-14 and S-19, from station (STA) 439 to STA 661, and between stringers S-14 and S-20, from STA 1180 or STA 1459 (depending on configuration) to STA 1621, and applicable on-condition actions. On-condition actions include obtaining and following alternative modification instructions and replacing the applicable fuselage skin panels or bond assemblies.

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 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](https://www.regulations.gov) under Docket No. FAA-2026-0745.

Costs of Compliance

The FAA estimates that this AD, if adopted as proposed, would affect 320 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 or records check	6 work-hours × \$85 per hour = \$510	\$0	\$510	\$163,200

The FAA estimates the following costs to do any necessary 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 these replacements:

ON-CONDITION COSTS

Action	Labor cost	Parts cost	Cost per product
Panels or Bond Assemblies Replacement	Up to 1,360 work-hours × \$85 per hour = \$115,600 ...	*\$	\$115,600

* The FAA has received no definitive data on which to base parts cost.

The FAA has received no definitive data on which to base the cost estimates for the on-condition alternative modification instructions specified in this proposed AD.

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–2026–0745; Project Identifier AD–2025–01574–T.

(a) Comments Due Date

The FAA must receive comments on this airworthiness directive (AD) by March 30, 2026.

(b) Affected ADs

None.

(c) Applicability

This AD applies to The Boeing Company Model 757–200 and –200CB series airplanes, certificated in any category, as identified in Boeing Alert Requirements Bulletin 757–53A0109 RB, dated September 25, 2025.

(d) Subject

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

(e) Unsafe Condition

This AD was prompted by an evaluation by the design approval holder (DAH) indicating that the inner skin of the lap splices, at the lower fastener row, is subject to widespread fatigue damage (WFD). The FAA is issuing this AD to address scratches that can grow into scratch cracks, which could interact with multi-site damage. This condition, if not addressed, could result in accelerated crack growth rate, which may result in the inability of a principal structural element to sustain limit load and lead to a decompression event.

(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 757–53A0109 RB, dated September 25, 2025, do all applicable actions identified in, and in accordance with, the Accomplishment Instructions of Boeing Alert Requirements Bulletin 757–53A0109 RB, dated September 25, 2025.

Note 1 to paragraph (g): Guidance for accomplishing the actions required by this AD can be found in Boeing Alert Service Bulletin 757–53A0109, dated September 25, 2025, which is referred to in Boeing Alert Requirements Bulletin 757–53A0109 RB, dated September 25, 2025.

(h) Exceptions to Requirements Bulletin Specifications

(1) Where the Compliance Time columns of the tables in the "Compliance" paragraph of Boeing Alert Requirements Bulletin 757–53A0109 RB, dated September 25, 2025, refer to the original issue date of Requirements Bulletin 757–53A0109 RB, this AD requires using the effective date of this AD.

(2) Where Boeing Alert Requirements Bulletin 757–53A0109 RB, dated September 25, 2025, specifies contacting Boeing for alternative modification instructions: This AD requires doing the alternative modification instructions and applicable on-condition actions using a method approved

in accordance with the procedures specified in paragraph (i) 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 Continued Operational Safety Branch, send it to the attention of the person identified in paragraph (j) of this AD. Information may be emailed to: AMOC@faa.gov. Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the responsible Flight Standards Office.

(2) 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) Additional Information

For more information about this AD, contact Wayne Ha, Aviation Safety Engineer, FAA, 2200 South 216th St., Des Moines, WA 98198; phone: 562-627-5238; email: wayne.ha@faa.gov.

(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 757-53A0109 RB, dated September 25, 2025.

(ii) [Reserved]

(3) For Boeing material identified in this AD, contact Boeing Commercial Airplanes, Attention: Contractual & Data Services (C&DS), 2600 Westminister 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 February 9, 2026.

Peter A. White,

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

[FR Doc. 2026-02736 Filed 2-10-26; 8:45 am]

BILLING CODE 4910-13-P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA-2025-4674; Airspace Docket No. 25-AWA-8]

RIN 2120-AA66

Establishment of Class D and Class E Airspace; Ceiba, PR

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: This action proposes to establish Class D and Class E airspace at the Jose Aponte de la Torre Airport (RVR), Ceiba, PR. The FAA is proposing this action due to the United States Marine Corps (USMC) recently beginning to operate an airport traffic control tower (ATCT) at the RVR airport.

DATES: Comments must be received on or before March 30, 2026.

ADDRESSES: Send comments identified by FAA Docket No. FAA-2025-4674 and Airspace Docket No. 25-AWA-8 using any of the following methods:

* *Federal eRulemaking Portal:* Go to www.regulations.gov and follow the online instructions for sending your comments electronically.

* *Mail:* Send comments to Docket Operations, M-30; U.S. Department of Transportation, 1200 New Jersey Avenue SE, Room W12-140, West Building Ground Floor, Washington, DC 20590-0001.

* *Hand Delivery or Courier:* Take comments to Docket Operations in Room W12-140 of the West Building Ground Floor at 1200 New Jersey Avenue SE, Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

* *Fax:* Fax comments to Docket Operations at (202) 493-2251.

Docket: Background documents or comments received may be read at www.regulations.gov at any time. Follow the online instructions for accessing the docket or go to the Docket Operations in Room W12-140 of the West Building Ground Floor at 1200 New Jersey Avenue SE, Washington,

DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FAA Order JO 7400.11K, Airspace Designations and Reporting Points, and subsequent amendments can be viewed online at www.faa.gov/air_traffic/publications/. You may also contact the Rules and Regulations Group, Policy Directorate, Federal Aviation Administration, 600 Independence Avenue SW, Washington, DC 20597; telephone: (202) 267-8783.

FOR FURTHER INFORMATION CONTACT:

Brian Vidis, Rules and Regulations Group, Policy Directorate, Federal Aviation Administration, 600 Independence Avenue SW, Washington, DC 20597; telephone: (202) 267-8783.

SUPPLEMENTARY INFORMATION:

Authority for This Rulemaking

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. 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. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of the airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it would modify the airspace structure as necessary to enhance the safe and efficient flow of air traffic at the Jose Aponte de la Torre Airport, Ceiba, PR.

Comments Invited

The FAA invites interested persons to participate in this rulemaking by submitting written comments, data, or views. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy-related aspects of the proposal. The most helpful comments reference a specific portion of the proposal, explain the reason for any recommended change, and include supporting data. To ensure the docket does not contain duplicate comments, commenters should submit only one time if comments are filed electronically, or commenters should send only one copy of written comments if comments are filed in writing.

The FAA will file in the docket all comments it receives, as well as a report summarizing each substantive public contact with FAA personnel concerning this proposed rulemaking. Before acting

on this proposal, the FAA will consider all comments it receives on or before the closing date for comments. The FAA will consider comments filed after the comment period has closed if it is possible to do so without incurring expense or delay. The FAA may change this proposal in light of the comments it receives.

Privacy: In accordance with 5 U.S.C. 553(c), DOT solicits comments from the public to better inform its rulemaking process. DOT posts these comments, without edit, including any personal information the commenter provides, to www.regulations.gov, as described in the system of records notice (DOT/ALL-14 FDMS), which can be reviewed at www.dot.gov/privacy.

Availability of Rulemaking Documents

An electronic copy of this document may be downloaded through the internet at www.regulations.gov. Recently published rulemaking documents can also be accessed through the FAA's web page at www.faa.gov/air_traffic/publications/airspace_amendments/.

You may review the public docket containing the proposal, any comments received, and any final disposition in person in the Dockets Operations office (see **ADDRESSES** section for address, phone number, and hours of operations). An informal docket may also be examined during normal business hours at the office of the Eastern Service Center, Federal Aviation Administration, Room 210, 1701 Columbia Avenue, College Park, GA 30337.

Incorporation by Reference

Class D and Class E airspace designations are published in paragraphs 5000 and 6005 of FAA Order JO 7400.11, Airspace Designations and Reporting Points, which is incorporated by reference in 14 CFR 71.1 on an annual basis. This document proposes to amend the current version of that order, FAA Order JO 7400.11K, dated August 4, 2025, and effective September 15, 2025. These updates would be published in the next update to FAA Order JO 7400.11. FAA Order JO 7400.11K, which lists Class A, B, C, D, and E airspace areas, air traffic service routes, and reporting points, is publicly available as listed in the **ADDRESSES** section of this document.

Background

The USMC began operating an ATCT at the RVR airport on September 12, 2025. The USMC plans to transition the operation of the ATCT to the United States Air Force (USAF) in early 2026, and USMC anticipates that USAF would manage the ATCT on a long-term basis thereafter. The USMC and USAF have requested Class D airspace to provide for the safe and efficient management of instrument flight rules (IFR) and visual flight rules (VFR) aircraft operations in the area. FAA is also establishing Class E airspace for containment of IFR arrival and departure aircraft transitioning to and from the enroute route structure.

The Proposal

The FAA is proposing an amendment to 14 CFR part 71 to establish Class D and Class E airspace at the Jose Aponte de la Torre Airport (RVR), Ceiba, PR, due to the USMC operating an ATCT at the RVR airport. The proposed Class D and Class E airspace would enhance the safe and efficient management of IFR and VFR operations in the area.

Class D airspace is proposed to be established extending upward from the surface to and including 2,500 feet mean sea level (MSL) within a 5-mile radius of the RVR airport. Class E airspace is proposed to be established extending upward from 700 feet above the surface within a 7-mile radius of the RVR airport.

Regulatory Notices and Analyses

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore: (1) is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this proposed rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

Environmental Review

This proposal will be subject to an environmental analysis in accordance

with FAA Order 1050.1G, "FAA National Environmental Policy Act Implementing Procedures" prior to any FAA final regulatory action.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(f), 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of FAA Order JO 7400.11K, Airspace Designations and Reporting Points, dated August 4, 2025, and effective September 15, 2025, is amended as follows:

Paragraph 5000 Class D Airspace.

* * * * *

ASO PR D Ceiba, PR [New]

Jose Aponte de la Torre Airport, PR
(Lat. 18°14'42" N, long. 065°38'36" W)

That airspace extending upward from the surface to and including 2,500 feet MSL within a 5-mile radius of Jose Aponte de la Torre Airport.

* * * * *

Paragraph 6005 Class E Airspace Areas Extending Upward from 700 Feet or More Above the Surface of the Earth.

* * * * *

ASO PR E5 Ceiba, PR [New]

Jose Aponte de la Torre Airport, PR
(Lat. 18°14'42" N, long. 065°38'36" W)

That airspace extending upward from 700 feet above the surface within a 7-mile radius of Jose Aponte de la Torre Airport.

* * * * *

Issued in Washington, DC, on February 9, 2026.

Alex W. Nelson,

Manager, Rules and Regulations Group.

[FR Doc. 2026-02727 Filed 2-10-26; 8:45 am]

BILLING CODE 4910-13-P

DEPARTMENT OF TRANSPORTATION**Federal Aviation Administration****14 CFR Part 71**

[Docket No. FAA–2026–0534; Airspace
Docket No. 26–ASO–2]

RIN 2120–AA66

**Amendment of Class E Airspace;
Covington, KY**

AGENCY: Federal Aviation
Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking
(NPRM); correction; extension of
comment period.

SUMMARY: The FAA is correcting an
NPRM published in the **Federal
Register** on January 20, 2026, proposing
to amend Class E airspace at Covington,
KY. Subsequent to publication, it was
discovered that the NPRM was
published with the wrong airspace
docket number used in two instances.
This action corrects those typographic
errors.

DATES: The comment period is
extended. Comments must be received
on or before March 30, 2026.

ADDRESSES: Send comments identified
by FAA Docket No. FAA–2026–0534
and Airspace Docket No. 26–ASO–2
using any of the following methods:

* *Federal eRulemaking Portal:* Go to
www.regulations.gov and follow the
online instruction for sending your
comments electronically.

* *Mail:* Send comments to Docket
Operations, M–30; U.S. Department of
Transportation, 1200 New Jersey
Avenue SE, Room W12–140, West
Building Ground Floor, Washington, DC
20590–0001.

* *Hand Delivery or Courier:* Take
comments to Docket Operations in
Room W12–140 of the West Building
Ground Floor at 1200 New Jersey
Avenue SE, Washington, DC, between 9
a.m. and 5 p.m., Monday through
Friday, except Federal holidays.

* *Fax:* Fax comments to Docket
Operations at (202) 493–2251.

Docket: Background documents or
comments received may be read at
www.regulations.gov at any time.
Follow the online instructions for
accessing the docket or go to Docket
Operations in Room W12–140 of the
West Building Ground Floor at 1200
New Jersey Avenue SE, Washington,
DC, between 9 a.m. and 5 p.m., Monday
through Friday, except Federal holidays.

FAA Order JO 7400.11K, Airspace
Designations and Reporting Points, and
subsequent amendments can be viewed
online at www.faa.gov/air_traffic/

publications/. You may also contact the
Rules and Regulations Group, Office of
Policy, Federal Aviation
Administration, 600 Independence
Avenue SW, Washington, DC 20597;
telephone: (202) 267–8783.

FOR FURTHER INFORMATION CONTACT:

Jeffrey Claypool, Federal Aviation
Administration, Operations Support
Group, Central Service Center, 10101
Hillwood Parkway, Fort Worth, TX
76177; telephone (817) 222–5711.

SUPPLEMENTARY INFORMATION:**Background**

The FAA published an NPRM in the
Federal Register (91 FR 2321; January
20, 2026), proposing to amend Class E
airspace at Covington, KY. Subsequent
to publication, the FAA discovered that
the NPRM was published with the
wrong airspace docket number in two
instances. This action corrects those
typographic errors.

Correction

The FAA is correcting **Federal
Register** Doc. No. 2026–00934,
published in the **Federal Register** on
January 20, 2026 (91 FR 2321), as
follows:

1. On page 2321, column 3, within the
header for the document, replace
“Docket No. 26–AGL–2” with “Docket
No. 26–ASO–2”.

2. On page 2321, column 3, within the
ADDRESSES section, replace “Airspace
Docket No. 26–AGL–2” with “Airspace
Docket No. 26–ASO–2”.

Issued in Fort Worth, Texas, on February
5, 2026.

Courtney E. Johns,

*Acting Manager, Operations Support Group,
ATO Central Service Center.*

[FR Doc. 2026–02692 Filed 2–10–26; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION**Federal Aviation Administration****14 CFR Part 71**

[Docket No. FAA–2025–1182; Airspace
Docket No. 25–ASO–15]

RIN 2120–AA66

**Establishment of Class E Airspace;
Clyde, NC**

AGENCY: Federal Aviation
Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking
(NPRM).

SUMMARY: This action proposes to
establish Class E airspace extending
upward from 700 feet above the surface

at Haywood Regional Medical Center,
Clyde, NC. Controlled airspace is
necessary for the safety and
management of instrument flight rules
(IFR) operations at this airport.

DATES: Comments must be received on
or before March 30, 2026.

ADDRESSES: Send comments identified
by FAA Docket No. FAA–2025–1182
and Airspace Docket No. 25–ASO–15
using any of the following methods:
* *Federal eRulemaking Portal:* Go to
www.regulations.gov and follow the
online instructions for sending your
comments electronically.

* *Mail:* Docket Operations, M–30; U.S.
Department of Transportation, 1200
New Jersey Avenue SE, Room W12–140,
West Building Ground Floor,
Washington, DC 20590–0001.

* *Hand Delivery or Courier:* Take
comments to Docket Operations in
Room W12–140 of the West Building
Ground Floor at 1200 New Jersey
Avenue SE, Washington, DC, between 9
a.m. and 5 p.m., Monday through
Friday, except for Federal holidays.

* *Fax:* Fax comments to Docket
Operations at (202) 493–2251.

Docket: Background documents or
comments received may be read at
www.regulations.gov at any time.
Follow the online instructions for
accessing the docket or go to the Docket
Operations in Room W12–140 of the
West Building Ground Floor at 1200
New Jersey Avenue SE, Washington,
DC, between 9 a.m. and 5 p.m., Monday
through Friday, except for Federal
holidays.

FAA Order JO 7400.11K, Airspace
Designations and Reporting Points, and
subsequent amendments can be viewed
online at www.faa.gov/air_traffic/
publications/. You may also contact the
Rules and Regulations Group, Office of
Policy, Federal Aviation
Administration, 600 Independence
Avenue SW, Washington, DC 20597;
Telephone: (202) 267–8783.

FOR FURTHER INFORMATION CONTACT:

Rachel Cruz, Operations Support Group,
Eastern Service Center, Federal Aviation
Administration, 1701 Columbia Avenue,
College Park, GA 30337; Telephone:
(404) 305–5571.

SUPPLEMENTARY INFORMATION:**Authority for This Rulemaking**

The FAA’s authority to issue rules
regarding aviation safety is found in
Title 49 of the United States Code.
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. This rulemaking is
promulgated under the authority

described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it would establish Class E airspace in Clyde, NC.

Comments Invited

The FAA invites interested persons to participate in this rulemaking by submitting written comments, data, or views. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy-related aspects of the proposal. The most helpful comments reference a specific portion of the proposal, explain the reason for any recommended change, and include supporting data. To ensure the docket does not contain duplicate comments, commenters should submit only one time if comments are filed electronically, or commenters should send only one copy of written comments if comments are filed in writing.

The FAA will file in the docket all comments it receives, as well as a report summarizing each substantive public contact with FAA personnel concerning this proposed rulemaking. Before acting on this proposal, the FAA will consider all comments it receives on or before the closing date for comments. The FAA will consider comments filed after the comment period has closed if it is possible to do so without incurring expense or delay. The FAA may change this proposal in light of the comments it receives.

Privacy: In accordance with 5 U.S.C. 553(c), DOT solicits comments from the public to better inform its rulemaking process. DOT posts these comments, without edits, including any personal information the commenter provides, to www.regulations.gov, as described in the system of records notice (DOT/ALL-14 FDMS), which can be reviewed at www.dot.gov/privacy.

Availability of Rulemaking Documents

An electronic copy of this document may be downloaded through the internet at www.regulations.gov. Recently published rulemaking documents can also be accessed through the FAA's web page at www.faa.gov/air_traffic/publications/airspace_amendments/.

You may review the public docket containing the proposal, any comments received, and any final disposition in person in the Dockets Operations Office (see **ADDRESSES** section for address,

phone number, and hours of operations). An informal docket may also be examined during regular business hours at the office of the Eastern Service Center, Federal Aviation Administration, Room 210, 1701 Columbia Ave., College Park, GA 30337.

Incorporation by Reference

Class E airspace designations are published in Paragraph 6005 of FAA Order JO 7400.11, Airspace Designations and Reporting Points, which is incorporated by reference in 14 CFR 71.1 on an annual basis. This document proposes to amend the current version of that order, FAA Order JO 7400.11K, Airspace Designations and Reporting Points, dated August 4, 2025, and effective September 15, 2025. These updates would be published in the next update to FAA Order JO 7400.11. FAA Order JO 7400.11K, which lists Class A, B, C, D, and E airspace areas, air traffic service routes, and reporting points, is publicly available as listed in the **ADDRESSES** section of this document.

The Proposal

The FAA proposes an amendment to 14 CFR part 71 to establish Class E airspace extending upward from 700 feet above the surface within a 10-mile radius of Haywood Regional Medical Center, Clyde, NC. Controlled airspace is necessary for the safety and management of instrument flight rules (IFR) operations in the area.

Regulatory Notices and Analyses

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore, (1) is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under Department of Transportation (DOT) Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this proposed rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

Environmental Review

This proposal will be subject to an environmental analysis in accordance with FAA Order 1050.1G, "FAA National Environmental Policy Act

Implementing Procedures," prior to any final regulatory action by the FAA.

Lists of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for part 71 continues to read as follows:

Authority: 49 U.S.C. 106(f), 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of FAA Order JO 7400.11K, Airspace Designations and Reporting Points, dated August 4, 2025, and effective September 15, 2025, is amended as follows:

* * * * *

Paragraph 6005 Class E Airspace Areas Extending Upward From 700 Feet or More Above the Surface of the Earth.

* * * * *

ASO NC E5 Clyde, NC [New]

Haywood Regional Medical Center, NC
(Lat. 35°31'34" N, long 82°56'36" W)

That airspace extending upward from 700 feet or more above the surface within a 10-mile radius of Haywood Regional Medical Center.

* * * * *

Issued in College Park, Georgia, on February 9, 2026.

Patrick Young,

Manager, Airspace & Procedures Team North, Eastern Service Center, Air Traffic Organization.

[FR Doc. 2026–02747 Filed 2–10–26; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 100

[Docket Number USCG–2026–0086]

RIN 1625–AA08

Special Local Regulation; Elizabeth River Western Branch, Portsmouth, VA

AGENCY: Coast Guard, Department of Homeland Security.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Coast Guard is proposing to establish a temporary special local regulation (SLR) for certain navigable waters of the Elizabeth River Western Branch. The SLR is needed to protect personnel, vessels, and the marine environment from potential hazards created by a boat race. This proposed rulemaking would prohibit persons and vessels from being in the regulated area unless specifically authorized by the Captain of the Port, Sector Virginia. We invite your comments on this proposed rulemaking.

DATES: Comments and related material must be received by the Coast Guard on or before March 13, 2026.

ADDRESSES: To submit comments and view available documents, go to <https://www.regulations.gov> and search for USCG–2026–0086.

FOR FURTHER INFORMATION CONTACT: If you have questions about this proposed rule, contact LCDR Justin Z. Strassfield, Sector Virginia Waterways Management Division, U.S. Coast Guard; by phone, at (206) 815–7367, or by email, at VirginiaWaterways@uscg.mil.

SUPPLEMENTARY INFORMATION:**I. Table of Abbreviations**

CFR Code of Federal Regulations
COTP Captain of the Port, Sector Virginia
DHS Department of Homeland Security
FR Federal Register
NPRM Notice of proposed rulemaking
§ Section
SLR Special Local Regulation
U.S.C. United States Code

II. Background and Authority

Coast Guard regulations define “regatta or marine parade” as an organized water event of limited duration which is conducted according to a prearranged schedule. 33 CFR 100.05(a). And, as explained in 33 CFR 100.15, Coast Guard requires that an organization planning to hold a regatta or marine event apply for a permit if the event, by its nature, circumstances, or location, will introduce extra or unusual hazards to the safety of life on the navigable waters of the United States. These permits may be approved by the Coast Guard, or by the state in which the event is to take place, if there is a Coast Guard-State agreement in place. See 33 CFR 100.10. Upon the approval of an application, the Captain of the Port, Sector Virginia (COTP) may promulgate such “Special Local Regulations” (SLR’s) as he or she deems necessary to ensure safety of life on the navigable waters immediately prior to, during, and immediately after the event. See 33 CFR 100.35(a).

On December 3, 2025, the American Society of Naval Engineers applied for a permit to race manned and unmanned vessels in the Elizabeth River Western Branch, in Portsmouth, VA on April 15–16, 2026. Hazards from vessels racing in the federal navigation channel include collisions with participating and nonparticipating vessels. The COTP has determined that potential hazards associated with the boat race are a safety concern for anyone within the channel of the Elizabeth River Western Branch between Western Branch Buoy 13 (LLNR 9785) and Western Branch Daybeacon 11 (LLNR 9780). Therefore, the COTP is proposing this rule under the authority in 46 U.S.C. 70041, to protect personnel, vessels, and the marine environment in the navigable waters within the regulated area.

III. Discussion of the Rule

This proposed rule would establish an SLR on April 15–16, 2026. The regulated area, which would be subject to enforcement from 8 a.m. until 3 p.m. on each of those two days, would cover all navigable waters within the channel of the Elizabeth River Western Branch between Western Branch Buoy 13 (LLNR 9785) and Western Branch Daybeacon 11 (LLNR 9780). No vessel or person not registered with the event sponsor as a participant in the race would be permitted to enter the regulated area without obtaining permission from the COTP or their designated representative. The regulatory text we are proposing appears at the end of this document.

IV. Regulatory Analyses

We developed this proposed rule after considering numerous statutes and Executive orders related to rulemaking. Below we summarize our analyses based on a number of these statutes and Executive orders.

A. Impact on Small Entities

The Regulatory Flexibility Act of 1980, 5 U.S.C. 601–612, as amended, requires Federal agencies to consider the potential impact of regulations on small entities during rulemaking. The term “small entities” comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. The Coast Guard certifies under 5 U.S.C. 605(b) that this proposed rule would not have a significant economic impact on a substantial number of small entities for the following reasons.

Vessel traffic would be able to safely transit around this regulated area. This

regulation would only impact a small area for 2 days. The enforcement period is during a time when vessel traffic is normally low and in a low traffic area. In addition, the Coast Guard would issue a Broadcast Notice to Mariners via VHF FM marine channel 16, which would allow small entities to adjust their transit plans, and the rule allows vessels to request permission to enter the regulated area from the COTP.

If you think that your business, organization, or governmental jurisdiction qualifies as a small entity and that this proposed rule would have a significant economic impact on it, please submit a comment (see **ADDRESSES**) explaining why you think it qualifies and how and to what degree this proposed rule would economically affect it.

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), if this proposed rule will affect your small business, organization, or governmental jurisdiction and you have questions, contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section. Small businesses may send comments to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards by calling 1–888–REG–FAIR (1–888–734–3247).

B. Collection of Information

This proposed rule will not call for a new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

C. Federalism and Indian Tribal Governments

We have analyzed this proposed rule under Executive Order 13132, Federalism, and have determined that it is consistent with the fundamental federalism principles and preemption requirements described in that Order.

Also, this proposed rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does 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.

D. Unfunded Mandates Reform Act

As required by The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538), the Coast Guard certifies that this proposed rule will not result in an annual expenditure of \$100,000,000

or more (adjusted for inflation) by a State, local, or tribal government, in the aggregate, or by the private sector.

E. Environment

We have analyzed this proposed rule under Department of Homeland Security Directive 023–01, Rev. 1, associated implementing instructions, and Environmental Planning COMDTINST 5090.1 (series), which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment.

This proposed rule is a special regulated area. It is categorically excluded from further review under paragraph L61.

V. Public Participation and Request for Comments

We view public participation as essential to effective rulemaking and will consider all comments and material received during the comment period. Your comment can help shape the outcome of this rulemaking. If you submit a comment, please include the docket number for this rulemaking, indicate the specific section of this document to which each comment applies, and provide a reason for each suggestion or recommendation.

Submitting comments. We encourage you to submit comments at <https://www.regulations.gov>. To do so, go to <https://www.regulations.gov>, type USCG–2026–0086 in the search box and click “Search.” Next, look for this document in the Search Results column, and click on it. Then click on the Comment option. If you cannot submit your material by using <https://www.regulations.gov>, call or email the person in the **FOR FURTHER INFORMATION CONTACT** section of this proposed rule for alternate instructions.

Viewing material in the docket. To view available documents, find the docket as described in the previous paragraph, and then select “Supporting & Related Material” in the Document Type column. We will post public comments in our online docket. Additional information is on the <https://www.regulations.gov> Frequently Asked Questions web page.

Personal information. We accept anonymous comments. Comments we post to <https://www.regulations.gov> will include any personal information you have provided. For more about privacy and submissions to the docket in response to this document, see DHS’s

eRulemaking System of Records notice (85 FR 14226, March 11, 2020).

List of Subjects in 33 CFR Part 100

Marine safety, Navigation (water), Reporting and recordkeeping requirements, Waterways.

For the reasons discussed in the preamble, the Coast Guard is proposing to amend 33 CFR part 100 as follows:

PART 100—SAFETY OF LIFE ON NAVIGABLE WATERS

- 1. The authority citation for part 100 continues to read as follows:

Authority: 46 U.S.C. 70041; 33 CFR 1.05–1.

- 2. Add § 100.T05–0086 to read as follows:

§ 100.T05–0086 Special local regulation; Elizabeth River Western Branch, Portsmouth, VA.

(a) *Location.* The following area is a regulated area: All waters of the Elizabeth River Western Branch federal navigation channel, from surface to bottom, between Western Branch Buoy 13 (LLNR 9785) and Western Branch Daybeacon 11 (LLNR 9780).

(b) *Definitions.* As used in this section, *designated representative* means a Coast Guard Patrol Commander, including a Coast Guard coxswain, petty officer, or other officer operating a Coast Guard vessel and a Federal, State, and local officer designated by or assisting the Captain of the Port Sector Virginia (COTP) in the enforcement of the regulated area. *Participant* means all persons and vessels registered with the event sponsor as a participant in the race.

(c) *Regulations.* (1) All non-participants are prohibited from entering, transiting through, anchoring in, or remaining within the regulated area described in paragraph (a) of this section unless authorized by the Captain of the Port, Sector Virginia (COTP) or their designated representative.

(2) To seek permission to enter, contact the COTP or the COTP’s representative on VHF–FM channel 16 or by telephone at 877–722–5727. Those in the special regulated area must comply with all lawful orders or directions given to them by the COTP or the COTP’s designated representative.

(3) The COTP will provide notice of the regulated area through advanced notice via broadcast notice to mariners and by on-scene designated representatives.

(d) *Enforcement period.* This section will be enforced from 8 a.m. to 3 p.m. on April 15, 2026 and April 16, 2026.

Peggy M. Britton,

Captain, U.S. Coast Guard, Captain of the Port, Sector Virginia.

[FR Doc. 2026–02750 Filed 2–10–26; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 100, 110, and 165

[Docket Number USCG–2025–0707]

RIN 1625–AA08, AA01, AA87

Special Local Regulation, Temporary Anchorage Ground Suspension, and Safety and Security Zones: Sail Boston, 250th Anniversary 2026; Boston Harbor, Boston, MA

AGENCY: Coast Guard, Department of Homeland Security.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Coast Guard is proposing to establish temporary regulations, including special local regulations and multiple safety and security zones, and to temporarily suspend certain anchorage grounds in Boston Harbor, Boston, MA between July 10 and July 16, 2026. These regulations are necessary to promote the safe navigation of vessels and safety of life during ‘Sail Boston,’ a gathering of tall ships and military ships to celebrate the 250th Anniversary of the founding of the United States. We invite your comments on this proposed rulemaking.

DATES: Comments and related material must be received by the Coast Guard on or before April 13, 2026. The dates for the stays and temporary sections are listed in the **SUPPLEMENTARY INFORMATION** section.

ADDRESSES: To submit comments and view available documents, go to <https://www.regulations.gov> and search for USCG–2025–0707.

FOR FURTHER INFORMATION CONTACT: If you have questions about this proposed rulemaking, call or email: Mr. Craig Lapiejko, Waterways Management, Coast Guard Northeast District, telephone 571–607–6314, email craig.d.lapiejko@uscg.mil or call or email Mr. Timothy Chase U.S Coast Guard Sector Boston Waterways Management at (617) 447–1620 or email timothy.w.chase@uscg.mil.

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

BNM Broadcast Notice to Mariners
CFR Code of Federal Regulations
COTP Captain of the Port, Sector Boston
CGD-NE Coast Guard Northeast District Commander
DHS Department of Homeland Security
FR Federal Register
LNM Local Notice to Mariners
MA Massachusetts
NPRM Notice of Proposed Rulemaking
§ Section
U.S.C. United States Code
TFR Temporary Final Rule

II. Background and Authority

Sail250®, a series of events which celebrates the 250th anniversary of the United States of America, has been designated as a Marine Event of National Significance under Coast Guard regulations.¹ Among this series of events is a multiport tall ships tour, which includes the ports of New Orleans, LA; Norfolk, VA; Baltimore, MD, and New York City, NY, and which ends at the Port of Boston. Additional information about Sail250® can be found at <https://www.sail250.org/>.

The Boston event, 'Sail Boston,' is being held from July 11, 2026, through July 16, 2026. It will commence with the arrival and anchoring of the tall ships to Broad Sound, Massachusetts Bay, MA on July 10th, 2026. The Sail Boston Tall Ship Parade of Sail into Boston Harbor will occur on July 11th, 2026, with participating tall ships mooring in various berths throughout the Port of Boston, MA until their departure on July 16th, 2026. There will also be tours of visiting United States Naval Vessels and foreign naval vessels. In addition, we anticipate making the existing Fan Pier Safety Zone (codified at 33 CFR 165.119(a)(3)), subject to enforcement for a fireworks display on July 11, and July 15, between 9:15 p.m. and 10:30 p.m.

In 1992, 2000, 2009, 2012 and 2017, events similar to those which are the subject of this Notice of Proposed Rulemaking (NPRM) drew several hundred thousand spectators by land, as well as by water, to Boston Harbor. Among them were 'Sail Boston' 1992, 2000, 2009, 2017, and 'War of 1812' in 2012. Based on experience with these past events, the Coast Guard anticipates that thousands of spectator craft will attend the 'Sail Boston' events this year. Due to the likely high concentration of spectator and participant vessels attending the series of events, the Coast Guard Northeast District Commander (CGD-NE) and the Captain of the Port, Sector Boston (COTP), have determined these proposed regulations are

necessary to ensure the safety of the 'Sail Boston' participants and spectators, and their vessels while operating in and around the Port of Boston before, during, and after the scheduled events are completed. The Coast Guard is proposing this rulemaking under authorities in 33 U.S.C. 2071; 46 U.S.C. 70006, 70034, 70041, 70051, 70124; 33 CFR 1.05-1, 6.04-1, 6.04-6, and 160.5; Department of Homeland Security Delegation No. 00170.1, Revision No. 01.4.

III. Discussion of Rule

The proposed regulations would create temporary spectator areas, vessel movement control measures, security zones around foreign naval vessels, and safety zones around each Tall Ship while anchored, transiting and moored in various berths in Boston Harbor. Additionally, these proposed regulations would temporarily suspend certain anchorage grounds. The proposed regulations would only be subject to enforcement at various specified times between July 10th, 2026, through July 16th, 2026.

Based on the latest Sail Boston event schedule, we are proposing regulations which, combined, would establish:

1. A 100-yard safety zone surrounding each participating Tall Ship while anchored in Broad Sound on July 10 and 11,
2. A safety zone surrounding each participating Tall Ship during the inbound 'Parade of Sail' on July 11,
3. Special local regulations (SLR) with Temporary Spectator Zones for viewing the 'Sail Boston Tall Ship Parade of Sail' on July 10 and 11 and vessel movement control measures in effect July 11 through July 16.
4. A Naval Force Protective Zone will be enforced around all U.S Navy vessels, while transiting or moored at the Flynn Cruise Port Terminal and various berths in Boston Harbor July 11 through July 16.
5. A security zone around each visiting foreign Naval Vessel from July 11 through July 16.
6. A 25-yard Safety Zone established around all moored tall ships.

Additional information about the special local regulations (SLRs), anchorage grounds, security zones and safety zones follows.

Special Local Regulations (33 CFR 100.T0199-0707)

As an organized water event of limited duration which is conducted according to a prearranged schedule is a "Regatta or marine parade," as defined at 33 CFR 100.05. The Coast Guard requires an individual or organization

planning to hold a regatta or marine parade which, by its nature, circumstances or location, will introduce extra or unusual hazards to the safety of life on the navigable waters of the United States, to submit an application to hold it. 33 CFR 100.15. On November 21, 2023, the event sponsor of the "Sail 250" submitted an application under 33 CFR 100.15 to conduct a parade of tall ships, "Sail 250 America's 250 Maritime Celebrations," on July 11th, 2026, with participating Tall Ships mooring in various berths throughout the Boston Harbor, Boston, MA, until their departure on July 16th, 2026.

After approving plans for the holding of a regatta or marine parade within his or her district or zone, a COTP is authorized to promulgate such SLRs as he or she deems necessary to ensure safety of life on the navigable waters immediately prior to, during, and immediately after the approved regatta or marine parade per 33 CFR 100.35. Due to the high-profile nature of this event, spectator vessels and support craft will be present, and together, they will certainly cause vessel congestion in Boston Harbor, Boston, MA. To address potential hazards associated with the significant amount of recreational boating traffic this event is expected to draw, the Coast Guard proposes to establish special local regulations that would institute vessel movement control measures and create spectator vessel areas in Boston Harbor that will be in effect during the entirety of the Sail Boston 250, Anniversary event. This temporary SLR, which would be designated as section 100.T0199-0707, is needed to facilitate timely access to maritime and transportation facilities by law enforcement support vessels and to protect the maritime public and participating vessels from possible hazards to navigation associated with dense vessel traffic.

Traffic Pattern

The proposed local regulation for vessel movement control establishes a counterclockwise traffic pattern around Boston Inner Harbor to ensure spectator vessels are following an organized route. A Coast Guard Patrol Commander (PATCOM) will be on-scene to facilitate the smooth flow of boating traffic and minimize traffic disruption on the waterway. A chartlet showing the counterclockwise traffic pattern around Boston Inner Harbor is below in figure 1.

¹ 46 CFR 26.03-8.

(Figure 1 Chartlet Showing the Counterclockwise Traffic Pattern Around Boston Inner Harbor)



The waterway between the World Trade Center Pier and the Fish Pier is a long, narrow area that does not provide sufficient space for unhindered navigation. With the number of Tall Ships that will be moored in this restricted waterway, there will not be adequate room for additional vessels to safely maneuver within the navigational constraints. As a result, waterside viewing from recreational vessels will be prohibited, and only vessels that are tenants of the Fish Pier and World Trade Center piers will be authorized access.

Spectator Areas

The Coast Guard proposes establishing 13 temporary spectator areas for use by recreational, special use, fishing, and commercial vessels during the arrival of the Tall Ships and naval vessels on July 10, 2026, and the Sail Boston Parade of Sail on July 11, 2026. These would be located in the vicinity of Boston North Channel, Long Island, Deer Island, President Roads, and Boston Inner Harbor. They would be available for use from 6 a.m. on July 10 through 5 p.m. on July 11, 2026.

On July 11, 2026, following the 'Parade of Sail,' vessel operators may depart from their respective spectator areas in sequence with the movement

and mooring of the final flotilla of tall ships. After the final flotilla of tall ships has passed Castle Island, vessel operators in spectator areas east of Castle Island may depart for locations outside of Boston Harbor. After the final flotilla of tall ships has safely moored, vessel operators would be allowed to depart from the remaining established spectator areas. Vessels transiting through Boston Harbor would be required to proceed in accordance with established vessel movement control measures directed by the COTP or the COTP's representative on scene.

The locations of the temporary spectator areas are shown on chartlets that can be found in the docket.

Temporary Suspension of Anchorage Grounds (33 CFR 110.138)

This proposal includes the temporary suspension of anchorage grounds established at 33 CFR 110.138, (Boston Harbor, Mass.) through a temporary stay of the regulations governing their use. The suspension of these anchorage grounds would be in effect from July 11, 2026, through July 16, 2026, to coincide with the periods that the spectator areas and traffic pattern regulations are temporarily established. The anchorages we propose to suspend are Anchorage 1—Bird Island Anchorage, Anchorage

2—President Roads Anchorage, Anchorage 3—Long Island Anchorage, Anchorage 4—Castle Island Anchorage, and Anchorage 5—Explosive Anchorage.

Safety Zones

The Coast Guard is proposing to establish safety zones in section 165.T01-0707. On July 10, 2026, tall ships participating in the Sail Boston Tall Ship Parade of Sail will rally in Broad Sound. The safety zones would extend out a 100-yard radius of each participating Tall Ship while anchored in Broad Sound. The regulation would be enforced from July 10, 2025, through July 11, 2025.

The Coast Guard is proposing to establish 1,000-yard safety zones ahead and astern and 100-yards on each side of participating Tall Ships, during their transit from their anchorages in Broad Sound to the start of the Tall Ship Parade of Sail and during the Tall Ship Parade of Sail into Boston Harbor. These would be enforced on July 11, 2026.

The Coast Guard is proposing to establish 25-yard safety zones surrounding participating Tall Ships while moored in Boston Harbor because the high density of spectators, combined with the volume of daily deep draft commercial vessel traffic, poses a

significant threat to the safety of life and property. The proposed regulations would be in effect from July 11, 2026, through July 16, 2026. These restrictions are intended to minimize the risks associated with the large number of recreational vessels anticipated to be operating within the confines of Boston Inner Harbor during the event.

Security Zone

To protect foreign naval vessels before, during, and after the Sail Boston events, the Coast Guard is proposing to establish a 100-yard security zone in 165.T01–1162 around each foreign naval vessel while it is within the Sector Boston COTP Zone. These would be enforced from 12:01 a.m. July 10, 2025, through 11:59 p.m. on July 16, 2025. The COTP would make notifications of the exact names of the vessels in advance of each enforcement period for the security zone to the local maritime community through the Local Notice to Mariners (LNMs) and Broadcast Notices to Mariners (BNMs). The Northeast Coast Guard District Local Notice to Mariners can be found at: <http://www.navcen.uscg.gov>.

IV. Regulatory Analyses

We developed this proposed rule after considering numerous statutes and Executive orders related to rulemaking. Below we summarize our analyses based on a number of these statutes and Executive orders

A. Impact on Small Entities

The Regulatory Flexibility Act of 1980, 5 U.S.C. 601–612, as amended, requires Federal agencies to consider the potential impact of regulations on small entities during rulemaking. The term “small entities” comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. The Coast Guard certifies under 5 U.S.C. 605(b) that this proposed rule would not have a significant economic impact on a substantial number of small entities for the following reasons.

Although this regulation temporarily suspends certain anchorage grounds, creates spectator areas, imposes traffic control measures, and safety zones and security zones in portions of Boston Harbor, Boston, MA, during the events, vessels needing to depart the temporary spectator areas may do so with permission from the COTP’s designated on-scene representative and vessels will have sufficient transit room around the outer edge of the designated spectator areas. The traffic control measures are

confined to areas of minimal distance, they follow the natural flow of Boston Harbor, Boston, MA, traffic, they are in compliance with the navigational rules of the road, and crossovers have been established for vessels wanting to change direction. The 25-yard safety zone around participating Tall Ships while moored will have no impact to vessel movement in Boston, Harbor, Boston, MA, and will only be in place during the five days of Sail Boston 250th Anniversary activities. Sail250®, Inc. over the past 6 months has held multiple public meetings discussing Sail Boston 250, 2026, events and during each meeting, these proposals have been discussed. An extensive advance notice will be made to mariners via appropriate means, which may include broadcast notice to mariners, local notice to mariners, marine safety information bulletin, local Port Operators Group meetings, Harbor Safety Committee meetings, the internet, USCG Sector Boston Facebook web page, handouts, and local newspapers and media. The advance notice will permit mariners to adjust their plans accordingly. Similar restrictions were established for other Sail Boston events in 1992, 2000, 2009, 2017, and War of 1812 in 2012. Based upon the Coast Guard’s experiences from those previous events of similar magnitude, these proposed regulations have been narrowly tailored to impose the least impact on maritime interests while providing the necessary level of safety.

B. Collection of Information

This proposed rule will not call for a new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

C. Federalism and Indian Tribal Governments

We have analyzed this proposed rule under Executive Order 13132, Federalism, and have determined that it is consistent with the fundamental federalism principles and preemption requirements described in that Order.

Also, this proposed rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does 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.

D. Unfunded Mandates Reform Act

As required by The Unfunded Mandates Reform Act of 1995 (2 U.S.C.

1531–1538), the Coast Guard certifies that this proposed rule will not result in an annual expenditure of \$100,000,000 or more (adjusted for inflation) by a State, local, or tribal government, in the aggregate, or by the private sector.

E. Environment

We have analyzed this proposed rule under Department of Homeland Security Directive 023–01, Rev. 1, associated implementing instructions, and Environmental Planning COMDTINST 5090.1 (series), which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment.

This proposed rule involves temporarily suspending permanent anchorages, proposing temporary spectator areas and vessel traffic control measures to facilitate the safety of all spectator and participant vessels in the Sail Boston 250 Tall Ship Parade of Sail and events. It is categorically excluded from further review under paragraphs L59(b), L60(a), and L61. A Record of Environmental Consideration supporting this determination is available in the docket.

V. Public Participation and Request for Comments

We view public participation as essential to effective rulemaking and will consider all comments and material received during the comment period. Your comment can help shape the outcome of this rulemaking. If you submit a comment, please include the docket number for this rulemaking, indicate the specific section of this document to which each comment applies, and provide a reason for each suggestion or recommendation.

Submitting comments. We encourage you to submit comments at <https://www.regulations.gov>. To do so, go to <https://www.regulations.gov>, type USCG–2025–0707 in the search box and click “Search.” Next, look for this document in the Search Results column, and click on it. Then click on the Comment option. If you cannot submit your material by using <https://www.regulations.gov>, call or email the person in the **FOR FURTHER INFORMATION CONTACT** section of this proposed rule for alternate instructions.

Viewing material in the docket. To view available documents, find the docket as described in the previous paragraph, and then select “Supporting & Related Material” in the Document

Type column. We will post public comments in our online docket. Additional information is on the <https://www.regulations.gov> Frequently Asked Questions web page.

Personal information. We accept anonymous comments. Comments we post to <https://www.regulations.gov> will include any personal information you have provided. For more about privacy and submissions to the docket in response to this document, see DHS's eRulemaking System of Records notice (85 FR 14226, March 11, 2020).

List of Subjects in 33 CFR Part 100, 110, 165

33 CFR Part 100

Marine safety, Navigation (water), Reporting and recordkeeping requirements, Waterways.

33 CFR Part 110

Anchorage grounds.

33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and record keeping requirements, Security measures, Waterways.

For the reasons discussed in the preamble, the Coast Guard proposes to amend 33 CFR parts 100, 110, and 165 as follows:

PART 100—SPECIAL LOCAL REGULATIONS/REGATTAS AND MARINE PARADES

- 1. The authority citation for Part 100 continues to read as follows:

Authorities: 46 U.S.C. 70041; 33 CFR 1.05–1.

- 2. Add § 100.T0199–0707 to read as follows:

§ 100.T0199–0707 Special Local Regulation: Sail Boston 250th, Anniversary 2026; Port of Boston, MA.

(a) *Regulated areas:* (1) *Traffic Pattern Regulated Area*—(i) *Location.* The following area is a special regulation area: All waters of Boston Harbor to include all waters west of a line drawn from the monument at Castle Island in approximate position 42°20'21" N, 71°00'37" W, to the Logan Airport Security Zone Buoy "24" in approximate position 42°20'45" N, 71°00'29" W, and then to land in approximate position 42°20'48" N, 71°00'27" W, including the Reserved Channel to the Summer Street retractile bridge in approximate position 42°20'34" N, 71°02'11" W, the Charles River to the Gridley Locks at the Charles River Dam in approximate position 42°22'07" N, 71°03'40" W, the Mystic

River at the Alford Street Bridge in approximate position 42°23'22" N, 71°04'16" W, and the Chelsea River to the McArdle Bridge in approximate position 42°23'09" N, 71°02'21" W. All positions are expressed in Degrees (°) Minutes (') Seconds (") (DMS) based on the World Geodetic System (WGS 84).

(ii) Traffic Pattern General Regulations.

(A) During the effective period, vessel operators transiting through the regulated area shall proceed in a counterclockwise direction at no wake speeds not to exceed five knots, unless otherwise authorized by the Captain of the Port (COTP).

(B) Vessel operators shall comply with the directions and orders of the COTP or the COTP's representative, upon being hailed by siren, radio, flashing lights, or other means. The COTP's representative may be any Coast Guard commissioned, warrant, or petty officer or any Federal, state, or local law enforcement officer who has been designated by the COTP to act on the COTP's behalf. The COTP's representative may be on a Coast Guard vessel, a Coast Guard Auxiliary vessel, a federal, state or local law enforcement or safety vessel, or a location on shore.

(C) From 4 p.m. on July 11, 2026, through 8 a.m. on July 16, 2026, vessel control measures will be implemented. The traffic pattern will be in a counterclockwise rotation, such that all vessels shall stay generally as far to the starboard side of the channel as is safe and practicable.

(D) To facilitate commercial ferry traffic with minimal disruption, commercial ferries within the regulated area, moving between stops on their normal routes, will be exempt from the mandatory counterclockwise traffic pattern. This exemption does not give ferries navigational precedence or in any way alter their responsibilities under the Rules of the Road or any other pertinent regulations.

(E) Vessel operators who are tenants of the World Trade Center and Fish Pier docks will be allowed access to this portion of the Waterway. Due to the mooring plan for the arriving Tall Ships severely restricting the channels, recreational craft will not be allowed access.

(F) Vessel operators transiting this area must maintain at least a 25-yard safe distance from all participating Sail Boston Tall Ships and must make way for all deep draft vessel traffic underway in the area.

(G) When a vessel greater than 125-feet enters the waterway between the Commonwealth Pier and the Fish Pier, no other vessel will be allowed to enter

until the larger vessel departs that area, unless authorized by the on-scene COTP's representative.

(H) From 4 p.m. 11 July through 8:00 a.m. 16 July, while the regulated area is in effect, only vessels which are tenants within the channels of the Commonwealth and the Fish Pier will be authorized access.

(I) The COTP may control the movement of all vessels operating on the navigable waters of Boston Harbor when the COTP has determined that such orders are justified in the interest of safety by reason of weather, visibility, sea conditions, temporary port congestion, or other temporary hazards circumstance.

(J) To obtain permissions required by this regulation, individuals may reach the COTP or a COTP representative via VHF channel 16 or 833–449–0593 (Sector Boston Command Center).

(iii) *Penalties.* Those who violate this section are subject to the penalties set forth in 46 U.S.C. 70036 and 46 U.S.C. 70052.

(iv) *Enforcement Period.* This section will be enforced from 11:59 p.m. on July 10, 2026, through 4 p.m. on July 16, 2026, unless otherwise noted. Readers should refer to paragraph (a)(1)(ii) of this section for additional information on specific enforcement times and locations

(2) *Spectator areas.* (i) *Locations and regulations—*

(A) *Spectator Area 1*—All waters bounded by the following coordinates: 42°22'06" N/071°02'43" W, 42°22'11" N/071°02'39" W, 42°22'07" N/071°02'32" W, and 42°22'03" N/071°02'35" W.

This spectator area is designated for the exclusive use of recreational vessels that are 45 feet or less in length and have superstructures that do not exceed 10 feet in height.

(B) *Spectator Area 2*—All waters bounded by the following coordinates: 42°21'41" N/071°02'25" W, 42°21'47" N/071°02'20" W, 42°21'35" N/071°01'53" W, and 42°21'29" N/071°01'58" W.

This spectator area is designated for the exclusive use of recreational vessels that are 45 feet or less in length and have superstructures that do not exceed 10 feet in height.

(C) *Spectator Area 3*—All waters bounded by the following coordinates: 42°21'26" N/071°01'51" W, 42°21'32" N/071°01'47" W, 42°21'25" N/071°01'33" W, and 42°21'19" N/071°01'37" W.

This spectator area is designated for the exclusive use of recreational vessels that are 45-feet or less in length and their height above water does not exceed 50-feet.

(D) *Spectator Area 4*—All waters bounded by the following coordinates:

42°21'19" N/071°01'37" W, 42°21'25" N/071°01'33" W, 42°21'09" N/071°01'02" W, and 42°21'04" N/071°01'06" W.

This spectator area is designated for the exclusive use of inspected and uninspected small passenger vessels (certificated by the Coast Guard under Subchapters T and K of Title 46, Code of Federal Regulations), and charter vessels that do not exceed 50-feet in height above the water line.

(E) *Spectator Area 5*—All waters bounded by the following coordinates: 42°21'04" N/071°01'06" W, 42°21'09" N/071°01'02" W, 42°20'48" N/071°00'29" W, and 42°20'47" N/071°00'29" W.

This spectator area is designated for the exclusive use of inspected and uninspected small passenger vessels (certificated by the Coast Guard under Subchapters T and K of Title 46, Code of Federal Regulations), and charter vessels that do not exceed 50-feet in height above the water line.

(F) *Spectator Area 6*—All waters bounded by the following coordinates: 42°20'09" N/070°59'39" W, 42°20'23" N/070°59'32" W, 42°20'19" N/071°59'17" W, and 42°20'07" N/070°59'24" W.

This spectator area is designated for the exclusive use of recreational vessels.

(G) *Spectator Area 7*—All waters bounded by the following coordinates: 42°20'06" N/070°59'23" W, 42°20'32" N/070°59'08" W, 42°20'32" N/070°58'31" W, and 42°20'05" N/070°58'45" W.

This spectator area is designated for the exclusive use of recreational vessels.

(H) *Spectator Area 8*—All waters bounded by the following coordinates: 42°20'06" N/070°58'43" W, 42°20'35" N/070°58'28" W, 42°20'33" N/070°57'29" W, and 42°20'05" N/070°57'31" W.

This spectator area is designated a Deep Draft and general spectator area, in the event a visiting foreign Naval Vessel is anchored within the zone, a 500-yard Naval Protective Zone will be established prohibiting all vessels from entering the established zone.

(I) *Spectator Area 9*—(i) All waters bounded by the following coordinates: 42°19'45" N/070°59'55" W, 42°19'58" N/070°59'55" W, 42°19'57" N/070°58'47" W, and 42°19'44" N/070°58'47" W.

This spectator area is designated as general transient spectator area for all vessels that do not exceed 50-feet in height above the water line, with no vessel remaining overnight. This spectator area is only applicable from 6 a.m. on July 11, 2026, until 4 p.m. on July 11, 2026.

(J) *Spectator Area 10*—All waters bounded by the following coordinates: 42°19'44" N/070°58'44" W, 42°19'58" N/070°58'47" W, 42°19'55" N/070°57'28" W, and 42°19'43" N/070°57'35" W.

This spectator area is designated for the exclusive use of recreational vessels with no vessel remaining overnight.

This spectator area is only applicable from 6 a.m. on July 11, 2026, until 4 p.m. on July 11, 2026.

(K) *Spectator Area 11*—All waters bounded by the following coordinates: 42°20'30" N/070°56'30" W, 42°21'58" N/070°56'05" W, and 42°21'32" N/070°55'27" W.

This spectator area is designated for the exclusive use of late arriving recreational vessels with no vessel remaining overnight. This spectator area is only applicable from 6 a.m. on July 11, 2026, until 4 p.m. on July 11, 2026.

(L) *Spectator Area 12*—All waters bounded by the following coordinates: 42°20'07" N/070°56'28" W, 42°21'43" N/070°54'51" W, 42°21'18" N/070°54'29" W, and 42°20'05" N/070°55'51" W.

This spectator area is designated for the exclusive use of late arriving recreational vessels with no vessel remaining overnight. This spectator area is only applicable from 6 a.m. on July 11, 2026, until 4 p.m. on July 11, 2026.

(M) *Spectator Area 13*—All waters bounded by the following coordinates: 42°19'55" N/070°56'40" W, 42°20'06" N/070°56'28" W, 42°20'05" N/070°55'51" W, and 42°19'51" N/070°56'05" W.

This spectator area is designated for the exclusive use of inspected and uninspected small passenger vessels (certificated by the Coast Guard under Subchapters T and K of Title 46, Code of Federal Regulations), and charter vessels with no vessel remaining overnight. This spectator area is only applicable from 6 a.m. on July 11, 2026, until 4 p.m. on July 11, 2026.

(ii) *Spectator Area General regulations.* The spectator area designated in paragraphs (2)(i)(A) through (M) of this section are expressed in Degrees (°) Minutes (') Seconds (") (DMS) based on the World Geodetic System (WGS 84), and subject to the following regulations:

(A) General Operational Requirements for all spectator areas. Vessel operators using any of the spectator areas established in this section shall:

(1) Ensure their vessels remain safely within the spectator area during marine events.

(2) Vessel operators shall comply with the directions and orders of the COTP or the COTP's representatives, upon being hailed by siren, radio, flashing lights, or other means. The COTP's representative may be any Coast Guard commissioned, warrant, or petty officer or any Federal, state, or local law enforcement officer who has been designated by the COTP to act on the COTP's behalf. The COTP's

representative may be on a Coast Guard vessel, a Coast Guard Auxiliary vessel, a federal, state, or local law enforcement or safety vessel, or a location on shore.

(3) Vacate spectator areas after termination of their effective periods.

(4) Buoy with identifiable markers and release anchors fouled on lobster trap lines if such anchors cannot be freed or raised.

(5) All vessels are required to exhibit appropriate anchoring lights as prescribed by the Rules of the Road (COLREGS) while at anchor

(6) Do not leave vessels unattended in any spectator area at any time.

(7) Do not tie off to any aid to navigation or buoy.

(8) Maintain at least 20 feet of clearance when maneuvering between vessels.

(9) Do not nest, raft, or tie off to other vessels in spectator areas.

(10) Based on COTP approval and direction, vessels commercially engaged in the collection and legal disposal of marine sewage may operate within spectator areas during the applicable periods.

Note 1 to § 100.T0199-0707: CAUTION: Mariners are cautioned that the areas designated as spectator areas in this section have not been subject to any special survey or inspection and that charts may not show all seabed obstructions or the shallowest depths. In addition, if you decide to anchor, spectator areas are in areas of substantial currents, and not all spectator areas are over good holding ground. Mariners are advised to take appropriate precautions when using these temporary spectator areas.

Note 2 to § 100.T0199-0707: NO-DISCHARGE ZONE: Boston Harbor, MA, located in EPA Region 01, is a No-Discharge Zone. No Discharge Zones prohibit the discharge of sewage from vessels to protect water quality. Mariners are warned they cannot discharge any treated or untreated sewage within the designated area and must instead retain it on board and use onshore pump-out facilities to dispose of it later. Additional information on commercial vessels or the location of onshore pump-out facilities dedicated to the collection and legal disposal of marine sewage may be found at <https://www.mass.gov/info-details/boat-pumpout-facilities>.

PART 110—ANCHORAGE REGULATIONS

■ 1. The authority citation for Part 110 continues to read as follows:

Authorities: 33 U.S.C. 2071; 46 U.S.C. 70006, 70034; 33 CFR 1.05-1; Department of Homeland Security Delegation No. 0170.1, Revision No. 4.

■ 2. Temporarily stay 33 CFR 110.138, (Boston Harbor, Mass.), effective from July 11, 2026, through July 16, 2026.

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for Part 165 continues to read as follows:

Authority: 46 U.S.C. 70034, 70051, 70124; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 00170.1, Revision No. 01.4.

■ 2. Add § 165.T01–0707 to read as follows:

§ 165.T01–0707 Safety Zone: Sail Boston 250th Anniversary 2026; Port of Boston, MA.

(a) *Location.* The following are safety zones (all coordinates are NAD 1983):

(1) All navigable waters from surface to bottom, within a 100-yard radius of each participating Tall Ship while anchored in Broad Sound.

(2) All navigable waters from surface to bottom, within 1000-yards ahead and astern and 100-yards on each side of participating Tall Ships, during their transit from anchorage to mooring.

(3) All navigable waters from surface to bottom, within 25-yards surrounding participating Tall Ships while moored at various locations throughout the Port of Boston.

(b) *Regulations.* While these safety zones are being enforced, the following regulations, along with those contained in 33 CFR 165.23, apply:

(1) No person or vessel may enter or remain in a safety zone without the permission of the COTP, Sector Boston or the COTP's representative.

(2) Any person or vessel permitted to enter the safety zones shall comply with the directions and orders of the COTP or the COTP's representative. Upon being hailed by siren, radio, flashing lights, or other means, the operator of a vessel within the zone shall proceed as directed. Any person or vessel within the security zone shall exit the zone when directed by the COTP or the COTP's representative.

(3) To obtain permissions required by this regulation, individuals may reach the COTP or a COTP representative via VHF channel 16 or 833–449–0593 (Sector Boston Command Center) to obtain permission.

(4) Penalties. Those who violate this section are subject to the penalties set forth in 46 U.S.C. 70036 and 46 U.S.C. 70052.

(c) COTP Representative. The COTP's representative may be any Coast Guard commissioned, warrant, or petty officer or any Federal, state, or local law enforcement officer who has been designated by the COTP to act on the COTP's behalf. The COTP's representative may be on a Coast Guard vessel, a Coast Guard Auxiliary vessel, a federal, state or local law enforcement or safety vessel, or a location on shore.

(d) Enforcement dates. Paragraph (a) of this section is applicable on July 10, 2026, through June 16, 2026.

■ 3. The authority citation for part 165 continues to read as follows:

Authority: 46 U.S.C. 70034, 70051, 70124; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 00170.1, Revision No. 01.4.

■ 4. Add § 165.T01–1162 to read as follows:

§ 165.T01–1162 Security Zones; Sail Boston, 250th Anniversary 2026; Boston Harbor, Boston, MA.

(a) The following areas are established as security zones:

(1) Security Zones for Foreign Naval Vessels.

(i) *Location.* All navigable waters within Sector Boston Marine Inspection and Captain of the Port Zone as described in 33 CFR 3.05–10 extending from the surface to bottom, within a 100-yard radius of any foreign flag naval vessels.

(ii) *Effective and enforcement periods.* This section will be effective from 12:01 a.m. July 10, 2026, through 11:59 p.m. on July 16, 2026. The Captain of the Port (COTP) will make notification of the exact names of the vessels in advance of each enforcement period for the security zone to the local maritime community through the Local Notice to Mariners (LNMs) and Broadcast Notices to Mariners (BNMs). The Coast Guard Northeast District Local Notice to Mariners can be found at: <http://www.navcen.uscg.gov>.

(b) *Definitions.* As used in this section, *designated representative* means a Coast Guard Patrol Commander, including a Coast Guard coxswain, petty officer, or other officer operating a Coast Guard vessel and a Federal, State, and local officer designated by or assisting the COTP in the enforcement of the security zone.

Foreign Naval Vessel means any naval vessel of a foreign state, which is not required to be licensed for entry into the U.S. for visit purposes under 22 CFR 126.6, provided it is not undergoing repair or overhaul.

(c) *Regulations.*

(1) Under the general security zone regulations in subpart C of this part, you may not enter the security zones described in paragraph (a) of this section unless authorized by the COTP or the COTP's designated representative.

(2) To seek permission to enter, contact the COTP or the COTP representative via VHF channel 16 or 833–449–0593 (Sector Boston Command Center) to obtain permission. Those in a security zone must comply with all lawful orders or directions given to

them by the COTP or the COTP representative.

M.E. Platt,

Rear Admiral, U.S. Coast Guard, Commander, Coast Guard Northeast District.

[FR Doc. 2026–02724 Filed 2–10–26; 8:45 am]

BILLING CODE 9110–04–P

ENVIRONMENTAL PROTECTION AGENCY**40 CFR Part 770**

[EPA–HQ–OPPT–2017–0245; FRL–12941–03–OCSP]

RIN 2070–AL36

Voluntary Consensus Standards Update; Formaldehyde Emission Standards for Composite Wood Products

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: The Environmental Protection Agency (EPA) is proposing to update the incorporation by reference of several voluntary consensus standards in the Agency's formaldehyde standards for composite wood products regulations under the Toxic Substances Control Act (TSCA) due to the standards having been updated or superseded by the issuing organizations. These new standards primarily update test methods and product standards concerning composite wood products that use formaldehyde. EPA is also proposing to conform these updated standards in the scope and definitional sections in the final rule and to incorporate by reference a new small scale quality control chamber test method, similar to current methods already incorporated by reference.

DATES: Comments must be received on or before March 13, 2026.

ADDRESSES: Submit your comments, identified by docket identification (ID) number EPA–HQ–OPPT–2017–0245, using the Federal eRulemaking Portal 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: For technical information contact: Maxim

Pohl, Existing Chemicals Risk Management Division (Mail Code 5133G), Office of Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460-0001; telephone number: (202) 566-2827; email address: pohl.maxim@epa.gov.

For general information contact: The TSCA Assistance Information Service Hotline, Goodwill Vision Enterprises, 422 South Clinton Ave., Rochester, NY 14620; telephone number: (800) 471-7127 or (202) 554-1404; email address: TSCA-Hotline@epa.gov.

SUPPLEMENTARY INFORMATION:

I. Executive Summary

A. Does this action apply to me?

You may be affected by this proposed rule if you manufacture (including import), sell, supply, or offer for sale in the United States any of the following: hardwood plywood, medium-density fiberboard, particleboard, and/or products containing these composite wood materials. You may also be affected by this proposed rule if you test or work with certification firms that certify such materials. The following list of North American Industrial Classification System (NAICS) codes is not intended to be exhaustive, but rather it provides a guide to help readers determine whether this document applies to them. Potentially affected entities may include:

- Veneer, plywood, and engineered wood product manufacturing (NAICS code 3212).
- Manufactured home (mobile home) manufacturing (NAICS code 321991).
- Prefabricated wood building manufacturing (NAICS code 321992).
- Furniture and related product manufacturing (NAICS code 337).
- Furniture merchant wholesalers (NAICS code 42321).
- Lumber, plywood, millwork, and wood panel merchant wholesalers (NAICS code 42331).
- Other construction material merchant wholesalers (NAICS code 423390) (e.g., merchant wholesale distributors of manufactured homes (i.e., mobile homes) and/or prefabricated buildings).
- Furniture stores (NAICS code 4421).
- Building material and supplies dealers (NAICS code 4441).
- Manufactured (mobile) home dealers (NAICS code 45393).
- Motor home manufacturing (NAICS code 336213).
- Travel trailer and camper manufacturing (NAICS code 336214).
- Recreational vehicle (RV) dealers (NAICS code 441210).

- Recreational vehicle merchant wholesalers (NAICS code 423110).
- Engineering services (NAICS code 541330).
- Testing laboratories (NAICS code 541380).
- Administrative management and general management consulting services (NAICS code 541611).
- All other professional, scientific, and technical services (NAICS code 541990).
- All other support services (NAICS code 561990).
- Business associations (NAICS code 813910).
- Professional organizations (NAICS code 813920).

If you have any questions regarding the applicability of this action, please consult the technical person listed under **FOR FURTHER INFORMATION CONTACT**.

B. What is the Agency's authority for taking this action?

EPA is proposing this rule pursuant to the authority in section 601 of TSCA, 15 U.S.C. 2697, relating to formaldehyde emission standards for composite wood products.

C. What action is the Agency taking?

The Agency is proposing to update the Incorporation-By-Reference (IBR) for certain voluntary consensus standards in 40 CFR 770.99 to reflect the most current standards issued by the relevant standards organizations. EPA is also proposing to conform these voluntary consensus standards in the scope and definitional sections of 40 CFR part 770. In addition, EPA is proposing to incorporate by reference at 40 CFR 770.99 an additional small scale quality control chamber test method, ISO 12460-2:2024(en).

D. Why is the Agency taking this action?

The Agency is proposing this action to update the incorporation by reference for several voluntary consensus standards at 40 CFR 770.99 to their current editions to address outdated, superseded, and withdrawn standards that have been updated between 2022 and 2024. These updates are needed because several of the standards in 40 CFR 770.99 are outdated. EPA is also proposing to conform these voluntary consensus standards in the scope and definitional sections of 40 CFR part 770 to reflect the current editions that must be used by regulated entities, if finalized as proposed. EPA is also proposing to incorporate by reference at 40 CFR 770.99 an additional small scale quality control chamber test method, ISO 12460-2:2024(en).

E. What are the incremental economic impacts?

EPA anticipates no additional costs to stakeholders associated with this notice of proposed rulemaking for updated standards. This is a routine action that proposes to update outdated voluntary consensus standards incorporated by reference at 40 CFR part 770.

II. Background

A. Regulatory Overview

1. Formaldehyde Emission Standards for Composite Wood Products

The Formaldehyde Standards for Composite Wood Products Act of 2010 (Pub. L. 111-199, 124 Stat. 1359) created Title VI of TSCA (15 U.S.C. 2697), established emission standards for formaldehyde from composite wood products, and directed EPA to implement and enforce a number of provisions covering composite wood products. On December 12, 2016, EPA published a final rule (2016 final rule) (Ref. 1) to reduce exposure to formaldehyde emissions from certain wood products produced domestically or imported into the United States. EPA worked with the California Air Resource Board (CARB) to help align the 2016 final rule with the Airborne Toxics Control Measure (ATCM) (Ref. 2) to the extent EPA deemed appropriate and practical considering TSCA Title VI. By including provisions for laminated products, product-testing requirements, labeling, recordkeeping, and import certification, the 2016 final rule requires that hardwood plywood, medium-density fiberboard, and particleboard products sold, supplied, offered for sale, imported to, or manufactured in the United States be in compliance with the emission standards. The 2016 final rule also established a third-party certification program for laboratory testing and oversight of formaldehyde emissions from manufactured and/or imported composite wood products.

2. 2018 Voluntary Consensus Standards Amendment

On February 7, 2018, EPA published a final rule (Ref. 3) to update several voluntary consensus standards incorporated by reference at 40 CFR 770.99. These updates applied to emission testing methods and regulated composite wood product construction characteristics. Several of the organizations that develop voluntary consensus standards (i.e., technical specifications for products or processes developed by standard-setting bodies) had updated, superseded, and/or withdrawn their standards through the

normal course of business to take into account new information, technology, and methodologies.

3. 2019 Technical Issues Amendment

On August 21, 2019, EPA amended 40 CFR part 770 via a final rule (2019 final rule) (Ref. 4) to address certain technical issues. The 2019 final rule:

- Further aligned testing requirements with the CARB ATCM;
- Clarified provisions addressing non-complying lots and how those provisions apply to fabricators, importers, retailers, and distributors who are notified by panel producers that composite wood products they were supplied are found to be non-compliant after those composite wood products have been further fabricated into component parts or finished goods;
- Clarified that regulated composite wood products and finished goods containing composite wood products must be labeled at the point of manufacture or fabrication, and if imported, the label must be applied to the products as a condition of importation;
- Addressed TSCA Title VI “manufactured-by” date issues; and
- Updated two voluntary consensus standards that were incorporated by reference in 40 CFR 770.99.

4. 2023 Voluntary Consensus Standards Amendment

On February 21, 2023, EPA published a final rule (2023 final rule) (Ref. 5) that amended 40 CFR part 770 to, among other things:

- Update the incorporation by reference for ten voluntary consensus standards to reflect the current editions that are in use by regulated entities and industry stakeholders. These updates were needed to ensure continued consistency with the standards adopted and used by industry.
- Allow for remote inspections in the event of unsafe conditions that would prevent a third-party certifier (TPC) from traveling in-person to the area. During the COVID-19 public health emergency, EPA provided temporary flexibility to allow TPCs to conduct remote inspections to satisfy the requirements of the rule. EPA made this flexibility permanent and allowed TPCs to conduct the required initial on-site inspection or quarterly inspections and sample collections remotely when in-person, on-site inspections are temporarily infeasible because of unsafe conditions.
- Include certain technical corrections and updates to create additional flexibilities for the third-party certification process, as well as

clarifying language as it relates to the production of wood products. Those corrections better aligned EPA’s rule with the CARB requirements.

B. Proposed Amendments

1. Voluntary Consensus Standards IBR Update

a. IBR Update

EPA is proposing to update the IBR of certain voluntary consensus standards in 40 CFR 770.99 to reflect the most recent editions of the following standards assembled by the American National Standards Institute (ANSI), the American Society for Testing and Materials (ASTM), the British Standards Institute (BSI), the International Organization for Standardization (ISO), and the National Institute of Standards and Technology (NIST):

i. Product Standard for Structural Glued Laminated Timber (ANSI A190.1–2022)

This standard was initiated by the Engineered Wood Association (APA) and approved through ANSI. The ANSI standard details the specific requirements for production, inspection, testing and certification of structural glued laminated timber. The standard also describes a quality control system for the laminator, which covers plant qualification, daily quality control, product marking, and the functions of an accredited inspection agency. ANSI last updated this standard on February 17, 2022 (Ref. 6). EPA proposes to update the version of the standard incorporated by reference in 40 CFR 770.99 from ANSI A190.1–2017 to ANSI A190.1–2022.

ii. Standard Test Method for Determining Formaldehyde Levels From Wood Product Using a Desiccator (ASTM D5582–22)

This standard was issued by ASTM and identifies procedures for testing formaldehyde emission potential from wood products by measuring airborne formaldehyde after samples of a specified surface area are placed in a small distilled water reservoir within a closed desiccator for 2 hours. The ASTM standard was last updated in August 2022 (Ref. 7). EPA proposes to update the version of the standard incorporated by reference in 40 CFR 770.99 from ASTM D5582–14 to ASTM D5582–22.

iii. Standard Test Method for Determining Formaldehyde Concentrations in Air From Wood Products Using a Small-Scale Chamber (ASTM D6007–22)

This standard was issued by ASTM and describes the procedure for using a small-scale chamber test method to measure formaldehyde concentrations in air emitted by wood product test specimens under defined test conditions of temperature and relative humidity. Results from the small-scale method are intended to be comparable to results obtained from testing larger samples using the large chamber test method, described in ASTM E1333. This ASTM standard was last updated in August 2022 (Ref. 8). EPA proposes to update the version of the standard incorporated by reference in 40 CFR 770.99 from ASTM D6007–14 to ASTM D6007–22.

iv. Standard Test Method for Determining Formaldehyde Concentrations in Air and Emission Rates From Wood Products Using a Large Chamber (ASTM E1333–22)

This standard was issued by ASTM and describes the procedure for using a large chamber test method to measure formaldehyde concentration in air and emission rate from wood products under conditions designed to simulate product use, while maintaining specific test conditions of temperature and relative humidity. The standard was last updated in August 2022 (Ref. 9). EPA proposes to update the version of the standard incorporated by reference in 40 CFR 770.99 from ASTM E1333–14 to ASTM E1333–22.

v. Wood-Based Panels—Determination of Formaldehyde Release—Part 3: Gas Analysis Method (BS EN ISO 12460–3:2023)

This standard was approved through ISO and BSI and describes a procedure for determination of accelerated formaldehyde release from wood-based panels. The standard was last updated in September 2023 (Ref. 10). EPA proposes to update the version of the standard incorporated by reference in 40 CFR 770.99 from BS EN ISO 12460–3:2020 to BS EN ISO 12460–3:2023.

vi. Wood-Based Panels—Determination of Formaldehyde Release—Part 3: Gas Analysis Method (ISO 12460–3:2023(E))

This standard was approved through ISO and describes a procedure for determination of accelerated formaldehyde release from wood-based panels. ISO 12460–3:2023(E) is identical to BS EN ISO 12460–3:2023. This version was incorporated to avoid potential confusion by regulated

stakeholders and allow manufacturers to choose which standard to use in each respective country. The standard was last updated in September 2023 (Ref. 11). EPA proposes to update the version of the standard incorporated by reference in 40 CFR 770.99 from ISO 12460–3:2020(E) to ISO 12460–3:2023(E).

vii. Structural Plywood (PS 1–22)

This standard was issued by NIST and describes the principal types and grades of structural plywood, covering the wood species, veneer grading, adhesive bonds, panel construction and workmanship, dimensions and tolerances, marking, moisture content and packaging of structural plywood intended for construction and industrial uses. Test methods to determine compliance and a glossary of trade terms and definitions are included, as is a quality certification program involving inspection, sampling, and testing of products identified as complying with this standard by qualified testing agencies. The NIST standard was last updated on October 2, 2023 (Ref. 12). EPA proposes to update the version of the standard incorporated by reference in 40 CFR 770.99 from PS 1–19 to PS 1–22.

b. Addition of ISO 12460–2:2024(en) as an Alternative Quality Control Test Method

EPA is proposing to add ISO 12460–2:2024(en), Wood-based panels—Determination of Formaldehyde Release—Part 2: Small-scale Chamber Method (Ref. 13), as a quality control test method in 40 CFR 770.20(b)(1) and to IBR the standard in 40 CFR 770.99. This standard was approved through ISO and describes the procedure for using a small-scale chamber test method to test formaldehyde emissions from wood products under defined test conditions of temperature, relative humidity, loading and air exchange rate by measuring the concentrations of formaldehyde in air from samples of a specified surface area. This standard is a small scale quality control chamber test method that EPA is proposing to incorporate by reference as an allowable alternative quality control test method, due to its similarity to other standards currently incorporated by reference for quality control methods, and to allow regulated entities to make use of the wider range of analytical methods the standard allows, such as laser absorption spectroscopy.

Industry has requested including the latest testing methodology which allows for greater industry flexibility in choosing quality control methods that

best fit their circumstances. Proposing this additional standard also aligns with the CARB ATCM, which recently incorporated ISO 12460–2:2024(en) as a valid small scale quality control chamber test method. EPA believes that this action is warranted to facilitate regulated entities using the most up-to-date voluntary consensus standards to comply with the regulation at 40 CFR part 770 as well as align with current CARB requirements. Based on its similarity to other standards currently incorporated by reference for quality control methods and requests from industry to include the latest testing methodology, EPA proposes to add this new ISO standard as a quality control method in 40 CFR 770.20(b)(1) and to incorporate it by reference in 40 CFR 770.99.

EPA will initiate additional notice-and-comment rulemaking when necessary to reflect any future changes to voluntary consensus standards incorporated by reference in 40 CFR 770.99.

c. Availability

Copies of the standards identified in these sections II.B.1.a. and II.B.1.b. of **SUPPLEMENTARY INFORMATION** are available for inspection at the OPPT Docket in the EPA Docket Center (EPA/DC) at Rm. 3334, EPA, West Bldg., 1301 Constitution Ave. NW, Washington, DC. The EPA/DC Public Reading Room hours of operation are 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. For BS EN ISO 12460–3:2023, EPA has included in the OPPT Docket the preliminary pages of the document, which affirm that the remainder of its body is an identical adoption of ISO 12460–3:2023(E) that is available in the OPPT Docket. The telephone number of the EPA/DC Public Reading room is (202) 566–1744, and the telephone number for the OPPT Docket is (202) 566–0280. If you have a disability and the format of any material on an EPA web page interferes with your ability to access the information, please contact EPA's Rehabilitation Act Section 508 (29 U.S.C. 794d) Program at <https://www.epa.gov/accessibility/forms/contact-us-about-section-508-accessibility> or via email at section508@epa.gov. To enable us to respond in a manner most helpful to you, please indicate the nature of the accessibility issue, the web address of the requested material, your preferred format in which you want to receive the material (electronic format (ASCII, etc.), standard print, large print, etc.), and your contact information. Additionally, each of these standards can be obtained directly from the publisher or standards development

organization, as described in the following paragraphs.

i. ANSI A190.1 2022

Electronic copies of these materials may be obtained from APA at no cost at: <https://www.apawood.org/>. Copies of this standard may also be obtained from APA—The Engineered Wood Association, 7011 South 19th Street, Tacoma, WA 98466, or by calling (253) 565–6600.

ii. ASTM D5582–22, ASTM D6007–22 and ASTM E1333–22

Copies of these materials may be obtained from ASTM International, 100 Barr Harbor Dr., P.O. Box C700, West Conshohocken, PA 19428–2959, or by calling (610) 832–9585, or at <http://www.astm.org>. For information about the electronic availability of this standard for public review in read-only format during the public comment period, visit <https://www.epa.gov/formaldehyde/formaldehyde-emission-standards-composite-wood-products>.

iii. BS EN ISO 12460–3:2023

Copies of these materials may be obtained from the British Standard Institute, 1950 Opportunity Way, Suite 900 Reston, VA 20190, or by calling (800) 217–1390, or at <https://www.bsigroup.com/>. This BSI standard is an identical adoption of ISO 12460–3:2023(E), which is available as described in the next paragraph.

iv. ISO 12460–3:2023(E) and ISO 12460–2:2024(en)

Copies of these materials may be obtained from the International Organization for Standardization, 1, ch. de la Voie-Creuse, CP 56, CH–1211, Geneva 20, Switzerland, or by calling +41–22–749–01–11, or at <http://www.iso.org>. For information about the electronic availability of this standard for public review in read-only format during the public comment period, visit <https://www.epa.gov/formaldehyde/formaldehyde-emission-standards-composite-wood-products>.

v. PS 1–22

Electronic copies of these materials may be obtained from the NIST at no cost at: <http://www.nist.gov>. You may purchase printed copies of these materials from NIST by calling (800) 553–6847. You must have an order number to purchase a NIST publication. Order numbers may be obtained from the Public Inquiries Unit at (301) 975–NIST. Mailing address: Public Inquiries Unit, NIST, 100 Bureau Dr., Stop 1070, Gaithersburg, MD 20899–1070. In addition, you may also purchase printed

copies of NIST publications from the U.S. Government Printing Office (GPO) if you have a GPO stock number. GPO orders may be mailed to: U.S. Government Printing Office, P.O. Box 979050, St. Louis, MO 63197-9000, placed by telephone at (866) 512-1800 (DC Area only: (202) 512-1800), or faxed to (202) 512-2104.

2. Technical Correction(s)

To conform to the proposed list of updated standards and the addition of one new standard listed in sections II.B.1.a. and II.B.1.b. of **SUPPLEMENTARY INFORMATION**, EPA is proposing to update 40 CFR 770.1 and 770.3 to reflect the standards that EPA proposes to incorporate by reference in 40 CFR 770.99.

C. Rationale for Proposed Changes

EPA is proposing to update the incorporation by reference of certain voluntary consensus standards in 40 CFR 770.99 that have been updated, superseded, or withdrawn by the issuing organizations. These new standards are needed to reflect the most recent editions of those standards issued by the relevant standards organizations. EPA is also proposing the addition of a new standard, ISO 12460-2:2024(en), to allow industry greater flexibility in choosing quality control methods that best fit their circumstances, such as laser absorption spectroscopy. This additional standard also aligns with the CARB ATCM, which recently incorporated ISO 12460-2:2024(en) as a valid small scale quality control chamber test method. EPA believes that this action is warranted to facilitate regulated entities using the most up-to-date voluntary consensus standards to comply with the regulation at 40 CFR part 770 as well as align with current CARB requirements.

III. Request for Comments

When necessary, EPA intends to reflect any future changes to voluntary consensus standards incorporated by reference in 40 CFR 770.99 through additional notice-and-comment rulemaking. EPA is seeking public comment on the proposed updates to these standards, as well as additional standards that should be considered relevant or standards that may soon be updated that are not currently listed as part of this proposed rule, especially where their incorporation into future updates could allow regulated entities the flexibility to use newer standards that reflect industry best practices. EPA would also be interested in receiving feedback on any realized or expected cost savings or TSCA compliance

efficiencies that might be realized with the adoption of these new standards.

EPA also is specifically seeking comments from stakeholders under TSCA Title VI regarding the new small scale quality control chamber test method, ISO 12460-2:2024(en), that is being proposed. EPA is also seeking comment from stakeholders under TSCA Title VI on the British Standards Institute standard BS EN ISO 12460-3:2023, specifically regarding whether this standard should be retained in the final rule or whether BS EN ISO 12460-3 should be removed as an incorporated standard, given that an identical, international version (ISO 12460-3:2023) is also proposed for incorporation into the rule.

IV. References

The following is a list of the documents that are specifically referenced in this document. The docket includes these documents and other information considered by EPA, including documents that are referenced within the documents that are included in the docket, even if the referenced document is not physically located in the docket. For assistance in locating these other documents, please consult the technical person listed under **FOR FURTHER INFORMATION CONTACT**.

1. EPA. Formaldehyde Emission Standards for Composite Wood Products. Final Rule. **Federal Register**. 81 FR 89674, December 12, 2016 (FRL-9949-90).
2. California Environmental Protection Agency Air Resources Board. Airborne Toxic Control Measure to Reduce Formaldehyde Emissions from Composite Wood Products. Final Regulation Order. April 2008.
3. EPA. Voluntary Consensus Standards Update; Formaldehyde Emission Standards for Composite Wood Products. Final Rule. **Federal Register**. 83 FR 5340, February 7, 2018 (FRL-9972-68).
4. EPA. Technical Issues; Formaldehyde Emission Standards for Composite Wood Products. Final Rule. **Federal Register**. 84 FR 43517, August 21, 2019 (FRL-9994-47).
5. EPA. Voluntary Consensus Standards Update; Formaldehyde Emission Standards for Composite Wood Products. Final Rule. **Federal Register**. 88 FR 10468, February 21, 2023 (FRL-8452-01).
6. American National Standards Institute (ANSI). American National Product Standard for Structural Glued Laminated Timber, ANSI A190.1-2022.
7. American Society for Testing and Materials (ASTM). ASTM D5582-22, Standard Test Method for Determining Formaldehyde Levels from Wood Products Using a Desiccator.
8. ASTM. ASTM D6007-22, Standard Test Method for Determining Formaldehyde Concentrations in Air from Wood Products Using a Small-Scale Chamber.

9. ASTM. ASTM E1333-22, Standard Test Method for Determining Formaldehyde Concentrations in Air and Emission Rates from Wood Products Using a Large Chamber.
10. British Standards Institute (BSI). BS EN ISO 12460-3:2023, Wood-based Panels—Determination of Formaldehyde Release—Part 3: Gas Analysis Method.
11. International Organization for Standardization (ISO). ISO 12460-3:2023(E), Wood-based Panels—Determination of Formaldehyde Release—Part 3: Gas Analysis Method.
12. National Institute of Standards and Technology (NIST). PS 1-22, Structural Plywood.
13. ISO. ISO 12460-2:2024(en) Wood-based panels—Determination of formaldehyde release Part 2: Small-scale chamber method.

V. Statutory and Executive Order Reviews

Additional information about these statutes and Executive Orders can be found at <https://www.epa.gov/laws-regulations/laws-and-executive-orders>.

A. Executive Order 12866: Regulatory Planning and Review and Executive Order 13563: Improving Regulation and Regulatory Review

This action is not a significant regulatory action under Executive Order 12866 (58 FR 51735, October 4, 1993) and was therefore not submitted to the Office of Management and Budget (OMB) for review under Executive Orders 12866 and 13563 (76 FR 3821, January 21, 2011).

B. Executive Order 14192: Unleashing Prosperity Through Deregulation

This action is not expected to be an Executive Order 14192 (90 FR 9065, January 31, 2025) regulatory action because this action is not significant under Executive Order 12866.

C. Paperwork Reduction Act (PRA)

This action does not impose any new information collection burden under the PRA, 44 U.S.C. 3501 *et seq.* Burden is defined in 5 CFR 1320.3(b). This action does not create any new reporting or recordkeeping obligations. OMB previously approved the information collection activities contained in the existing regulations and assigned OMB control number 2070-0185.

D. Regulatory Flexibility Act (RFA)

I certify that this action will not have a significant economic impact on a substantial number of small entities under the RFA, 5 U.S.C. 601 *et seq.* In making this determination, EPA concludes that the impact of concern for this action is any significant adverse economic impact on small entities, and

the Agency is certifying that this action will not have a significant economic impact on a substantial number of small entities because the proposed rule would update incorporation by reference of voluntary consensus standards in 40 CFR part 770 by adopting the most current versions of those standards and by adding one new voluntary consensus standard as a quality control test method. The updated versions of the standards are substantially similar to the previous versions. EPA expects that many small entities are already complying with the updated versions of the proposed standards listed Unit II.B. This action would allow these entities the flexibility to use the most up to date versions of the standards instead of using outdated versions that do not reflect industry best practice. This action also adds one new voluntary consensus standard as a quality control test method in 40 CFR 770.20(b)(1), which regulated entities may opt to use in lieu of the other approved quality control methods, thereby increasing regulatory flexibility. We have therefore concluded that this action will have no net regulatory burden for all directly regulated small entities.

E. Unfunded Mandates Reform Act (UMRA)

This action does not contain an unfunded mandate of \$100 million (in 1995 dollars and adjusted annually for inflation) or more as described in UMRA, 2 U.S.C. 1531–1538, and does not significantly or uniquely affect small governments. The action imposes no enforceable duty on any state, local or tribal governments. As discussed in Unit V.D., the proposed rule would impose no net regulatory burdens on the private sector.

F. Executive Order 13132: Federalism

This action does not have federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999) because it will not have substantial direct effects 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.

G. Executive Order 13175: Consultation and Coordination With Indian Tribal Governments

This action does not have tribal implications as specified in Executive Order 13175 (65 FR 67249, November 9, 2000), because it will not have substantial direct effects on tribal governments, on the relationship

between the Federal government and the Indian tribes, or on the distribution of power and responsibilities between the Federal government and Indian tribes. Thus, E.O. 13175 does not apply to this action.

H. Executive Order 13045: Protection of Children From Environmental Health Risks and Safety Risks

EPA interprets Executive Order 13045 (62 FR 19885, April 23, 1997), as applying only to those regulatory actions that concern environmental health or safety risks that the Agency has reason to believe may disproportionately affect children, per the definition of “covered regulatory action” in section 2–202 of Executive Order 13045. This action is not subject to Executive Order 13045 because it does not concern an environmental health risk or safety risk. Since this action does not concern human health, EPA’s Policy on Children’s Health also does not apply.

I. Executive Order 13211: Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use

This action is not subject to Executive Order 13211 (66 FR 28355, May 22, 2001), because it is not a significant regulatory action under Executive Order 12866.

J. National Technology Transfer and Advancement Act (NTTAA)

This action involves voluntary standards under NTTAA section 12(d), 15 U.S.C. 272. EPA is proposing to adopt the use of ANSI A190.1–2022, ASTM D5582–22, ASTM D6007–22, ASTM E1333–22, BS EN ISO 12460–3:2023, ISO 12460–3:2023(E), ISO 12460–2:2024(en) and PS 1–22. Additional information about these standards, including how to access them, is provided in Unit II.B.1. of **SUPPLEMENTARY INFORMATION**. The following standards appear in the amendatory text of this document and have already been approved for the locations in which they appear: ANSI A135.4–2012, ANSI A135.5–2012, ANSI A135.6–2012, ANSI A135.7–2012, ANSI/HPVA HP–1–2020, ISO/IEC 17011:2017(E), ISO/IEC 17020:2012(E), ISO/IEC 17025:2017(E), ISO/IEC 17065:2012(E), and PS 2–18. No changes are proposed to the currently-approved IBR material.

List of Subjects in 40 CFR Part 770

Environmental protection, Formaldehyde, Incorporation by reference, Reporting and recordkeeping

requirements, Third-party certification, Toxic substances, Wood.

Dated: February 6, 2026.

Douglas M. Troutman,
Assistant Administrator, Office of Chemical Safety and Pollution Prevention.

Therefore, for the reasons set forth in the preamble, EPA proposes to amend 40 CFR part 770 as follows:

PART 770—FORMALDEHYDE STANDARDS FOR COMPOSITE WOOD PRODUCTS

■ 1. The authority citation for part 770 continues to read as follows:

Authority: 15 U.S.C. 2697(d).

■ 2. Amend § 770.1 by revising paragraphs (c)(3) and (7) to read as follows:

§ 770.1 Scope and applicability.

* * * * *

(c) * * *
(3) Structural plywood, as specified in PS 1–22 (incorporated by reference, see § 770.99).

* * * * *

(7) Glued laminated lumber, as specified in ANSI A190.1–2022, Standard for Wood Products—Structural Glued Laminated Timber (incorporated by reference, see § 770.99).

* * * * *

■ 3. Amend § 770.3 by revising the definitions for “Hardboard”, “Hardwood plywood”, and “Quality control limit or QCL” to read as follows:

§ 770.3 Definitions

* * * * *

Hardboard means a composite panel composed of cellulosic fibers, consolidated under heat and pressure in a hot press by: A wet process; or a dry process that uses a phenolic resin, or a resin system in which there is no formaldehyde as part of the resin cross-linking structure; or a wet formed/dry pressed process; and that is commonly or commercially known, or sold, as hardboard, including any product conforming to one of the following ANSI standards: Basic Hardboard (ANSI A135.4–2012) (incorporated by reference, see § 770.99), Prefinished Hardboard Paneling (ANSI A135.5–2012) (incorporated by reference, see § 770.99), Engineered Wood Siding (ANSI A135.6–2012) (incorporated by reference, see § 770.99), or Engineered Wood Trim (ANSI A135.7–2012) (incorporated by reference, see § 770.99). There is a rebuttable presumption that products emitting more than 0.06 ppm formaldehyde as measured by ASTM E1333–22 (incorporated by reference, see § 770.99)

or ASTM D6007–22 (incorporated by reference, see § 770.99) are not hardboard.

* * * *

Hardwood plywood means a hardwood or decorative panel that is intended for interior use and composed of (as determined under ANSI/HPVA HP–1–2020 (incorporated by reference, see § 770.99)) an assembly of layers or plies of veneer, joined by an adhesive with a lumber core, a particleboard core, a medium-density fiberboard core, a hardboard core, a veneer core, or any other special core or special back material. Hardwood plywood does not include military-specified plywood, curved plywood, or any plywood specified in PS 1–22 (incorporated by reference, see § 770.99), or PS 2–18 (incorporated by reference, see § 770.99). In addition, hardwood plywood includes laminated products except as provided at § 770.4.

* * * *

Quality control limit or QCL means the value from the quality control method test that is the correlative equivalent to the applicable emission standard based on the ASTM E1333–22 method (incorporated by reference, see § 770.99) or, upon showing equivalence in accordance with § 770.20(d), the ASTM D6007–22 method (incorporated by reference, see § 770.99).

* * * *

■ 4. Amend § 770.7 by revising paragraphs (a)(5)(i)(D) and (F), (b)(5)(i) introductory text, (c)(1)(ii) and (v), (c)(2)(iv) and (viii), and (c)(4)(i)(B) and (v)(C) to read as follows:

§ 770.7 Third-party certification.

(a) * * *

(5) * * *

(i) * * *

(D) A review of the approach that the TPC laboratory will use for establishing correlation or equivalence between ASTM E1333–22 and ASTM D6007–22, if used, (incorporated by reference, see § 770.99) or allowable formaldehyde test methods listed under § 770.20.

* * * *

(F) A review of the accreditation credentials of the TPC laboratory, including a verification that the laboratory has been accredited to ISO/IEC 17025:2017(E) (incorporated by reference, see § 770.99) with a scope of accreditation to include this part—Formaldehyde Standards for Composite Wood Products and the formaldehyde test methods ASTM E1333–22 and ASTM D6007–22, if used, by an EPA TSCA Title VI Laboratory AB

(incorporated by reference, see § 770.99).

* * * *

(b) * * *

(5) * * *

(i) *Accreditation.* EPA TSCA Title VI Laboratory ABs must determine the accreditation eligibility, and accredit if appropriate, each TPC seeking recognition under the EPA TSCA Title VI Third-Party Certification Program by performing an assessment of each TPC. The assessment must include an on-site assessment by the EPA TSCA Title VI Laboratory AB to determine whether the laboratory meets the requirements of ISO/IEC 17025:2017(E) (incorporated by reference, see § 770.99), is in conformance with ISO/IEC 17020:2012(E) (incorporated by reference, see § 770.99) and the EPA TSCA Title VI TPC requirements under this part including the formaldehyde test methods ASTM E1333–22 and ASTM D6007–22 (incorporated by reference, see § 770.99), if used. In performing the on-site assessment, the EPA TSCA Title VI Laboratory AB must:

* * * *

(c) * * *

(1) * * *

(ii) Be, or have a contract with a laboratory that is, accredited by an EPA TSCA Title VI Laboratory AB to ISO/IEC 17025:2017(E) (incorporated by reference, see § 770.99) with a scope of accreditation to include this part—Formaldehyde Standards for Composite Wood Products—and the formaldehyde test methods ASTM E1333–22 and ASTM D6007–22, if used (incorporated by reference, see § 770.99);

* * * *

(v) Have demonstrated experience in performing or verifying formaldehyde emissions testing on composite wood products, including experience with test method ASTM E1333–22 and ASTM D6007–22, if used, (incorporated by reference, see § 770.99), and experience evaluating correlation between test methods. Applicant TPCs that have demonstrated experience with test method ASTM D6007–22 only, must be contracting testing with a laboratory that has a large chamber and demonstrate its experience with ASTM E1333–22.

* * * *

(c) * * *

(2) * * *

(iv) A copy of the TPC laboratory's certificate of accreditation from an EPA TSCA Title VI Laboratory AB to ISO/IEC 17025:2017(E) (incorporated by reference, see § 770.99) with a scope of accreditation to include this part—Formaldehyde Standards for Composite Wood Products—and the formaldehyde

test methods ASTM E1333–22 and ASTM D6007–22 (incorporated by reference, see § 770.99), if used;

* * * *

(viii) A description of the TPC's experience with test method ASTM E1333–22 and/or ASTM D6007–22, if used, (incorporated by reference, see § 770.99), and experience evaluating correlation between test methods. Applicant TPCs that have experience with test method ASTM D6007–22 only, must be contracting testing with a laboratory that has a large chamber and describe its experience with ASTM E1333–22; and

* * * *

(c) * * *

(4) * * *

(i) * * *

(B) Verify each panel producer's quality control test results compared with test results from ASTM E1333–22 and ASTM D6007–22, if used, (incorporated by reference, see § 770.99) by having the TPC laboratory conduct quarterly tests and evaluate test method equivalence and correlation as required under § 770.20;

* * * *

(v) * * *

(C) Notification of a panel producer exceeding its established QCL for three consecutive quality control tests within 72 hours of the time that the TPC becomes aware of the third consecutive exceedance. The notice must include the product type, dates of the quality control tests that exceeded the QCL, quality control test results, ASTM E1333–22 (incorporated by reference, see § 770.99) or ASTM D6007–22 method (incorporated by reference, see § 770.99) correlative equivalent values in accordance with § 770.20(d), the established QCL value(s) and the quality control method used.

* * * *

■ 5. Amend § 770.10 by revising paragraph (b) introductory text to read as follows:

§ 770.10 Formaldehyde emission standards.

* * * *

(b) The emission standards are based on test method ASTM E1333–22 (incorporated by reference, see § 770.99), and are as follows:

* * * *

■ 6. Amend § 770.15 by revising paragraphs (c)(1)(v) and (2)(iii) to read as follows:

§ 770.15 Composite wood product certification.

* * * *

(c) * * *

(1) * * *

(v) At least five tests conducted under the supervision of an EPA TSCA Title VI TPC pursuant to test method ASTM E1333–22 or ASTM D6007–22 (incorporated by reference, see § 770.99). Test results obtained by ASTM D6007–22 must include a showing of equivalence in accordance with § 770.20(d)(1);

* * * * *

(2) * * *

(iii) At least five tests conducted under the supervision of an EPA TSCA Title VI TPC pursuant to test method ASTM E1333–22 or ASTM D6007–22 (incorporated by reference, see § 770.99). Test results obtained by ASTM D6007–22 must include a showing of equivalence in accordance with § 770.20(d)(1);

* * * * *

■ 7. Amend § 770.17 by revising paragraph (a)(3) to read as follows:

§ 770.17 No-added formaldehyde-based resins.

* * * * *

(a) * * *

(3) At least one test conducted under the supervision of an EPA TSCA Title VI TPC pursuant to test method ASTM E1333–22 or ASTM D6007–22 (incorporated by reference, see § 770.99). Test results obtained by ASTM D6007–22 must include a showing of equivalence in accordance with § 770.20(d)(1); and

* * * * *

■ 8. Amend § 770.18 by revising paragraph (a)(3) to read as follows:

§ 770.18 Ultra low-emitting formaldehyde resins.

* * * * *

(a) * * *

(3) At least two tests conducted under the supervision of an EPA TSCA Title VI TPC pursuant to test method ASTM E1333–22 or ASTM D6007–22 (incorporated by reference, see § 770.99). Test results obtained by ASTM D6007–22 must include a showing of equivalence in accordance with § 770.20(d)(1); and

* * * * *

■ 9. Amend § 770.20 by:

■ a. Adding paragraph (b)(1)(viii)

■ b. Revising paragraphs (b)(1)(i) through (iii), (c)(1) and (2)(iv), (d) introductory text, (d)(1) introductory text, (d)(1)(i) through (iii), (d)(2) introductory text, and (d)(2)(i).

The additions and revisions read as follows:

§ 770.20 Testing requirements.

* * * * *

(b) * * *

(1) * * *

(i) ASTM D6007–22 (incorporated by reference, see § 770.99).

(ii) ASTM D5582–22 (incorporated by reference, see § 770.99).

(iii) BS EN ISO 12460–3:2023 (incorporated by reference, see § 770.99) or ISO 12460–3:2023(E) (incorporated by reference, see § 770.99).

* * * * *

(viii) ISO 12460–2:2024(en) (incorporated by reference, see § 770.99).

* * * * *

(c) * * *

(1) *Allowable methods.* Quarterly testing must be performed using ASTM E1333–22 (incorporated by reference, see § 770.99) or, with a showing of equivalence pursuant to paragraph (d) of this section, ASTM D6007–22 (incorporated by reference, see § 770.99).

* * * * *

(2) * * *

(iv) Test results may represent a single chamber value or, if using the ASTM D6007–22 apparatus, the average value of testing nine specimens representing evenly distributed portions of an entire panel. The nine specimens must be tested in groups of three specimens, resulting in three data points, which must be averaged to represent one test value for the panel those specimens represent.

* * * * *

(d) *Equivalence or correlation.*

Equivalence between ASTM E1333–22 (incorporated by reference, see § 770.99) and ASTM D6007–22 (incorporated by reference, see § 770.99) must be demonstrated by EPA TSCA Title VI TPCs at least once each year or whenever there is a significant change in equipment, procedure, or the qualifications of testing personnel, or reason to believe that the equivalence is no longer valid. Equivalence may be demonstrated between several similar model or size and construction ASTM E1333–22 (incorporated by reference, see § 770.99) and ASTM D6007–22 (incorporated by reference, see § 770.99) apparatuses located in the same EPA TSCA Title VI TPC laboratory. Once equivalence has been established for three consecutive years, equivalence must be demonstrated every two years or whenever there is a significant change in equipment, procedure, or the qualifications of testing personnel. Correlation between ASTM E1333–22 (incorporated by reference, see § 770.99) or, upon a showing of equivalence in accordance with paragraph (d) of this section, ASTM D6007–22 (incorporated by reference, see § 770.99) and any other

test method used for quality control testing must be demonstrated by EPA TSCA Title VI TPCs or panel producers, respectively, before the certification of composite wood products, and then whenever there is a significant change in equipment, procedure, the qualifications of testing personnel, or reason to believe that the correlation is no longer valid. Correlation may be established between several similar model or size and construction mill quality control test methods defined in paragraph (b)(1) of this section located at any one physical mill quality control testing laboratory to the EPA TSCA Title VI TPC's laboratory's ASTM E1333–22 (incorporated by reference, see § 770.99) and/or ASTM D6007–22 (incorporated by reference, see § 770.99) apparatus. If the TPC laboratory's ASTM E1333–22 or equivalent ASTM D6007–22 test chamber is used for panel producer quality control testing, no correlation as determined in paragraph (d)(2) of this section would be required. Equivalence and correlation sample selection should be conducted in accordance with paragraph (c)(2)(iv) of this section.

(1) *Equivalence between ASTM E1333–22 and ASTM D6007–22 when used by the TPC for quarterly testing.* Equivalence must be demonstrated for at least five comparison sample sets in each range tested by the TPC, which compare the results of the two methods. Equivalence must be demonstrated for any ranges listed in paragraph (d)(1)(iv) of this section that represent the formaldehyde emissions of composite wood products tested by the TPC.

(i) * * *

(A) For the ASTM E1333–22 method (incorporated by reference, see § 770.99), each comparison sample must consist of the result of testing panels, using the applicable loading ratios specified in the ASTM E1333–22 method (incorporated by reference, see § 770.99), from similar panels of the same product type tested by the ASTM D6007–22 method (incorporated by reference, see § 770.99).

(B) For the ASTM D6007–22 method (incorporated by reference, see § 770.99), each comparison sample shall consist of testing specimens representing portions of panels similar to the panels tested in the ASTM E1333–22 method (incorporated by reference, see § 770.99) and matched to their respective ASTM E1333–22 method (incorporated by reference, see § 770.99) comparison sample result. The ratio of air flow to sample surface area specified in ASTM D6007–22 (incorporated by reference, see § 770.99) must be used.

(C) The five comparison sample must consist of testing a minimum of five sample sets as measured by the ASTM

E1333–22 method (incorporated by reference, see § 770.99).
(ii) *Average and standard deviation.* The arithmetic mean, $\bar{X}$, and standard

deviation, S , of the difference of all comparison sets must be calculated as follows:

$$\bar{X} = \sum_{i=1}^n D_i/n \quad S = \sqrt{\sum_{i=1}^n (D_i - \bar{X})^2 / (n - 1)}$$

Where $\bar{X}$ = arithmetic mean; S = standard deviation; n = number of sets; D_i = difference between the ASTM E1333–22 and ASTM D6007–22 method (incorporated by reference, see § 770.99) values for the i th set; and i ranges from 1 to n .

(iii) *Equivalence determination.* The ASTM D6007–22 method (incorporated by reference, see § 770.99) is considered equivalent to the ASTM E1333–22 method (incorporated by reference, see § 770.99) if the following condition is met:

$$|\bar{X}| + 0.88S \leq C$$

Where C is equal to:

0.026 for the lower range;
0.038 for the intermediate range; and
0.052 for the upper range.

* * *

(2) *Correlation between ASTM E1333–22 (incorporated by reference, see § 770.99), or equivalent ASTM D6007–22 (incorporated by reference, see § 770.99), and any quality control test method.* Correlation must be demonstrated by establishing an acceptable correlation coefficient (“ r ” value) or following the threshold approach at paragraph (d)(2)(i)(B) of this section.

(i) *Correlation.* The correlation must be based on a minimum sample size of five data pairs and a simple linear regression (unless the threshold approach at paragraph (d)(2)(i)(B) of this section is used) where the dependent variable (Y -axis) is the quality control test value and the independent variable (X -axis) is the ASTM E1333–22 (incorporated by reference, see § 770.99) test value or, upon a showing of equivalence in accordance with paragraph (d) of this section, the equivalent ASTM D6007–22 (incorporated by reference, see § 770.99) test value. Either composite wood products or formaldehyde emissions reference materials can be used to establish the correlation.

(A) *Cluster Approach.* A panel producer may work with its EPA TSCA Title VI TPC to develop a correlation and linear regression between the TPC’s ASTM E1333–22 (incorporated by

reference, see § 770.99) or equivalent ASTM D6007–22 (incorporated by reference, see § 770.99) test method and the panel producer’s quality control method under paragraph (b) of this section. In the event of clustered test results, a panel producer may fit a line through a point near the origin (the intersection of the X and Y axes) and the average value of the clustered data pairs. The point near the origin should represent the value for the EPA TSCA Title VI TPC’s ASTM E1333–22 (incorporated by reference, see § 770.99) or equivalent ASTM D6007–22 (incorporated by reference, see § 770.99) test method and the panel producer’s quality control method under § 770.20(b) when each testing apparatus is empty or when a very low emitting sample is tested. The average value of the clustered data pairs represents the average of a minimum of five data pairs that compare the test results of the EPA TSCA Title VI TPC’s ASTM E1333–22 (incorporated by reference, see § 770.99) or equivalent ASTM D6007–22 (incorporated by reference, see § 770.99) test method with the panel producer’s quality control method under paragraph (b) of this section. The line between the point near the origin and the average value of the cluster provides the linear regression. This line may be used by the panel producer and TPC to develop a quality control limit for the product.

(B) *Threshold Approach.* As an alternative to the linear regression and cluster approaches, a panel producer may use the average value of the clustered data pairs from the EPA TSCA Title VI TPC’s ASTM E1333–22 (incorporated by reference, see § 770.99) or equivalent ASTM D6007–22 (incorporated by reference, see § 770.99) test method and the panel producer’s quality control method under paragraph (b) of this section as the quality control limit for the product. In this approach, no linear regression line is established. The average value would be assigned as the upper quality control limit for production of the subject composite

wood product and must be below the applicable emission standard.

* * *

■ 11. Amend § 770.99 by:

- a. Revising paragraphs (a)(1), (b)(3) through (5), (c)(1), and (i)(1); and
- b. Revising and republishing paragraph (g).

The revisions read as follows:

§ 770.99 Incorporation by reference.

* * *

(a) * * *

(1) ANSI A190.1–2022, Product Standard for Structural Glued Laminated Timber, Approved February 17, 2022; IBR approved for § 770.1(c).

* * *

(b) * * *

(3) ASTM D5582–22, Standard Test Method for Determining Formaldehyde Levels from Wood Products Using a Desiccator, Approved August, 2022; IBR approved for § 770.20(b).

(4) ASTM D6007–22, Standard Test Method for Determining Formaldehyde Concentrations in Air from Wood Products Using a Small-Scale Chamber, Approved August, 2022; IBR approved for §§ 770.3; 770.7(a) through (c); 770.15(c); 770.17(a); 770.18(a); 770.20(b) through (d).

(5) ASTM E1333–22, Standard Test Method for Determining Formaldehyde Concentrations in Air and Emission Rates from Wood Products Using a Large Chamber, Approved August, 2022; IBR approved for §§ 770.3; 770.7(a) through (c); 770.10(b); 770.15(c); 770.17(a); 770.18(a); 770.20(c) and (d).

* * *

(c) * * *

(1) BS EN ISO 12460–3:2023, Wood-based panels.—Determination of formaldehyde release—Part 3: Gas analysis method, September 2023; IBR approved for § 770.20(b).

* * *

(g) * * *

(1) ISO 12460–2:2024(en) Wood-based panels.—Determination of formaldehyde release—Part 2: Small-scale chamber method, Second edition, February 2024; IBR approved for § 770.20(b).

- (2) ISO 12460–3:2023(E), Wood-based panels.—Determination of formaldehyde release—Part 3: Gas analysis method, Fourth edition, September 2023; IBR approved for § 770.20(b).

(3) ISO/IEC 17011:2017(E) Conformity assessments—Requirements for accreditation bodies accrediting conformity assessments bodies (Second Edition), November 2017; IBR approved for §§ 770.3; 770.7(a) and (b).
- (4) ISO/IEC 17020:2012(E), Conformity assessment—Requirements for the operation of various bodies performing inspection, Second edition, 2012–03–01; IBR approved for §§ 770.3; 770.7(a) through (c).

(5) ISO/IEC 17025:2017(E), General requirements for the competence of testing and calibration laboratories (Third Edition), November 2017; IBR approved for §§ 770.3; 770.7(a) through (c).
- (6) ISO/IEC 17065:2012(E), Conformity assessment—Requirements for bodies certifying products, processes and services, First edition, 2012–09–15; IBR approved for §§ 770.3; 770.7(a) and (c).

* * * * *

(i) * * *

(1) PS 1–22, Structural Plywood, October 2, 2023; IBR approved for §§ 770.1(c); 770.3.
- [FR Doc. 2026–02715 Filed 2–10–26; 8:45 am]

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Notices

Federal Register

Vol. 91, No. 28

Wednesday, February 11, 2026

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.

ADMINISTRATIVE CONFERENCE OF THE UNITED STATES

Adoption of Recommendations

AGENCY: Administrative Conference of the United States.

ACTION: Notice.

SUMMARY: The Assembly of the Administrative Conference of the United States adopted four recommendations at the fully virtual Eighty-fourth Plenary Session: Obtaining Government Records for Use in Agency Proceedings; Temporary Rules; Organization, Management, and Operation of Agency Adjudication Offices; and Federal Agency Collaboration with State, Tribal, Local, and Territorial Governments.

FOR FURTHER INFORMATION CONTACT: For Recommendations 2026–1 and 2026–2, Eyal Lurie-Pardes; Recommendation 2026–3, Lea Robbins; and Recommendation 2026–4, Becaja Caldwell. For each of these recommendations the address and telephone number are: Administrative Conference of the United States, Suite 706 South, 1120 20th Street NW, Washington, DC 20036; Telephone 202–480–2080.

SUPPLEMENTARY INFORMATION: The Administrative Conference Act, 5 U.S.C. 591–596, established the Administrative Conference of the United States. The Conference studies the efficiency, adequacy, and fairness of the administrative procedures used by Federal agencies and makes recommendations to agencies, the President, Congress, and the Judicial Conference of the United States for procedural improvements (5 U.S.C. 594(1)). For further information about the Conference and its activities, see www.acus.gov.

The Assembly of the Conference met during its Eighty-fourth Plenary Session on January 21, 2026, to consider four proposed recommendations and

conduct other business. All four recommendations were adopted.

Recommendation 2026–1, *Obtaining Government Records for Use in Agency Proceedings*, provides agencies with best practices for making government records available for use in agency proceedings in order to promote the fairness, accuracy, consistency, timeliness, and efficiency of agency decision making. It provides guidance on procedures by which private parties and agency decision makers may obtain federal records for use in agency proceedings—both when the parties bear responsibility for obtaining the records and when the agency decision maker holds that responsibility.

Recommendation 2026–2, *Temporary Rules*, identifies best practices for temporary rules. Temporary rules cease to be effective after a specific calendar date or upon the occurrence of a future event unless an agency takes action to extend the rule, make it permanent, or repeal it. The proposed recommendation provides guidance to agencies on determining whether to issue a temporary rule, drafting and publishing temporary rules, conducting timely assessments of temporary rules and taking appropriate action, and developing internal procedures for temporary rules. It also recommends that Congress consider how specific agencies might use temporary rules to respond efficiently and effectively to emergencies.

Recommendation 2026–3, *Organization, Management, and Operation of Agency Adjudication Offices*, provides agencies with best practices for organizing, managing, and operating agency adjudication offices. It encourages agencies to collect, analyze, and use data to identify and adopt the organizational, management, and operational practices that are best suited to each agency's particular circumstances and most effective in promoting fairness, accuracy, consistency, efficiency, and timeliness in the adjudications they conduct.

Recommendation 2026–4, *Federal Agency Collaboration with State, Tribal, Local, and Territorial Governments*, provides agencies with a framework that federal agencies should use to identify and collaborate more effectively with relevant state, tribal, local, and territorial governments (STLTGs). It provides guidance on practices agencies

can adopt when initiating, managing, and evaluating collaborations with STLTGs that promote a culture of improved coordination and strengthen working relationships between governments.

The Conference based its recommendations on research reports and prior history that are posted at: <https://www.acus.gov/event/84th-plenary-session>.

Authority: 5 U.S.C. 595.

Dated: February 9, 2026.

Shawne C. McGibbon,
General Counsel.

Appendix—Recommendations of the Administrative Conference of the United States

Administrative Conference Recommendation 2026–1

Obtaining Government Records for Use in Agency Proceedings

Adopted January 21, 2026

Federal agencies conduct a vast number of administrative proceedings each year, including proceedings to decide applications for benefits, services, licenses, and permits, as well as enforcement actions against persons suspected of violating the law.¹ In order for agency officials and private parties to participate meaningfully in a proceeding, they frequently need access to government records² made, collected, received, or maintained by the federal agency conducting the proceeding or another federal agency.

Although agencies are responsible for maintaining government records, agency decision makers and parties who participate in agency proceedings often face challenges in obtaining them. A record may not be collected or maintained by the same agency or organizational unit that is responsible for conducting a proceeding or in a format that is readily usable or disclosable in the proceeding. Agencies may lack sufficient resources to collect or provide the necessary records in a timely manner, especially in complex or high-volume proceedings. When private parties are responsible for obtaining records, they may face administrative burdens in understanding what records they need and where to find them, and in

¹ This Recommendation addresses agency proceedings that meet the definition of “adjudication” under the Administrative Procedure Act (APA). See 5 U.S.C. 551(7). It does not address proceedings that meet the APA’s definition of “rule making.” See *id.* § 551(5).

² Several statutes define what constitutes a “record.” See, e.g., 5 U.S.C. 552(f)(2), 552a(a)(4); 44 U.S.C. 3301(a)(1)(A).

navigating agency processes for requesting or obtaining them.³

When designed well and implemented effectively, certain procedural and technological reforms for accessing government records have the potential to reduce burdens on agencies and private parties and to promote the fairness, accuracy, efficiency, and timeliness of agency proceedings.

Some agencies have robust programs for efficiently collecting records for use in their proceedings while minimizing burdens on private parties to gather and provide that information themselves. In some cases, agencies obtain records from within the agency. For example, the U.S. Department of Veterans Affairs administers a variety of benefits programs by, among other things, making records from its Veterans Health Administration available to adjudicators in the agency's Veterans Benefits Administration.⁴

Agencies also frequently obtain records from other federal agencies to reduce administrative burdens, particularly in proceedings related to benefits or services.⁵ Many agencies have information-sharing agreements under the Computer Matching and Privacy Protection Act of 1988, which governs certain automated data sharing between federal agencies and includes procedural requirements to ensure that shared information is accurate and used only for authorized purposes.⁶ For example, the Department of Education allows applicants to prefill answers to some questions on the Free Application for Federal Student Aid by automatically transferring relevant federal tax return information using a consent-based information-sharing process developed by the Department and the Internal Revenue Service.⁷ Agencies may also enter into memoranda of understanding or other agreements to share information.⁸

In other circumstances, private parties to agency proceedings may need to obtain records from agencies, whether for the purpose of providing them to the agency conducting the proceeding (a process sometimes called "request and return") or for their own use in a proceeding.⁹ For example, consistent with Administrative Conference recommendations,¹⁰ many agencies allow

parties in adjudications involving an evidentiary hearing to inspect non-privileged materials in agency files or seek production of non-privileged records through discovery. However, discovery is circumscribed or unavailable in some contexts, and, even when it is available, it may not provide all the records the parties need in such proceedings.¹¹ In proceedings in which discovery is unavailable or does not provide the needed records, parties may need to file individual requests under the Freedom of Information Act,¹² the Privacy Act,¹³ or agency-specific procedures to obtain the records. Although such requests may be useful in some circumstances or necessary in the absence of other available methods, they may not be the most efficient option for parties or agencies, especially when the agency conducting the proceeding already maintains the records at issue.¹⁴

To reduce burdens on parties and agencies associated with accessing records, agencies have established other systems and processes that parties can use to access records independently. Some agencies use online self-help portals that allow parties to obtain records about themselves or their past interactions with the agency more quickly and efficiently.¹⁵ However, portals are costly to establish and maintain and may not be worth the expense if parties rarely seek to obtain records. Many agencies also proactively disclose records, especially previous decisions that parties may find useful in understanding agency policies and interpretations of the law.¹⁶

This Recommendation identifies best practices for making government records available for use in agency proceedings. It addresses circumstances in which the agency has the responsibility for obtaining records, when records are shared among different agency components, when records are shared among different agencies for use in determining an applicant's eligibility for benefits or services, and when private parties bear the responsibility for obtaining records. This Recommendation also offers best

practices for how agencies should make records available in agency proceedings in order to promote the fairness, accuracy, consistency, timeliness, and efficiency of agency decision making.

Recommendation

Making Records Available in General

1. Unless prohibited by law or permitted by an exception established by law allowing withholding of records, an agency should make relevant records that it maintains available to:

- a. Relevant officials internally;
- b. Relevant officials at other agencies when needed for administrative proceedings to determine an applicant's eligibility or ineligibility for benefits or services, or the level of such benefits or services; and
- c. Private parties participating in such proceedings or preparing to initiate such proceedings.

With regard to the public generally, unless prohibited by law or permitted by an exception established by law allowing withholding of records, an agency should make agency legal materials available to the extent practicable.

2. When private parties request records that pertain to them, an agency should not withhold access to those records solely based on the privacy interests of requesting parties.

3. When determining how to make records available for use in administrative proceedings, an agency should consider, among other things, the following factors:

- a. Whether the agency is required by statute to make the record available using a particular method;
- b. Whether a particular method promotes fairer, more efficient, more accurate, or timelier use of a record in a proceeding as compared to other methods; and
- c. Whether a particular method is less costly or burdensome to the government or private parties compared to other methods.

Internal Agency Procedures for Making Records Available for Use by Agency Officials

4. When a record is needed for use in a proceeding, an agency should ensure that relevant agency officials can easily obtain it, preferably in electronic format, unless it would be impracticable to do so.

5. An agency should not require parties to request and return records for the agency's use in proceedings if the agency already maintains the records.

6. When parties submit information to an agency in connection with a proceeding, the agency should supplement the party's submission with relevant information from the agency's records when feasible and appropriate, such as by prepopulating a party's application form with information previously submitted by the party or otherwise maintained by that agency or, with the consent of the party, another federal agency with whom information sharing is permissible under governing law.

Interagency Sharing of Records

7. When an agency regularly needs information created, collected, or maintained by another agency for use in determining an applicant's eligibility for benefits or services

³ See Admin. Conf. of the U.S., Recommendation 2023–6, *Identifying and Reducing Burdens on the Public in Administrative Proceedings*, 89 FR 1511 (Jan. 10, 2024).

⁴ See Margaret B. Kwoka, *Obtaining Government Records for Use in Agency Proceedings* 12–13 (Dec. 11, 2025) (report to the Admin. Conf. of the U.S.).

⁵ This Recommendation does not cover records of state and local agencies, although federal agencies often obtain such records for use in their proceedings. See 5 U.S.C. 552a(a)(10).

⁶ 5 U.S.C. 552a(a)(8); see also Natalie R. Ortiz, Cong. Rsch. Serv., R47325, *Computer Matching and Privacy Protection Act: Data Integration and Individual Rights* (2022).

⁷ 26 U.S.C. 6103(l); U.S. Dep't of Educ., *Privacy Act of 1974; Matching Program*, 88 FR 42052 (June 29, 2023).

⁸ See Kwoka, *supra* note 4, at 7.

⁹ See *id.* at 5.

¹⁰ See, e.g., Admin. Conf. of the U.S., Recommendation 2016–4, *Evidentiary Hearings Not Required by the Administrative Procedure Act*, ¶ 10,

81 FR 94314, 94315 (Dec. 23, 2016); Admin. Conf. of the U.S., Recommendation 70–4, *Discovery in Agency Adjudication*, 38 FR 19786 (July 23, 1973); see also Michael Asimow, Admin. Conf. of the U.S., *Federal Administrative Adjudication Outside the Administrative Procedure Act* 75, 86–87 (2019).

¹¹ See Kwoka, *supra* note 4, at 36–37.

¹² 5 U.S.C. 552.

¹³ *Id.* at § 552a.

¹⁴ See Kwoka, *supra* note 4, at 28–32, 47–48; see also 5 U.S.C. § 552, 552(a).

¹⁵ See Kwoka, *supra* note 4, at 44–45; cf. Admin. Conf. of the U.S., Recommendation 2023–4, *Online Processes in Agency Adjudication*, 88 FR 42681 (July 3, 2023).

¹⁶ See Admin. Conf. of the U.S., Recommendation 2022–4, *Precedential Decision Making in Agency Adjudication*, ¶ 11–12, 15–16, 88 FR 2312 (Jan. 13, 2023); Admin. Conf. of the U.S., Recommendation 2017–1, *Adjudication Materials on Agency websites*, 82 FR 31039 (July 5, 2017). Such records may also include legal materials, which are "documents that establish, interpret, apply, explain, or address the enforcement of legal rights and obligations, along with constraints imposed, implemented, or enforced by or upon an agency." See Admin. Conf. of the U.S., Recommendation 2023–1, *Proactive Disclosure of Agency Legal Materials*, 88 FR 42678 (July 3, 2023).

it should consult with the other agency to determine whether the records containing that information are fit for the purpose of determining eligibility and how the records should be used. When determining whether such records are fit for such purpose, the agency should consider, among other things, their accuracy, completeness, timeliness, and relevance. If the records are fit for use in proceedings regularly conducted by the recipient agency, the source agency and the recipient agency should enter into an interagency agreement for the sharing of records.

8. Consistent with Recommendation 2012–5, *Improving Coordination of Related Agency Responsibilities*, an agency should make interagency agreements for sharing records publicly available and regularly assess their effectiveness.

Procedures for Parties To Obtain Records in Agency Adjudications Involving an Evidentiary Hearing

9. An agency should allow parties in adjudications involving an evidentiary hearing to inspect non-privileged materials in agency files or seek production of non-privileged records through discovery, consistent with Recommendation 2016–4, *Evidentiary Hearings Not Required by the Administrative Procedure Act*, and Recommendation 70–4, *Discovery in Agency Adjudication*.

Procedures for Parties To Submit Individual Requests for Records

10. An agency should establish written procedures for parties to submit individual requests for records that are regularly needed in proceedings, including records the parties previously submitted, unless other procedures for obtaining the records (such as those established under the Freedom of Information Act (FOIA)) are sufficient or otherwise warranted based on the factors described in Paragraph 3.

11. An agency should publish the procedures described in Paragraph 10 in the **Federal Register** and codify them in the *Code of Federal Regulations*. The procedures should specify the records that parties may request and how parties should request them, how the agency will review and respond to requests (including, as practicable, the agency's expected timeframe for responding), and whether parties may request review of the agency's response by a higher-level agency official.

12. When an agency has authority to withhold records pursuant to an exemption established by law, but when the application of the exemption is not mandatory and no other law prohibits disclosure, the agency should consider making discretionary disclosures of the records in response to individual requests when those records are needed for use in administrative proceedings.

13. When a party submits an individual request for a record that is needed for use in a proceeding, the agency should consider staying the proceeding or extending deadlines in the proceeding to allow the party sufficient time to obtain and review the records.

Online Self-Help Portals for Parties To Obtain Records About Themselves

14. An agency should consider establishing an online self-help portal to allow parties to obtain records about themselves when parties regularly request specific categories of records for which little or no redaction is necessary.

15. When offering an online self-help portal, an agency should include relevant records submitted by parties and relevant decisional documents issued by the agency that were made available to the parties during the proceeding. As applicable, agencies should follow the best practices for organization, user guidance, and cybersecurity described in Recommendation 2023–4, *Online Processes in Agency Adjudication*.

Proactive Public Disclosure

16. An agency should consider making records publicly available beyond what is required by law when such records would be useful to parties in administrative proceedings, including decisions and filings associated with prior adjudicative proceedings consistent with Recommendation 2017–1, *Adjudication Materials on Agency websites*.

17. When an agency proactively makes records publicly available, it should organize and index such records to allow parties to locate the information they need efficiently.

Other Considerations When Making Records Available in Proceeding

18. When not prohibited by law, an agency should consider using informal or ad hoc methods for making records available if doing so would avoid the use of more costly methods for obtaining the same information. For example, preferred methods could include providing an explanation for an agency decision by email rather than requiring the party to file a FOIA request for the same information.

19. An agency should not charge fees for requesting and obtaining records for use in administrative proceedings unless such fees are required by law.

20. To the extent practicable, an agency should design its records to enable faster disclosure, whether upon request, through a portal, or on an online database, such as by allowing automatic redaction of private information.

Administrative Conference Recommendation 2026–2

Temporary Rules

Adopted January 21, 2026

When an agency promulgates a rule,¹ it typically intends that the rule will remain in effect indefinitely until the agency amends or

¹ This Recommendation applies to “rules” as defined in the Administrative Procedure Act (APA) (5 U.S.C. 551(4)), except that it does not address interpretive rules and general statements of policy for which the agency has invoked the APA’s exemption from notice-and-comment procedures. See 5 U.S.C. 553(b). However, when invoking the exemption for interpretive rules and general statements of policy, agencies may take into account the provisions of this Recommendation to the extent applicable.

repeals it. However, an agency may also promulgate a rule that will cease to be effective after a specific calendar date or upon the occurrence of a future event unless the agency takes action to extend the rule, make it permanent, or repeal it. This Recommendation refers to such rules as “temporary rules.”²

There may be several advantages to adopting a temporary rule. For example, when an agency intends a rule to address a time-limited issue, adopting a temporary rule enables the agency to promulgate and repeal the rule efficiently in a single proceeding and can help to avoid public confusion. A temporary rule may also give an agency the flexibility to address emergency situations or deviate temporarily from a regulatory framework while clarifying for the public that the deviation is of limited duration. In addition, using temporary rules enables an agency to commit to updating the rule or reviewing its effectiveness after a specified period. This can promote consideration of public feedback in rapidly evolving circumstances.

At the same time, there may be disadvantages associated with temporary rules. For example, an agency must commit to expending limited resources to determine whether a temporary rule should be extended, made permanent, or allowed to expire and, if warranted, must take additional action to extend it or make it permanent. When agencies do not monitor their temporary rules effectively or lack anticipated resources to make updates, they may unintentionally allow such rules to expire or may mistakenly allow expired rules to remain in the *Code of Federal Regulations* (CFR). This could impede agency program operations, create public confusion, and undermine predictability and confidence. In addition, frequent changes to regulatory

² The term “temporary rule” is used differently in some contexts. For example, some courts and agencies use the term to refer to interim final rules. See Eyal Lurie-Pardes, Temporary Rules 7 (Dec. 18, 2025) (report to the Admin. Conf. of the U.S.). Unlike the rules that this Recommendation addresses, interim final rules do not expire. See Admin. Conf. of the U.S., Recommendation 2024–6, *Public Participation in Agency Rulemaking Under the Good Cause Exemption*, 89 Fed. Reg. 106408 (Dec. 30, 2024). In addition, as discussed below, the Office of the Federal Register (OFR) has a special process for publishing “temporary rules,” which it defines as rules that “respond[] to a situation that requires a rule be effective for a short, definable period of time.” Nat’l Archives & Records Admin., Off. of the Fed. Reg., Federal Register Document Drafting Handbook 3–67 (Aug. 2018 Edition, Revision 2.2, June 2025), <https://www.archives.gov/files/federal-register/write/handbook/ddh.pdf> [hereinafter Document Drafting Handbook]. An earlier recommendation of the Administrative Conference similarly defines “temporary rules” as “those that address a temporary emergency or expire by their own terms within a relatively brief period.” Admin. Conf. of the U.S., Recommendation 95–4, *Procedures for Noncontroversial and Expedited Rulemaking*, 60 Fed. Reg. 43110 (Aug. 18, 1995). This Recommendation uses the term “temporary rules” to encompass a broader range of rules because it addresses any rule that expires after a specific calendar date or upon the occurrence of a future event absent agency action to extend the rule or make it permanent.

frameworks resulting from numerous temporary rules may undermine regulatory certainty, making it difficult for regulated parties to adjust their behavior or make long-term compliance decisions. Such changes may also require the public to expend additional resources to monitor, and provide the agency with input on, temporary rules. More frequent changes could also lead to more frequent agency expenditures for related public communication, record development, impact analysis, or consultations (such as with state, local, and tribal governments³).

Agencies regularly use temporary rules in at least five circumstances. First, agencies use temporary rules to establish or amend a regulatory framework for a limited period. For example, the Coast Guard uses temporary rules to establish temporary safety zones, security zones, and special local regulations for marine events, fireworks displays, bridge construction, and other occurrences that might pose a safety concern.⁴

Second, agencies use temporary rules to respond to unforeseen emergencies that necessitate immediate and often short-term modifications to existing regulatory frameworks. For example, many agencies adopted temporary rules during the COVID-19 pandemic that altered preexisting regulatory frameworks for a defined period or for the duration of the public health emergency as determined by the Secretary of Health and Human Services.⁵

Third, agencies use temporary rules to implement statutory changes and judicial decisions in a timely manner. For example, the National Marine Fisheries Service once promulgated a rule temporarily reinstating an earlier rule to implement a district court ruling invalidating the rule that replaced it.⁶

Fourth, agencies use temporary rules to amend rules that they must update on an annual, biennial, or other recurring basis, as mandated by law.⁷ For example, the Environmental Protection Agency uses temporary rules to set annual standards for “nationally applicable renewable fuel volume targets” under the Clean Air Act.⁸

Fifth, agencies use temporary rules as a vehicle for regulatory learning. Rules establishing pilot programs, demonstration projects, and other regulatory experiments, for example, often are effective for limited periods.⁹ Agencies may also promulgate temporary rules as a means of committing to retrospective review of those rules.¹⁰

There are several considerations involved in developing, promulgating, and managing temporary rules. First, when an agency chooses to promulgate a temporary rule, it must determine when the rule should expire. There is significant variation in the duration of temporary rules, ranging from several hours to several years. In some cases, the agency knows or can reasonably predict how long the rule should be in effect. In other cases, agencies anticipate that conditions will change but lack sufficient certainty regarding the timing of the change.

Agencies must also consider how they will promulgate a temporary rule and, if warranted, provide an opportunity for the public to participate in the rulemaking. Agencies are generally subject to the rulemaking requirements of 5 U.S.C. 553, including the requirements for notice and comment, when they promulgate temporary rules. However, because temporary rules are often used to address emergencies or implement statutory changes or judicial decisions, agencies frequently find good cause to forgo pre-promulgation notice and comment.¹¹ Some agencies also have specific statutory authority to promulgate temporary rules without pre-promulgation notice and comment, especially in emergency situations.¹²

Agencies must also consider how to publish temporary rules in the **Federal Register** and the CFR. If an agency publishes a temporary rule in the **Federal Register** using a standard final rule document, the Office of the Federal Register (OFR) will codify the rule in the CFR but will not remove it from the CFR when the rule expires. As a result, the agency would need to publish a new rule in the **Federal Register** to remove the rule from the CFR as of the date it is no longer effective. An agency might use this approach to remove a temporary rule from the CFR when it ceases to be effective based on an event that occurs after the publication of the initial temporary rule.

listings to reflect advances in medical knowledge. See, e.g., 88 Fed. Reg. 37704 (June 8, 2023); see also 50 Fed. Reg. 50068, 50071 (Dec. 6, 1985). ACUS has issued several recommendations encouraging agencies to create “a culture of retrospective review,” identify regulations that are subject to periodic retrospective review, establish a review plan for them, and disclose whether and how they use algorithmic tools to support retrospective review. See Admin. Conf. of the U.S., Recommendation 2023–3, *Using Algorithmic Tools in Retrospective Review of Agency Rules*, 88 Fed. Reg. 42681 (July 3, 2023); Admin. Conf. of the U.S., Recommendation 2021–2, *Periodic Retrospective Review*, 86 Fed. Reg. 36080 (July 8, 2021); Admin. Conf. of the U.S., Recommendation 2017–6, *Learning from Regulatory Experience*, 82 Fed. Reg. 61783 (Dec. 29, 2017); Admin. Conf. of the U.S., Recommendation 2014–5, *Retrospective Review of Agency Rules*, 79 Fed. Reg. 75114 (Dec. 17, 2014); Admin. Conf. of the U.S., Recommendation 95–3, *Review of Existing Agency Regulations*, 60 Fed. Reg. 43108 (Aug. 18, 1995).

¹¹ 5 U.S.C. 553(b)(B). The Conference has identified best practices for rulemaking in such circumstances. See Recommendation 2024–6, *supra* note 2. Neither this Recommendation nor Recommendation 2024–6 addresses the circumstances under which agencies may lawfully assert the good cause exemption.

¹² See, e.g., 16 U.S.C. 1533(b)(7).

Alternatively, agencies may publish a specific type of temporary rule document in the **Federal Register** if they want OFR to remove the rule from the CFR when it is no longer effective. As explained in OFR’s *Document Drafting Handbook*, agencies can use this process when the temporary rule “responds to a situation that requires a rule be effective for a short, definable period of time.”¹³ Under this process, the agency must specify the calendar date that the rule becomes effective and the calendar date the rule expires in the **DATES** caption of the rulemaking document published in the **Federal Register**.¹⁴ OFR will then ensure that the temporary rule does not appear in the CFR after it expires.¹⁵ With the approval of the Director of the Federal Register, agencies may also designate sections of the CFR with a “T” to identify them as temporary.¹⁶ This can be particularly helpful when an agency wishes to maintain a specific section-numbering system after a regulatory transition period or when the agency issues temporary rules on a recurring basis.

This Recommendation identifies best practices for temporary rules, including guidelines for determining when to issue a temporary rule, drafting and publishing temporary rules, conducting timely assessments of temporary rules and taking appropriate action, and developing internal procedures for temporary rules. It also recommends that Congress consider how specific agencies might use temporary rules to respond efficiently and effectively to emergencies.

Recommendation

Determining Whether To Issue a Temporary Rule

1. If an agency determines or reasonably expects that a rule will only be necessary for a limited time, it should consider issuing a temporary rule—that is, a rule that will cease to be effective after a specific calendar date or upon the occurrence of a future event unless the agency takes action to extend the rule. Circumstances in which it may be appropriate to issue a temporary rule include:

¹³ Document Drafting Handbook, *supra* note 2, at 3–67. OFR generally does not designate rules as temporary if their duration exceeds three years.

¹⁴ Under OFR’s process, agencies generally must specify the calendar date after which the rule expires. Otherwise, OFR approval would be necessary. For example, during the COVID-19 pandemic, OFR allowed certain rules to be classified as temporary based on the expiration of the “public health emergency” to be determined by the Secretary of HHS after issuance of the rules. See Lurie-Pardes, *supra* note 2, at 8 n.55.

¹⁵ Document Drafting Handbook, *supra* note 2, at 3–67. OFR also ensures that temporary rules are accurately reflected in the Electronic Code of Federal Regulations (eCFR), which is a web version of the CFR that is updated daily but is not an official legal edition of the CFR. See eCFR, Nat’l Archives & Records Admin., <https://www.ecfr.gov> (last visited Dec. 4, 2025). If the rule’s duration is at least several days but less than one year, it will appear in the eCFR but may not necessarily appear in the annual printed volumes of the CFR. See Lurie-Pardes, *supra* note 2, at 8.

¹⁶ Document Drafting Handbook, *supra* note 2, at 3–67.

³ See Admin. Conf. of the U.S., Recommendation 2025–2, *Consultation with State, Local, and Tribal Governments in Regulatory Policymaking*, 90 Fed. Reg. 27517 (June 27, 2025).

⁴ See, e.g., 83 Fed. Reg. 2060 (Jan. 16, 2018).

⁵ See, e.g., 85 Fed. Reg. 19326 (Apr. 6, 2020); 85 Fed. Reg. 17285 (Mar. 27, 2020).

⁶ 79 Fed. Reg. 36433 (June 27, 2014).

⁷ Lurie-Pardes, *supra* note 2, at 16–17.

⁸ See, e.g., 87 Fed. Reg. 39600 (July 1, 2022).

⁹ See, e.g., 89 Fed. Reg. 57353 (July 15, 2024); 85 Fed. Reg. 74875 (Nov. 24, 2020).

¹⁰ For example, since the 1980s, the Social Security Administration has included calendar expiration dates in rules that amend the Listing of Impairments that the agency uses to evaluate disability claims. The agency includes expiration dates to ensure it periodically reviews and updates

a. When the rule responds to a condition of finite duration;

b. When the rule responds to an emergency, even if the exact duration of the emergency is initially unknown;

c. When the rule responds to a statutory amendment, judicial decision, or other situation temporarily while the agency develops a more permanent approach; and

d. When a statute requires, or the rule requires or would benefit from, updating on an annual or other periodic basis.

2. An agency should consider whether issuing a temporary rule would help the agency learn from regulatory experience. Circumstances in which it may be appropriate to issue a temporary rule for this purpose include:

a. When the rule establishes a pilot program, demonstration project, or other form of regulatory experimentation; and

b. When the agency seeks to commit to retrospective review of a rule and has sufficient resources to conduct the retrospective review and take appropriate follow-up rulemaking action, if any, before the rule expires.

3. In deciding whether to designate a rule as temporary, agencies should consider a variety of factors, including:

a. Whether doing so would increase efficiency by combining issuance and repeal of the rule;

b. Whether the agency or regulated parties would benefit from increased flexibility to deviate temporarily from a regulatory framework;

c. Whether benefits are likely to ensue from committing to review a rule in advance, such as with pilot or demonstration projects;

d. The feasibility of reviewing the rule after a certain specified period, including the burden on agency staff and resources;

e. The risk that the agency may unintentionally allow the rule to expire and the consequences of that expiration; and

f. Whether doing so would undermine the need for regulatory certainty.

Drafting and Publishing a Temporary Rule

4. When an agency promulgates a temporary rule, it should:

a. Explain in the preamble to the rule (and to the proposed rule, if applicable) why the rule is effective for a limited period and how the agency determined that period;

b. If it contemplates further action, discuss in any preamble what action the agency currently contemplates taking to extend the rule, amend it, or make it permanent; and

c. Specify the effective period of the rule in the text of the rule published in the *Code of Federal Regulations* (CFR).

5. If an agency intends for the Office of the Federal Register (OFR) to automatically remove a temporary rule from the CFR when it expires on a specific date, the agency should indicate in the “ACTION” caption of the document published in the **Federal Register** that the rule is “temporary” and specify in the “DATES” caption of the document the calendar date after which the rule expires.

6. Even if an agency does not intend for OFR to remove a temporary rule from the CFR when it expires, the agency should still consider referring to the rule as “temporary”

(including in the “ACTION” caption of the document published in the **Federal Register**) when doing so would promote clarity.

7. When an agency provides that a rule will expire upon the occurrence of a future event rather than on a specific calendar date, the agency should explain in the preamble to the rule how the public can determine when the event has occurred. As soon as practicable after determining the specific calendar date upon which such a rule has expired or will expire, the agency should inform the public of that date and, when necessary, repeal the rule by publishing a new rule in the **Federal Register**.

8. An agency should consider requesting a numbering deviation from the Director of the Federal Register pursuant to 1 CFR 21.14(b) to include a “T” in the section number of any temporary rule when doing so would promote clarity.

9. An agency that promulgates a high volume of temporary rules should consult with OFR in developing a standardized template for drafting such rules.

Conducting a Timely Assessment of a Temporary Rule and Taking Appropriate Action

10. The extension of a temporary rule is a separate rulemaking requiring an agency, absent an exception, to (a) publish a notice of proposed rulemaking in the **Federal Register** to extend the rule, (b) explain in the notice why the agency proposes to extend the rule, and (c) invite public comment on the extension. If an agency for good cause finds that pre-promulgation notice and public procedure are impracticable, unnecessary, or contrary to the public interest, it should follow the practices for obtaining public input on the rule identified in Recommendation 2024–6, *Public Engagement in Agency Rulemaking Under the Good Cause Exemption*, and Recommendation 2018–7, *Public Engagement in Rulemaking*.

11. If an agency anticipates that it may need to extend a temporary rule or make the rule permanent, it should develop a timeline for assessing the rule and taking any appropriate action sufficiently before the rule expires to avoid uncertainty.

Developing An Internal Policy on Temporary Rules

12. An agency should develop an internal policy on temporary rules. The policy, which should be made available to relevant agency personnel and the public, should address:

a. Circumstances in which it may be appropriate for the agency to issue a temporary rule;

b. Considerations for determining when a temporary rule should expire;

c. Procedures for drafting a temporary rule;

d. Procedures for submitting a temporary rule to OFR for publication in the **Federal Register** and the CFR;

e. Procedures for obtaining public input on a temporary rule, including with respect to whether and when the rule should expire;

f. Procedures for assessing whether a temporary rule should be extended, amended, made permanent, or allowed to expire; and

g. Procedures for extending a temporary rule, including public notice and any opportunities for public participation.

Recommendation for Congress

13. When Congress specifically provides for an agency’s emergency rulemaking authority, it should consider whether it would be beneficial specifically to authorize the agency to promulgate rules that are effective for a limited period without pre-promulgation notice and comment. In doing so, Congress should specify how long such rules may remain in effect, identify any required opportunities for post-promulgation public participation, and set forth any procedure for extending such rules.

Administrative Conference Recommendation 2026–3

Organization, Management, and Operation of Agency Adjudication Offices

Adopted January 21, 2026

Most agencies that adjudicate cases have specific components, below the agency-head level, that are responsible primarily for conducting hearings or reviewing the decisions of lower-level adjudicators.¹ These components, referred to in this Recommendation as “adjudication offices,” go by many names, including “Office of Hearings and Appeals,” “Office of Administrative Law Judges,” “Appeals Council,” and “Board of Appeals.”

There is considerable variation in the organization, management, and operation of adjudication offices. For example, some adjudication offices perform both hearing and appellate functions, while some agencies assign those functions to separate offices. Some adjudication offices are centralized, while others are distributed across locations nationwide. Some adjudication offices are headed by an adjudicator (often designated a “chief judge” or “chair”), while others are headed by an official who is not an adjudicator (often designated a “director”). Still other adjudication offices incorporate aspects of both models, in which a chief judge or chair oversees adjudication-related matters, and a director oversees operational matters, such as technology, human resources, budget planning, office space, and procurement. In some adjudication offices, support personnel are assigned to specific adjudicators, while in other offices, support personnel are managed centrally. Some adjudication offices have dedicated resources for technology and human resources, while others rely on separate agency components for such services. Some adjudication offices

¹ This Recommendation does not address adjudications not involving an evidentiary hearing, see Admin. Conf. of the U.S., Recommendation 2023–5, *Best Practices for Adjudication Not Involving an Evidentiary Hearing*, 89 FR 1509 (Jan. 10, 2024), nor does it address offices that issue decisions subject to de novo review by an administrative law judge, administrative judge, or agency head (e.g., initial determinations regarding applications for benefits). Additionally, this Recommendation does not address adjudication by Senate-confirmed officials, which was the subject of Recommendation 2024–3, *Senate-Confirmed Officials and Administrative Adjudication*, 89 FR 56276 (July 9, 2024).

have devoted considerable resources to developing centralized manuals and handbooks to guide adjudicative personnel, while others have not systematically recorded their practices.

Important aspects of organization, management, and operation include the assignment of duties to an adjudication office; the placement of an adjudication office within an agency hierarchy; the geographical distribution of adjudicators and support personnel; the division of an adjudication office into smaller subunits, including local offices, and the management of those subunits; the functions and duties assigned to managers; the availability and use of performance management tools, including performance metrics, expectations, appraisal (when permitted), and feedback and training; the development and implementation of caseload management practices; and the allocation and use of technology, personnel, and other resources.²

Statutes or governmentwide regulations may determine important aspects of the organization, management, and operation of adjudication offices. Some adjudication offices are established by statute, for example, and the statutes that establish those offices may specify requirements for organizing, managing, and operating them. In cases of formal adjudication, the Administrative Procedure Act requires, among other things, that agencies generally separate adjudicative personnel from investigative and prosecutorial personnel,³ prohibit ex parte communications between agency decision makers and interested persons outside the agency,⁴ assign administrative law judges (ALJs) to cases in rotation so far as practicable,⁵ and abstain from assigning duties to ALJs that are inconsistent with their duties and responsibilities.⁶ Agencies are also prohibited from rating the job performance of ALJs or granting them awards and incentives.⁷ Additionally, agencies are required to publish descriptions of their central and field organization in the **Federal Register**.⁸

Nonetheless, agencies may retain significant discretion in how they organize, manage, and operate their adjudication offices. As the Administrative Conference has recognized, how agencies exercise that discretion can have a significant impact on the fairness, accuracy, consistency, efficiency, and timeliness of agency adjudication. The Conference has recommended, for example, that agencies establish organizational units, supervisory structures, and central and field operations that enhance timely decision making.⁹ The

Conference has also adopted recommendations regarding, among other things, the separation of adjudicative personnel from investigative and prosecutorial personnel;¹⁰ ex parte communications;¹¹ supervision of adjudicative personnel;¹² provision of training for adjudicative personnel;¹³ development and use of production measures and expectations;¹⁴ use of quality assurance techniques;¹⁵ and access to technology, personnel, and other resources.¹⁶ Additionally, the Conference has recommended that agencies make certain organizational, management, and operational materials available to the public, including policies governing the appointment and supervision of agency adjudicators,¹⁷ guidance documents and explanatory materials relating to adjudicative procedures,¹⁸ and case processing data and goals.¹⁹ Such transparency enhances the legitimacy and accountability of agency decisions, promotes uniformity in agency adjudications, and increases public support for and confidence in agency actions. Building on these recommendations, this Recommendation offers agencies a general framework for organizing, managing, and operating adjudication offices.

Of course, agencies and adjudication offices vary greatly in terms of their mission; the legal requirements under which they operate; the volume, complexity, and variation of their caseloads; their workforce needs; the management challenges they face; and the resources available to them. Because of these variations, the Conference has encouraged agencies to collect, analyze, and

use data to evaluate and improve the timeliness, efficiency, and quality of their adjudications.²⁰ Such data also allow agencies to identify the organizational, management, and operational practices that are best suited to their particular circumstances and most effective in promoting fairness, accuracy, consistency, efficiency, and timeliness in the adjudications they conduct.

Recommendation

Information Collection and Use

1. Agencies, particularly those that adjudicate a high volume of cases, should ensure that electronic case management or other systems track, at a minimum, the following information necessary for determining how to organize, manage, and operate their adjudication offices:

- a. Data for assessing the timeliness of decision making, as described in Recommendation 2023–7, *Improving Timeliness in Agency Adjudication*;
- b. Data for assessing the quality of decision making, as described in Recommendation 2021–10, *Quality Assurance Systems in Agency Adjudication*;
- c. Data regarding the allocation and use of technology, funding, office space, and other resources; and
- d. Data regarding the use and performance of adjudication office personnel, including, as applicable:
 - i. The type and number of adjudicators and support personnel within and across adjudication offices;
 - ii. The type and number of cases assigned to adjudicators and support personnel during a standard reporting period (e.g., week, month, quarter, year);
 - iii. The number of decisions written by adjudicators and support personnel during a standard reporting period; and
 - iv. The amount of time, by case type, that adjudication offices take to complete the decisional process, including the time it takes for (1) support personnel to perform case management tasks such as case intake, docketing, assignment, scheduling, and completion; (2) adjudicators to commence and complete hearings; (3) adjudicators or support personnel to review case files and issue legally sound and policy-compliant decisions; and (4) appellate adjudicators to complete their review of hearing-level decisions.

2. Agencies should seek assessments, including responses to structured inquiries, as well as more general types of feedback on the organization, management, and operation of adjudication offices. Sources of feedback may include agency adjudicators and support personnel, other government personnel both inside and outside the agency, parties to adjudicative proceedings and their representatives, and other non-government organizations and interested persons.

3. Agencies should undertake more tailored inquiries when necessary to help assess specific issues related to the

¹⁰ Admin. Conf. of the U.S., Recommendation 2016–4, *Evidentiary Hearings Not Required by the Administrative Procedure Act*, ¶ 3, 81 FR 94314, 94315 (Dec. 23, 2016).

¹¹ *Id.* ¶ 2.

¹² Admin. Conf. of the U.S., Recommendation 2019–9, *Recruiting and Hiring Agency Attorneys*, 84 FR 71355 (Dec. 27, 2019).

¹³ Admin. Conf. of the U.S., Recommendation 2023–4, *Online Processes in Agency Adjudication*, ¶ 23, 88 FR 42681, 42684 (July 3, 2023); Recommendation 2023–7, *supra* note 9, ¶ 21.

¹⁴ Under OFR's process, agencies generally must specify the calendar date after which the rule expires. Otherwise, OFR approval would be necessary. For example, during the COVID–19 pandemic, OFR allowed certain rules to be classified as temporary based on the expiration of the "public health emergency" to be determined by the Secretary of HHS after issuance of the rules. *See* Lurie-Pardes, *supra* note 2, at 8 n.55.

¹⁵ Admin. Conf. of the U.S., Recommendation 2021–10, *Quality Assurance Systems in Agency Adjudication*, 87 FR 1722 (Jan. 12, 2022).

¹⁶ Admin. Conf. of the U.S., Recommendation 2018–3, *Electronic Case Management in Federal Administrative Adjudication*, 83 FR 30686 (June 29, 2018); Recommendation 2023–7, *supra* note 9, ¶ 16.

¹⁷ Admin. Conf. of the U.S., Recommendation 2020–5, *Publication of Policies Governing Agency Adjudicators*, ¶ 1, 86 FR 6622, 6623 (Jan. 22, 2021).

¹⁸ Admin. Conf. of the U.S., Recommendation 2018–5, *Public Availability of Adjudication Rules*, ¶ 1, 84 FR 2142, 2142 (Feb. 6, 2019); Admin. Conf. of the U.S., Recommendation 2020–3, *Agency Appellate Systems*, ¶ 21, 86 FR 6618, 6620 (Jan. 22, 2021); Recommendation 2016–4, *supra* note 10, ¶ 29.

¹⁹ Recommendation 2023–7, *supra* note 9, ¶ 25.

² *See* Jennifer Lee Koh, Organization, Management, and Operation of Agency Adjudication Offices (Dec. 4, 2025) (report to the Admin. Conf. of the U.S.).

³ 5 U.S.C. 554(d).

⁴ *Id.* §§ 554(d)(1), 557(d).

⁵ *Id.* § 3105.

⁶ *Id.*

⁷ 5 CFR 930.206; *see also* 5 U.S.C. 4301(2)(D).

⁸ 5 U.S.C. 552(a)(1)(A), (a)(2)(C).

⁹ Admin. Conf. of the U.S., Recommendation 2023–7, *Improving Timeliness in Agency Adjudication*, ¶ 13, 89 FR 1513, 1515 (Jan. 10, 2024).

²⁰ Recommendation 2023–7, *supra* note 9; Recommendation 2023–4, *supra* note 13; Recommendation 2021–10, *supra* note 15; Recommendation 2018–3, *supra* note 16.

organization, operation, and management of their adjudication offices.

4. Agencies should use the information described in Paragraphs 1–3 to help them determine, among other things:

- a. The most suitable organizational placement of adjudication offices within the broader agency hierarchy and the internal hierarchy of each adjudication office;
- b. Whether and how to subdivide the adjudication office (e.g., based on geography or subject matter);
- c. The roles and responsibilities of adjudicators and support personnel, including how to best utilize and assign support personnel (e.g., assigning teams of support personnel to specific adjudicators or pooling staff resources);
- d. Reasonable performance metrics or expectations for adjudicators and support personnel; and
- e. Appropriate tools for managing adjudicators and support personnel.

Management and Resources

5. Agencies should designate high-level officials within their adjudication offices who are responsible for performing or overseeing essential management duties or, when appropriate, liaising with other agency components that perform such duties. Essential management duties include:

- a. Managing operations and resources, such as technology, human resources, budget planning, office space, and procurement;
- b. Managing case workloads, such as intake, docketing, assignment, scheduling, and completion;
- c. Performing quality assurance and reviewing work product;
- d. Facilitating the appointment, supervision, and training of adjudicators;
- e. Hiring, supervising, and training support personnel, including conducting performance appraisals;
- f. Handling personnel matters;
- g. Developing and implementing office procedures and policies;
- h. Communicating with members of the public;
- i. Reporting to the agency head and communicating with other relevant components of the agency; and
- j. Coordinating periodic evaluative and strategic planning activities.

6. In determining which type of high-level official to assign management duties (e.g., a head adjudicator such as a chief judge or chair, or a head official who is not an adjudicator such as a director), agencies should consider the size, caseload, resources, and capacity of the adjudication office and the subject matter expertise required to efficiently perform necessary management tasks. Based on these factors, agencies should consider dividing management tasks between high-level officials when appropriate.

7. The heads of adjudication offices should report directly to the agency head or deputy agency head, as appropriate, unless a statute provides otherwise or such a reporting structure would adversely affect the integrity of agency adjudications.

8. Agencies should decide whether to assign cases to adjudicators with management responsibilities and, if so, determine the size of their caseload (e.g., full,

partial, or minimal) by balancing the adjudicator's management duties with the agency's adjudicative needs.

9. Agencies should permit and encourage use of a broad range of tools for managing adjudicators and support personnel, including:

- a. Data-based timeliness and productivity measures or expectations, as described in Recommendation 2023–7, *Improving Timeliness in Agency Adjudication*;
- b. Quality assurance techniques, as described in Recommendation 2021–10, *Quality Assurance Systems in Agency Adjudication*;
- c. Training, both general and focused;
- d. Peer feedback and collaboration;
- e. Performance appraisals for non-ALJ adjudicators and adjudication office support personnel; and
- f. Handbooks, manuals, bench books, and similar materials that supplement codified regulations by prescribing case management practices.

10. Agencies should provide high-volume adjudication offices with dedicated human, financial, technological, and other resources to support operational needs and increase adjudicative capacity. Adjudication offices that rely on shared or agency-wide resources should have designated personnel with primary responsibility for liaising with other components of the agency for specific resource issues.

11. Agencies should modernize electronic systems, particularly those that are necessary to (a) support adjudicative processes, such as case management and technology, and (b) collect accurate and quality data.

Strategic Planning

12. Agencies should engage periodically in evidence-based and transparent evaluation of their organizational, management, and operational practices to assess whether current practices are meeting agency goals and adjudicative needs. In doing so, agencies should use the information described in Paragraphs 1–3 to assess, among other things:

- a. Organizational structures and the placement of adjudication offices within the broader agency hierarchy;
- b. Internal reporting structures of adjudication offices;
- c. Roles and responsibilities of management officials, including the assignment of cases to adjudicators with management responsibilities;
- d. Resource allocation to and within an adjudication office, including the use and assignment of adjudicators and support personnel; and
- e. Performance metrics or expectations for adjudicators and support personnel.

Communication and Transparency

13. Agencies should publish, and update as necessary, the following materials on their websites:

- a. Organizational charts that include both (i) the internal hierarchy of adjudication offices, and (ii) where each adjudication office is located within the broader agency hierarchy;
- b. Descriptions of the positions responsible for performing or overseeing essential management duties or liaising with separate agency components that perform such duties;

c. Policies and practices governing the appointment and supervision of adjudicators, as described in Recommendation 2020–5, *Publication of Policies Governing Agency Adjudicators*, and, as appropriate, support personnel;

d. Brief explanations of an adjudication office's operation, such as the processes for case intake, docketing, assignment, scheduling, and completion; and

e. Any handbooks, manuals, bench books, or similar materials that supplement codified regulations by prescribing case management practices, as described in Recommendation 2018–5, *Public Availability of Adjudication Rules*.

14. Agencies should publish in the **Federal Register** descriptions of how their adjudication offices are organized and the functions of those offices.

15. Agencies should make reasonable efforts to raise public awareness of upcoming changes to their adjudication offices, especially those that have the potential to affect significantly the rights of parties or other interested persons.

16. When agencies use performance metrics in appraising the performance of employees, as defined in 5 U.S.C. 4301, and members of the Senior Executive Service, or in setting expectations for ALJs, who are not subject to performance appraisals, they should disclose publicly such metrics or expectations and explain how they were developed. For adjudicators and support personnel who are subject to performance appraisals, agencies should disclose publicly (a) how they use such measures to appraise employee performance, and (b) whether employees are eligible for incentive awards based on such performance.

Administrative Conference Recommendation 2026–4

Federal Agency Collaboration With State, Tribal, Local, and Territorial Governments

Adopted January 21, 2026

Many federal agencies regularly collaborate with state, tribal, local, and territorial governments (STLTGs) to administer federal programs. Some collaborations are required by law, while others are initiated voluntarily by agencies themselves. Some collaborations are relatively formal, while others are relatively informal. Some collaborations are short in duration while others persist for decades or longer. Federal agencies collaborate with STLTGs to carry out many administrative functions, including permitting and licensing,¹ regulatory enforcement,² benefits administration,³ and

¹ For example, the U.S. Army Corps of Engineers collaborates with state and local environmental agencies when it reviews requests from non-federal interests to construct navigation projects for harbors. See 33 U.S.C. 2233.

² For example, the Drug Enforcement Administration cooperates with state, local, and tribal agencies concerning the traffic and abuse of controlled substances. See, e.g., 21 U.S.C. 873.

³ For example, under the Patient Protection and Affordable Care Act, the Department of Health and Human Services oversees states' operation and enforcement of certain insurance exchanges. See, e.g., 42 U.S.C. 18031; see also 42 U.S.C. 18041.

resource management.⁴ The nature and type of collaboration can also vary widely. For example, federal agencies may be required to consult with STLTTGs when they engage in regulatory policymaking, a specific form of collaboration that the Administrative Conference addressed in a recent recommendation.⁵ Across the federal government, collaborations with STLTTGs serve as critical conduits for implementing many federal programs.⁶

When used and managed successfully, collaborations with STLTTGs enable federal agencies to administer programs more effectively. Successful collaborations can help federal agencies meet specific local needs and foster innovation. They also allow federal agencies and STLTTGs to allocate scarce resources more efficiently, leverage external capabilities, and promote greater participation in federal administration.

At the same time, federal agencies frequently face challenges in initiating and managing collaborations with the 50 states, 574 federally recognized tribes, five territories and the District of Columbia, and more than 90,000 local governments with which they may collaborate. For example, the complexity of the legal and policy frameworks governing the actions of federal agencies and STLTTGs can make it difficult for all individuals involved in collaborations to understand their roles and responsibilities.⁷ Federal agencies and STLTTGs may also lack sufficient human, financial, technological, or other resources to collaborate effectively.⁸ Changes in personnel within federal agencies and STLTTGs may pose challenges for maintaining working relationships over time. In addition, federal agencies and STLTTGs may lack the authority or practical means to communicate and collaborate effectively on an ongoing basis toward common goals.⁹ Successful collaboration requires an

understanding of the unique needs of each STLTTG, rather than applying a uniform approach.

Federal agencies have adopted a range of practices to overcome challenges, collaborate more effectively, and create enduring working relationships with STLTTGs. For example, federal agencies have adopted practices to ensure they communicate with relevant STLTTGs at the outset of a collaboration and throughout its duration; work with STLTTGs to identify common objectives and plan strategically; clarify leadership, points of contact, and processes; adopt performance management techniques for collaborating; sustain relationships and ensure continuity through major changes, including changes in personnel or political leadership and changes in relevant law; and obtain feedback on and evaluate and strengthen collaborations. Federal agencies have also developed guidelines¹⁰ to assist personnel who work with STLTTGs and entered into formal written agreements with STLTTGs when doing so helps establish shared terminology, definitions, and standard operating procedures, and promotes transparency and accountability in implementation. Federal agencies have also benefited from convening advisory committees that include STLTTG representatives and from engaging with national organizations that represent STLTTGs.

In Recommendation 2025–2, the Conference identified best practices for consulting with state, local, and tribal governments in regulatory policymaking. Building on Recommendation 2025–2, this Recommendation provides a framework that federal agencies should use to identify and collaborate more effectively with relevant STLTTGs in a broader range of contexts. It encourages agencies to adopt practices for initiating, managing, and evaluating collaborations with STLTTGs that promote a culture of improved coordination and strengthen working relationships between governments. In adopting the practices that follow, agencies must be mindful of their unique missions and demands on scarce resources.

Recommendation

Facilitating Collaboration Generally With State, Tribal, Local, and Territorial Governments (STLTTGs)

1. Federal agencies should establish organizational units, supervisory structures, and central and field operations, as appropriate, that establish or reinforce collaboration with STLTTGs and facilitate appropriate communication among agency personnel involved in collaborations at all levels.

2. Federal agencies should develop or maintain general guidelines to assist personnel in initiating, managing, and evaluating collaborations with STLTTGs.

Among other things, the guidelines should provide information about collaborating with different types of STLTTGs and highlight their differences and commonalities.

3. Federal agencies should collaborate with STLTTGs, even if not required to do so by law, when doing so would help agencies meet specific local needs and foster innovation; allow agencies to allocate scarce resources more efficiently; allow agencies to benefit from the expertise and resources of other entities; promote greater participation in federal administration; or otherwise help agencies administer federal programs more effectively.

4. For each program, federal agencies should designate one or more officials in an appropriate office who will be primarily responsible for initiating, coordinating, and evaluating collaborations with STLTTGs with an awareness of the different types of STLTTGs and their differences and commonalities.

5. Federal agencies should identify and reduce, as appropriate, administrative burdens that STLTTGs face when collaborating with federal agencies, for example by:

- a. Reducing regulatory burdens;
- b. Simplifying application and reporting processes;
- c. Enhancing the availability of technical assistance; or
- d. Providing funding opportunities.

6. Federal agency personnel involved in intergovernmental affairs, regional offices, and other agency personnel should meet regularly with STLTTGs to coordinate their relationships.

7. When federal agencies draft annual strategic and performance plans pursuant to the Government Performance and Results Act (31 U.S.C. 1115b, 1120(b)), they should describe how they collaborate with STLTTGs to achieve performance goals.

8. Federal agencies should review and update as necessary their Human Capital Operating Plans (5 CFR pt. 250) to ensure their hiring and position management needs are aligned properly with their operational goals for collaboration with STLTTGs.

Initiating Specific Collaborations With STLTTGs and Responding to Major Changes

9. Early in the implementation of federal programs and following major changes—such as changes in personnel or political leadership or changes in relevant law—federal agencies should develop a list of those STLTTGs that are most relevant to their work and determine whether, when, and how to collaborate with relevant STLTTGs. In reaching their determination, agencies should engage with:

- a. Government personnel involved in intergovernmental affairs, regional offices, and other relevant agency personnel;
- b. STLTTGs;
- c. Relevant advisory committees and similar entities that include STLTTG representatives;
- d. National organizations that represent STLTTGs; and
- e. Other persons interested in or affected by the collaboration.

10. When establishing a collaboration with an STLTTG or revisiting a collaboration in light of a major change, federal agencies

⁴ For example, the Federal Highway Administration works with state, local, and tribal governments to facilitate transportation planning. See, e.g., 23 U.S.C. 134–135, 201–202.

⁵ Admin. Conf. of the U.S., Recommendation 2025–2, *Consultation with State, Local, and Tribal Governments in Regulatory Policymaking*, 90 FR 27518 (June 27, 2025).

⁶ The Conference has identified several areas in which federal agencies should consider collaborating with STLTTGs, including to improve notice of regulatory changes to interested persons; promote timeliness in agency adjudication; publicize opportunities for public participation in agency decision making; and reduce burdens on the public in administrative processes. See, e.g., Admin. Conf. of the U.S., Recommendation 2022–2, *Improving Notice of Regulatory Changes*, 87 FR 39798 (July 5, 2022); Admin. Conf. of the U.S., Recommendation 2023–7, *Improving Timeliness in Agency Adjudication*, 89 FR 1513 (Jan. 10, 2024); Admin. Conf. of the U.S., Recommendation 2025–3, *Public Participation in Agency Adjudication*, 90 FR 27519 (June 27, 2025); and Admin. Conf. of the U.S., Recommendation 2023–6, *Identifying and Reducing Burdens on the Public in Administrative Processes*, 89 FR 1511 (Jan. 10, 2024).

⁷ See Pamela J. Clouser McCann & Jennifer L. Selin, *Federal Agency Collaboration with State, Local, Tribal, and Territorial Governments* 39, 43–44 (Dec. 5, 2025) (report to the Admin. Conf. of the U.S.).

⁸ See *id.* at 41–42.

⁹ See *id.* at 41–47.

¹⁰ See, e.g., *EPA Policy for the Administration of Environmental Programs on Indian Reservations*, Env't Prot. Agency, <https://www.epa.gov/tribal/epa-policy-administration-environmental-programs-indian-reservations-epa-indian-policy> (last visited Sept. 22, 2025).

should discuss the following topics with the STLTG and, as appropriate, formalize agreements in writing:

- a. The nature and type of the collaboration (e.g., provision of financial assistance, consultation, technical support);
- b. The legal and policy frameworks that govern the actions of federal officials and the STLTG;
- c. Objectives for the collaboration and metrics for determining whether the collaboration is successful;
- d. The leadership and points of contact for the federal agency and the STLTG;
- e. Procedures for managing the collaboration and communicating with the STLTG, including mechanisms for obtaining feedback and evaluating the collaboration;
- f. The information the federal agency and the STLTG may and will share with each other and the public, and the processes by which such information will be shared; and
- g. The human, financial, technological, and other resources available to the federal agency and the STLTG.

Strengthening Specific Collaborations With STLTGs

11. Federal agencies should develop guidelines to assist personnel involved in specific collaborations in coordinating and managing them. Such guidelines should:

- a. Identify the official responsible for making significant decisions regarding the collaboration;
- b. Establish mechanisms to ensure relevant personnel communicate regularly;
- c. Establish mechanisms to ensure relevant personnel coordinate their communications with STLTGs;
- d. Specify processes for documenting engagements with STLTGs;
- e. Specify processes for sharing information with or receiving information from the STLTG, including information that may be sensitive or protected by law; and
- f. Establish mechanisms for obtaining STLTG feedback and acting on it as appropriate.

12. Federal agencies should ensure that personnel involved in a collaboration with an STLTG receive training as needed on topics including:

- a. The laws and policies governing the actions of the STLTG;
- b. Best practices for engaging with the STLTG;
- c. Guidelines for sharing information with or receiving information from the STLTG, including information that may be sensitive or protected by law; and
- d. Procedures for managing the collaboration and communicating with the STLTG.

13. To understand on-the-ground conditions and available resources and to foster stronger working relationships, federal officials involved in collaborations with STLTGs, should:

- a. Involve personnel in their regional and local offices in collaborations with STLTGs, as appropriate;
- b. Visit the states, localities, tribal nations, and territories with which they collaborate; and
- c. Attend conferences and meetings in which STLTGs participate and otherwise

take advantage of opportunities to interact with STLTGs in person.

14. To facilitate coordination among agency personnel and ensure continuity of operations, federal agencies should develop or maintain repositories of records and information related to specific collaborations with particular STLTGs. Such repositories may include information such as:

- a. Any written agreements between the federal agency and STLTGs (see Paragraph 10);
- b. Federal agency officials' substantive communication as part of collaborations;
- c. The guidelines to assist personnel involved in specific collaborations (see Paragraph 11); and
- d. The points of contact for the STLTG.

Evaluating Collaborations With STLTGs

15. Federal agencies should provide opportunities on an ongoing or periodic basis for the following persons and entities to provide feedback on their collaborations with STLTGs:

- a. Agency personnel involved in collaborations with STLTGs;
- b. STLTGs;
- c. Relevant advisory committees and similar entities that include STLTG representatives;
- d. National organizations that represent STLTGs; and
- e. Other persons interested in or affected by the collaboration.

16. Federal agencies should collect information about their collaborations with STLTGs to evaluate performance in achieving the objectives for their collaborations, implement improvements, and engage in strategic planning. Such information should include:

- a. How collaborations develop over time; and
- b. Progress in achieving the performance metrics for collaborations.

17. Federal agencies should have a community of practice to share information about their experiences with and practices for improving collaboration with STLTGs.

Public Availability of Information About Collaborations With STLTGs

18. Federal agencies should provide up-to-date information on their websites describing:

- a. Collaborations with STLTGs;
- b. The leadership and points of contact for the federal agency for specific collaborations (see Paragraph 10(d));
- c. The federal agency official(s) with primary responsibility for coordinating and evaluating collaborations with STLTGs (see Paragraph 4);
- d. A general point of contact for STLTG collaborations;
- e. Written agreements regarding collaborations, as appropriate (see Paragraph 10); and
- f. Information about opportunities to provide feedback on collaborations (see Paragraph 15).

[FR Doc. 2026-02753 Filed 2-10-26; 8:45 am]

BILLING CODE 6110-01-P

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

[Docket No. APHIS-2026-0001]

Ball Horticultural Company: Availability of a Petition for a Determination of Nonregulated Status and Draft Plant Pest Risk Assessment for Red Flower Petals African Marigold (*Tagetes erecta*) Event pBALL123-022-BE113.

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Notice of availability.

SUMMARY: We are advising the public that the Animal and Plant Health Inspection Service has received a petition from Ball Horticultural Company seeking a determination of nonregulated status for African marigold (*Tagetes erecta*) event pBALL123-022-BE113 which has been developed using genetic engineering to produce red flower petals. We are making the petition and draft plant pest risk assessment available for public review and comment.

DATES: We will consider all comments that we receive on or before April 13, 2026.

ADDRESSES: You may submit comments by either of the following methods:

- *Federal eRulemaking Portal:* Go to www.regulations.gov. Enter APHIS-2026-0001 in the Search field. Select the Documents tab, then select the Comment button in the list of documents.

- *Postal Mail/Commercial Delivery:* Send your comment to Docket No. APHIS-2026-0001, Regulatory Analysis and Development, PPD, APHIS, 5601 Sunnyside Avenue #AP760, Beltsville, MD 20705.

The petition, draft plant pest risk assessment, and any comments we receive on this docket may be viewed at www.regulations.gov, or in our reading room, which is located in 1620 of the USDA South Building, 14th Street and Independence Avenue SW, Washington, DC. Normal reading room hours are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. To be sure someone is there to help you, please call (202) 799-7039 before coming.

FOR FURTHER INFORMATION CONTACT: Mr. Alan Pearson, Biotechnology Regulatory Services, APHIS, USDA, 5601 Sunnyside Avenue, AP100-3-WS-1151, Beltsville, MD 20705; (301) 851-3944; email: alan.pearson@usda.gov.

SUPPLEMENTARY INFORMATION: Under the authority of the plant pest provisions of

the Plant Protection Act (7 U.S.C. 7701 *et seq.*), the regulations in 7 CFR part 340, "Introduction of Organisms and Products Altered or Produced Through Genetic Engineering Which Are Plant Pests or Which There Is Reason to Believe Are Plant Pests," regulate, among other things, the introduction (importation, interstate movement, or release into the environment) of organisms and products altered or produced through genetic engineering that are plant pests or that there is reason to believe are plant pests. Such organisms and products are considered "regulated articles."

Section 340.6(a) of the regulations provides that any person may submit a petition to the Animal and Plant Health Inspection Service (APHIS) seeking a determination that an article should not be regulated under 7 CFR part 340. Paragraphs (b) and (c) of § 340.6 describe the form that a petition for a determination of nonregulated status must take and the information that must be included in the petition.

APHIS has received a petition (APHIS Petition Number 25–205–01p) from Ball Horticultural Company seeking a determination of nonregulated status for African marigold (*Tagetes erecta*) event pBALL123–022–BE113, designated as pBALL123, which has been developed using genetic engineering to produce red flower petals. The petition states that the information provided indicates that pBALL123 is unlikely to pose a plant pest risk and therefore should not be regulated under APHIS' regulations in 7 CFR part 340.

As part of our decision-making process regarding the organism's regulatory status, APHIS prepared a draft plant pest risk assessment (PPRA) to assess the plant pest risk of the organism. APHIS' draft PPRA compared the pest risk posed by pBALL123 with that of the nonmodified variety from which it was derived. The draft PPRA concluded that pBALL123 is unlikely to pose an increased plant pest risk compared to the nonmodified African marigold.

Paragraph (d) of § 340.6 provides that APHIS will publish a notice in the **Federal Register** providing 60 days for public comment on petitions for a determination of nonregulated status. In accordance with § 340.6(d), we are publishing this notice to inform the public that APHIS will accept written comments regarding the petition and draft PPRA from interested or affected persons for a period of 60 days from the date of this notice. The petition and draft PPRA are available for public review and comment, and copies are available as indicated under **ADDRESSES**

and from the individual listed under the **FOR FURTHER INFORMATION CONTACT** section of this notice. We are particularly interested in receiving comments regarding biological or ecological issues, and we encourage the submission of scientific data, studies, or research to support your comments.

After the comment period closes, APHIS will review and evaluate any information received during the comment period and any other relevant information. Based upon available information, APHIS will respond to the petitioner either approving or denying the petition. APHIS will post its regulatory determination on its website and publish a notice of availability in the **Federal Register**.

Authority: 7 U.S.C. 7701–7772 and 7781–7786; 31 U.S.C. 9701; 7 CFR 2.22, 2.80, and 371.3.

Done in Washington, DC, this 9th day of February 2026.

Kelly Moore

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 2026–02746 Filed 2–10–26; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

[Docket No. APHIS–2025–1067]

Soil Culture Solutions, LLC: Availability of a Petition for a Determination of Nonregulated Status and Draft Plant Pest Risk Assessment for HLB-Resistant Carrizo Citrange Rootstock (CarriCea)

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Notice of availability.

SUMMARY: We are advising the public that the Animal and Plant Health Inspection Service has received a petition from Soil Culture Solutions, LLC seeking a determination of nonregulated status for CarriCea Carrizo citrange rootstock which has been developed using genetic engineering for improved resistance to citrus greening disease (also known as Huanglongbing or HLB). We are making the petition and draft plant pest risk assessment available for public review and comment.

DATES: We will consider all comments that we receive on or before April 13, 2026.

ADDRESSES: You may submit comments by either of the following methods:

- **Federal eRulemaking Portal:** Go to www.regulations.gov. Enter APHIS–2025–1067 in the Search field. Select the Documents tab, then select the Comment button in the list of documents.

- **Postal Mail/Commercial Delivery:** Send your comment to Docket No. APHIS–2025–1067, Regulatory Analysis and Development, PPD, APHIS, 5601 Sunnyside Avenue, #AP760, Beltsville, MD 20705.

The petition, draft plant pest risk assessment, and any comments we receive on this docket may be viewed at www.regulations.gov, or in our reading room, which is located in 1620 of the USDA South Building, 14th Street and Independence Avenue SW, Washington, DC. Normal reading room hours are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. To be sure someone is there to help you, please call (202) 799–7039 before coming.

FOR FURTHER INFORMATION CONTACT: Mr. Alan Pearson, Biotechnology Regulatory Services, APHIS, USDA, 5601 Sunnyside Avenue, AP100–3–WS–1151, Beltsville, MD 20705; (301) 851–3944; email: alan.pearson@usda.gov.

SUPPLEMENTARY INFORMATION: Under the authority of the plant pest provisions of the Plant Protection Act (7 U.S.C. 7701 *et seq.*), the regulations in 7 CFR part 340, "Introduction of Organisms and Products Altered or Produced Through Genetic Engineering Which Are Plant Pests or Which There Is Reason to Believe Are Plant Pests," regulate, among other things, the introduction (importation, interstate movement, or release into the environment) of organisms and products altered or produced through genetic engineering that are plant pests or that there is reason to believe are plant pests. Such organisms and products are considered "regulated articles."

Section 340.6(a) of the regulations provides that any person may submit a petition to the Animal and Plant Health Inspection Service (APHIS) seeking a determination that an article should not be regulated under 7 CFR part 340. Paragraphs (b) and (c) of § 340.6 describe the form that a petition for a determination of nonregulated status must take and the information that must be included in the petition.

APHIS has received a petition (APHIS Petition Number 25–125–01p) from Soil Culture Solutions, LLC (SoilCea) seeking a determination of nonregulated status for Carrizo citrange rootstock, designated as event CarriCea, which has been developed using genetic engineering for improved resistance to citrus greening disease (also known as

Huanglongbing or HLB). The petition states that the information provided indicates that CarriCea is unlikely to pose a plant pest risk and therefore should not be regulated under APHIS' regulations in 7 CFR part 340.

As part of our decision-making process regarding the organism's regulatory status, APHIS prepared a draft plant pest risk assessment (PPRA) to assess the plant pest risk of the organism. APHIS' draft PPRA compared the pest risk posed by CarriCea with that of the nonmodified variety from which it was derived. The draft PPRA concluded that CarriCea is unlikely to pose an increased plant pest risk compared to the nonmodified citrange rootstock.

Paragraph (d) of § 340.6 provides that APHIS will publish a notice in the **Federal Register** providing 60 days for public comment on petitions for a determination of nonregulated status. In accordance with § 340.6(d), we are publishing this notice to inform the public that APHIS will accept written comments regarding the petition and draft PPRA from interested or affected persons for a period of 60 days from the date of this notice. The petition and draft PPRA are available for public review and comment, and copies are available as indicated under **ADDRESSES** and from the individual listed under the **FOR FURTHER INFORMATION CONTACT** section of this notice. We are particularly interested in receiving comments regarding biological or ecological issues, and we encourage the submission of scientific data, studies, or research to support your comments.

After the comment period closes, APHIS will review and evaluate any information received during the comment period and any other relevant information. Based upon available information, APHIS will respond to the petitioner either approving or denying the petition. APHIS will post its regulatory determination on its website and publish a notice of availability in the **Federal Register**.

Authority: 7 U.S.C. 7701–7772 and 7781–7786; 31 U.S.C. 9701; 7 CFR 2.22, 2.80, and 371.3.

Done in Washington, DC, this 9th day of February 2026.

Kelly Moore,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 2026–02741 Filed 2–10–26; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

[Docket No. APHIS–2025–1066]

U.S. Department of Agriculture, Agricultural Research Service: Availability of a Petition for a Determination of Nonregulated Status and Draft Plant Pest Risk Assessment for Early and Near-Continuous Flowering T1190 Apple (*Malus x Domestica*)

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Notice of availability.

SUMMARY: We are advising the public that the Animal and Plant Health Inspection Service has received a petition from the U.S. Department of Agriculture, Agricultural Research Service seeking a determination of nonregulated status for T1190 apple (*Malus x domestica*), which has been developed using genetic engineering to promote early and near-continuous flowering. We are making the petition and draft plant pest risk assessment available for public review and comment.

DATES: We will consider all comments that we receive on or before April 13, 2026.

ADDRESSES: You may submit comments by either of the following methods:

- **Federal eRulemaking Portal:** Go to www.regulations.gov. Enter APHIS–2025–1066 in the Search field. Select the Documents tab, then select the Comment button in the list of documents.
- **Postal Mail/Commercial Delivery:** Send your comment to Docket No. APHIS–2025–1066, Regulatory Analysis and Development, PPD, APHIS, 5601 Sunnyside Avenue, #AP760, Beltsville, MD 20705.

The petition, draft plant pest risk assessment, and any comments we receive on this docket may be viewed at www.regulations.gov, or in our reading room, which is located in 1620 of the USDA South Building, 14th Street and Independence Avenue SW, Washington, DC. Normal reading room hours are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. To be sure someone is there to help you, please call (202) 799–7039 before coming.

FOR FURTHER INFORMATION CONTACT: Mr. Alan Pearson, Biotechnology Regulatory Services, APHIS, USDA, 5601 Sunnyside Avenue, AP100–3–WS–1151, Beltsville, MD 20705; (301) 851–3944 email: alan.pearson@usda.gov.

SUPPLEMENTARY INFORMATION: Under the authority of the plant pest provisions of the Plant Protection Act (7 U.S.C. 7701 *et seq.*), the regulations in 7 CFR part 340, “Introduction of Organisms and Products Altered or Produced Through Genetic Engineering Which Are Plant Pests or Which There Is Reason to Believe Are Plant Pests,” regulate, among other things, the introduction (importation, interstate movement, or release into the environment) of organisms and products altered or produced through genetic engineering that are plant pests or that there is reason to believe are plant pests. Such organisms and products are considered “regulated articles.”

Section 340.6(a) of the regulations provides that any person may submit a petition to the Animal and Plant Health Inspection Service (APHIS) seeking a determination that an article should not be regulated under 7 CFR part 340. Paragraphs (b) and (c) of § 340.6 describe the form that a petition for a determination of nonregulated status must take and the information that must be included in the petition.

APHIS has received a petition (APHIS Petition Number 25–127–01p) from the U.S. Department of Agriculture, Agricultural Research Service seeking a determination of nonregulated status for T1190 apple (*Malus x domestica*), which has been developed using genetic engineering to promote early and near-continuous flowering. The petition states that the information provided indicates that T1190 apple is unlikely to pose a plant pest risk and therefore should not be regulated under APHIS' regulations in 7 CFR part 340.

As part of our decision-making process regarding the organism's regulatory status, APHIS prepared a draft plant pest risk assessment (PPRA) to assess the plant pest risk of the organism. APHIS' draft PPRA compared the pest risk posed by T1190 apple with that of the nonmodified variety from which it was derived. The draft PPRA concluded that T1190 apple is unlikely to pose an increased plant pest risk compared to the nonmodified apple.

Paragraph (d) of § 340.6 provides that APHIS will publish a notice in the **Federal Register** providing 60 days for public comment on petitions for a determination of nonregulated status. In accordance with § 340.6(d), we are publishing this notice to inform the public that APHIS will accept written comments regarding the petition and draft PPRA from interested or affected persons for a period of 60 days from the date of this notice. The petition and draft PPRA are available for public review and comment, and copies are

available as indicated under **ADDRESSES** and from the individual listed under the **FOR FURTHER INFORMATION CONTACT** section of this notice. We are particularly interested in receiving comments regarding biological or ecological issues, and we encourage the submission of scientific data, studies, or research to support your comments.

After the comment period closes, APHIS will review and evaluate any information received during the comment period and any other relevant information. Based upon available information, APHIS will respond to the petitioner either approving or denying the petition. APHIS will post its regulatory determination on its website and publish a notice of availability in the **Federal Register**.

Authority: 7 U.S.C. 7701–7772 and 7781–7786; 31 U.S.C. 9701; 7 CFR 2.22, 2.80, and 371.3.

Done in Washington, DC, this 9th day of February 2026.

Kelly Moore,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 2026–02745 Filed 2–10–26; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

[Docket No. APHIS–2026–0034]

Request for Revision to and Extension of Approval of an Information Collection; Importation of Gypsy Moth Host Materials From Canada

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Revision to and extension of approval of an information collection; comment request.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice announces the Animal and Plant Health Inspection Service's intention to request a revision to and extension of approval of an information collection associated with the regulations to prevent the introduction of gypsy moth from Canada into noninfested areas of the United States.

DATES: We will consider all comments that we receive on or before April 13, 2026.

ADDRESSES: You may submit comments by either of the following methods:

- *Federal eRulemaking Portal:* Go to <http://www.regulations.gov>. Enter APHIS–2026–0034 in the Search field. Select the Documents tab, then select

the Comment button in the list of documents.

- *Postal Mail/Commercial Delivery:* Send your comment to Docket No. APHIS–2026–0034, Regulatory Analysis and Development, PPD, APHIS, 5601 Sunnyside Ave., #AP760, Beltsville, MD 20705.

Supporting documents and any comments we receive on this docket may be viewed at <http://www.regulations.gov> or in our reading room, which is in Room 1620 of the USDA South Building, 14th Street and Independence Avenue SW, Washington, DC. Normal reading room hours are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. To be sure someone is there to help you, please call (202) 799–7039 before coming.

FOR FURTHER INFORMATION CONTACT: For information on the regulations for the importation of gypsy moth host material from Canada, contact Ms. Lydia Colón, Senior Regulatory Policy Specialist, PPQ, APHIS, 1400 Independence Ave. SW, Washington, DC 20250; (301) 851–2302. For more information on the information collection reporting process, contact Ms. Sheniqua Harris, APHIS' Paperwork Reduction Act Coordinator, at (301) 851–2528 or email APHIS.PRA@usda.gov.

SUPPLEMENTARY INFORMATION:

Title: Importation of Gypsy Moth Host Materials From Canada.

OMB Control Number: 0579–0142.

Type of Request: Revision to and extension of approval of an information collection.

Abstract: The Plant Protection Act (PPA, 7 U.S.C. 7701 *et seq.*) authorizes the Secretary of Agriculture to prohibit or restrict the importation, entry, exportation, or interstate movement of plants, plant products, and other articles to prevent the introduction of plant pests into the United States or their dissemination within the United States. This authority has been delegated to the Animal and Plant Health Inspection Service (APHIS), which administers regulations to implement the PPA. Regulations governing the importation of gypsy moth host material into the United States from Canada are contained in 7 CFR 319.77–1 through 319.77–5.

The regulations are intended to prevent the introduction of gypsy moth into noninfested areas of the United States by placing certain inspection and documentation requirements on gypsy moth host material (*i.e.*, regulated articles) imported from Canada. Under the regulations, depending on the place of origin of the regulated articles and their destination in the United States,

certain information collection activities are required such as a phytosanitary certificate, certificate of origin, written statement, compliance agreement, and emergency action notification.

We are asking the Office of Management and Budget (OMB) to approve our use of these information collection activities, as described, for an additional 3 years. APHIS has amended this information collection by increasing the number of Respondents. In addition, APHIS has removed the following activities from this information collection:

- Compliance Agreement (PPQ Form 519) (moved to a new common form information collection).
- Emergency Action Notification (PPQ Form 523) (moved to a new common form information collection).

The purpose of this notice is to solicit comments from the public (as well as affected agencies) concerning our information collection. These comments will help us:

- (1) Evaluate whether the 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 our estimate of the burden of the 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 on those who are to respond, through use, as appropriate, of automated, electronic, mechanical, and other collection technologies; *e.g.*, permitting electronic submission of responses.

Estimate of burden: The public burden for this collection of information is estimated to average 0.419 hours per response.

Respondents: Canadian plant health authorities; growers, exporters, or shippers of Christmas trees, shrubs, logs, pulpwood, and other articles from gypsy moth-infested provinces in Canada; and private individuals entering the United States with mobile homes or outdoor household articles.

Estimated annual number of respondents: 3,343.

Estimated annual number of responses per respondent: 5.

Estimated annual number of responses: 17,945.

Estimated total annual burden on respondents: 7,524 hours. (Due to averaging, the total annual burden hours may not equal the product of the annual number of responses multiplied by the reporting burden per response.)

All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record.

Done in Washington, DC, this 5th day of February 2026.

Kelly Moore,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 2026–02714 Filed 2–10–26; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF AGRICULTURE

Commodity Credit Corporation

Domestic Sugar Program—FY 2026 Reassignment of Cane Sugar and Beet Sugar Marketing Allotments and Processor Allocations

AGENCY: Commodity Credit Corporation, U.S. Department of Agriculture.

ACTION: Notice.

SUMMARY: The United States Department of Agriculture (USDA) is issuing this notice to: (1) revise fiscal year (FY) 2026 (crop year 2025) State cane sugar allotments and allocations to sugarcane processors; and (2) revise the FY 2026 (crop year 2025) beet sugar allocations. Actions (1) and (2) apply to all domestic cane and beet sugar marketed for human consumption in the United States from October 1, 2025, through September 30, 2026.

FOR FURTHER INFORMATION CONTACT: Carlann Unger; telephone: (773) 573–5163; or email, Carlann.Unger@usda.gov. Individuals with disabilities who require alternative means for communication should contact the 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:

FY 2026 Cane Reassignment

In accordance with section 359e of the Agricultural Adjustment Act of 1938 (7 U.S.C. 1359ee), after evaluating each sugarcane State and sugarcane processor's ability to market its full allotment and allocation, USDA is transferring 315,464 short tons, raw value of Florida FY 2026 allotment to Louisiana, which results in the transfer of allocations from Florida sugarcane processors with surplus allocation to Louisiana sugarcane processors with deficit allocation, as shown in the table below.

FY 2026 Beet Reassignment

In addition, after evaluating each beet sugar processor's ability to market its full allocation, USDA is transferring allocations from beet sugar processors with surplus allocation to beet sugar processors with deficit allocation, also shown in the table below.

TABLE 1—FY 2026 REVISED BEET AND CANE ALLOTMENTS AND ALLOCATIONS

[Short tons, raw value]

Distribution	Initial FY26 allotments & allocations	Reassignments	Revised allotments & allocations
Beet Sugar	5,525,221	0	5,525,221
Cane Sugar	4,640,779	0	4,640,779
Imports .....	.....	0	0
Total OAQ	10,166,000	0	10,166,000
Beet Processors' Marketing Allocations			
Amalgamated Sugar Co	1,182,992	70,374	1,253,366
American Crystal Sugar Co	2,031,883	30,412	2,062,295
Michigan Sugar Co	570,620	49,008	619,628
Minn-Dak Farmers Co-op	383,721	– 18,201	365,520
So. Minn Beet Sugar Co-op	745,729	– 204,443	541,286
Western Sugar Co	564,013	58,593	622,606
Wyoming Sugar Company, LLC	46,264	14,256	60,519
Total Beet Sugar	5,525,221	0	5,525,221
State Cane Sugar Allotments			
Florida	2,616,569	– 315,464	2,301,104
Louisiana	2,024,210	315,464	2,339,675
Texas .....	.....	0	0
Total Cane Sugar	4,640,779	0	4,640,779
Cane Processors' Marketing Allocations			
Florida:			
Florida Crystals	1,077,310	– 213,789	863,521
Growers Co-op. of FL	470,682	– 30,795	439,888
U.S. Sugar Corp	1,068,577	– 70,880	997,696
Total Florida	2,616,569	– 315,464	2,301,104
Louisiana:			
Sugar Growers and Refiners	1,405,272	215,900	1,621,172
M.A. Patout & Sons	618,938	99,565	718,502
Total Louisiana	2,024,210	315,464	2,339,675
Texas:			

TABLE 1—FY 2026 REVISED BEET AND CANE ALLOTMENTS AND ALLOCATIONS—Continued
[Short tons, raw value]

Distribution	Initial FY26 allotments & allocations	Reassignments	Revised allotments & allocations
Rio Grande Valley	0	0	0

* Values may not sum to column total due to rounding.

USDA will closely monitor stocks, consumption, imports and all sugar market and program variables on an ongoing basis and may make program adjustments during FY 2026 if needed.

William Beam,

Executive Vice President, Commodity Credit Corporation.

[FR Doc. 2026–02723 Filed 2–10–26; 8:45 am]

BILLING CODE 3411–E2–P

COMMISSION ON CIVIL RIGHTS

Notice of Public Meeting of the Oregon Advisory Committee to the U.S. Commission on Civil Rights

AGENCY: Commission on Civil Rights.

ACTION: Announcement of meeting.

SUMMARY: Notice is hereby given, pursuant to the provisions of the rules and regulations of the U.S. Commission on Civil Rights (Commission), and the Federal Advisory Committee Act (FACA), that a business meeting of the Oregon Advisory Committee to the Commission will hold a public business meeting via Zoom. The purpose of the meeting is to review and discuss the committee's project proposal.

DATES: Monday, February 23, 2026, from 12:30 p.m.–1:30 p.m. Pacific Time.

ADDRESSES: The meeting will be held via Zoom.

Registration Link (Audio/Visual):
<https://www.zoomgov.com/j/1605589611>.

Join by Phone (Audio Only): 1–833 435 1820 USA Toll Free; Webinar ID: 160 558 9611.

Agenda: <https://usccr.app.box.com/folder/364192458928> (note: a final meeting agenda will be available prior to the meeting date).

FOR FURTHER INFORMATION CONTACT: Kayla Fajota, Designated Federal Officer at kfajota@usccr.gov, or (434) 515–2395.

SUPPLEMENTARY INFORMATION: This virtual committee meeting is available to the public through the registration link above. Any interested member of the public may join at the link to listen to this meeting. An open comment period will be provided to allow members of the public to make a

statement as time allows. Pursuant to the Federal Advisory Committee Act, public minutes of the meeting will include a list of persons who are present at the meeting. If joining via phone, callers can expect to incur regular charges for calls they initiate over wireless lines, according to their wireless plan. The Commission will not refund any incurred charges. Callers will incur no charge for calls they initiate over land-line connections to the toll-free telephone number. Closed captioning is available by selecting “CC” in the Zoom meeting platform. To request additional accommodations, please email Angelica Trevino, Support Services Specialist at atrevino@usccr.gov at least 10 business days prior to the meeting.

Members of the public are entitled to submit written comments; the comments must be received within 30 days following the meeting. Written comments may be emailed to Kayla Fajota, Designated Federal Officer at kfajota@usccr.gov. Persons who desire additional information may contact the Regional Programs Coordination Unit at (434) 515–2395.

Records generated from this meeting may be inspected and reproduced at the Regional Programs Coordination Unit Office, as they become available, both before and after the meeting. Records of the meetings will be available via the file sharing website: <https://usccr.app.box.com/folder/271061562007?s=r6h92j9j27b78vvft9voq7b6kzdpblbl> as well as at: www.facadatabase.gov under the Commission on Civil Rights, selecting the Advisory Committee of interest. Persons interested in the work of this Committee are directed to the Commission's website, <http://www.usccr.gov>, or may contact the Regional Programs Coordination Unit at the above phone number.

Dated: February 9, 2026

David Mussatt,

Supervisory Chief, Regional Programs Unit.

[FR Doc. 2026–02742 Filed 2–10–26; 8:45 am]

BILLING CODE P

COMMISSION ON CIVIL RIGHTS

Notice of Public Meeting of the Alaska Advisory Committee to the U.S. Commission on Civil Rights

AGENCY: Commission on Civil Rights.

ACTION: Announcement of meeting.

SUMMARY: Notice is hereby given, pursuant to the provisions of the rules and regulations of the U.S. Commission on Civil Rights (Commission), and the Federal Advisory Committee Act (FACA), that a business meeting of the Alaska Advisory Committee to the Commission will hold a public business meeting via Zoom. The purpose of the meeting is to review and discuss the committee's project proposal.

DATES: Monday, February 27, 2026, from 12:30 p.m.–1:30 p.m. Alaska Standard Time.

ADDRESSES: The meeting will be held via Zoom.

Registration Link (Audio/Visual):
<https://www.zoomgov.com/j/1607734227>.

Join by Phone (Audio Only): 1–833 435 1820 USA Toll Free; Webinar ID: 160 773 4227.

Agenda: <https://usccr.app.box.com/folder/364191068540> (note: a final meeting agenda will be available prior to the meeting date).

FOR FURTHER INFORMATION CONTACT: Kayla Fajota, Designated Federal Officer at kfajota@usccr.gov, or (434) 515–2395.

SUPPLEMENTARY INFORMATION: This virtual committee meeting is available to the public through the registration link above. Any interested member of the public may join at the link to listen to this meeting. An open comment period will be provided to allow members of the public to make a statement as time allows. Pursuant to the Federal Advisory Committee Act, public minutes of the meeting will include a list of persons who are present at the meeting. If joining via phone, callers can expect to incur regular charges for calls they initiate over wireless lines, according to their wireless plan. The Commission will not refund any incurred charges. Callers will incur no charge for calls they initiate over land-line connections to

the toll-free telephone number. Closed captioning is available by selecting "CC" in the Zoom meeting platform. To request additional accommodations, please email Angelica Trevino, Support Services Specialist at atrevino@usccr.gov at least 10 business days prior to the meeting.

Members of the public are entitled to submit written comments; the comments must be received within 30 days following the meeting. Written comments may be emailed to Kayla Fajota, Designated Federal Officer at kfajota@usccr.gov. Persons who desire additional information may contact the Regional Programs Coordination Unit at (434) 515-2395.

Records generated from this meeting may be inspected and reproduced at the Regional Programs Coordination Unit Office, as they become available, both before and after the meeting. Records of the meetings will be available via the file sharing website: <https://usccr.app.box.com/folder/271059500656?s=7zq5h28nnzfbv55gk4r5y1iybzewmknz> as well as at: www.facadatabase.gov under the Commission on Civil Rights, selecting the Advisory Committee of interest. Persons interested in the work of this Committee are directed to the Commission's website, <http://www.usccr.gov>, or may contact the Regional Programs Coordination Unit at the above phone number.

Dated: February 9, 2026.

David Mussatt,

Supervisory Chief, Regional Programs Unit.

[FR Doc. 2026-02744 Filed 2-10-26; 8:45 am]

BILLING CODE P

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[B-16-2026]

Foreign-Trade Zone (FTZ) 46, Notification of Proposed Production Activity; General Electric Company; (Production and Testing of Jet Engines); Peebles, Ohio

General Electric submitted a notification of proposed production activity to the FTZ Board (the Board) for its facility in Peebles, Ohio within FTZ 46. The notification conforming to the requirements of the Board's regulations (15 CFR 400.22) was received on February 3, 2026.

Pursuant to 15 CFR 400.14(b), FTZ production activity would be limited to the specific foreign-status material(s)/ component(s) and specific finished product(s) described in the submitted notification (summarized below) and

subsequently authorized by the Board. The benefits that may stem from conducting production activity under FTZ procedures are explained in the background section of the Board's website—accessible via www.trade.gov/ftz.

The proposed finished product is gas turbine aircraft engines (duty rate of duty-free).

The proposed foreign-status materials/components include: synthetic polymer paint; synthetic polymer varnish; modified natural polymer paint; modified natural polymer varnish; lubricating oils; prepared glues; prepared adhesives; plastic tubing; plastic pipes; plastic hoses; plastic washers; plastic O-rings; plastic gaskets; plastic seals; plastic retainers; plastic blocks; plastic clamps; plastic bushings; plastic spacers; plastic straps; plastic strips; plastic sleeves; plastic covers; plastic grommets; plastic isolator; plastic damper; plastic connectors; rubber seals; rubber washers; rubber gaskets; rubber pipe fittings; rubber flange connectors; rubber grommets; rubber blocks; rigid containers; slag wool insulation; slag wool shield; carbon fiber bushing; carbon fiber clamps; carbon fiber gaskets; carbon fiber seals; carbon fiber spacers; carbon fiber vanes; carbon fibers blades; glass fiber insulation blankets; glass wool insulation blankets; stainless steel pipe fittings; stainless steel tube fittings; non-alloy steel pipe fittings; non-alloy steel tube fittings; steel stranded wire; non stainless alloy threaded fasteners; base metal threaded fasteners; carbon steel threaded fasteners; stainless steel threaded fasteners; iron nuts; steel nuts; steel flat washer; steel cotter ins; steel retaining rings; steel connectors for hoses; steel general purpose plugs; steel general purpose spacers; steel general purpose clamps; steel general purpose bushings; steel general purpose caps; steel general purpose sleeves; nickel alloy cold formed wire; nickel tube fittings; nickel pipe fittings; nickel stranded wire; nickel screws; nickel bolts; nickel conduit; nickel couplings; nickel pins; nickel enclosures; nickel seals; nickel washers; nickel fittings; nickel connectors; nickel gears; nickel lockwire; nickel lugs; nickel nuts; nickel joints; nickel rings; nickel rivets; nickel rotors; nickel spacers; nickel springs; nickel studs; nickel clips; nickel thermocouples; nickel inserts; nickel tubes; nickel vanes; titanium bolts; titanium screws; titanium pins; titanium seals; titanium spacers; titanium nuts; titanium washers; titanium connectors; base metal mounting fixtures; base metal brackets; base metal blind rivets;

base metal tubular rivets; base metal bifurcated rivets; base metal identification plates; gas turbine aircraft engines; aircraft turbines; aircraft engine seal assemblies; base metal aircraft engine thermal blankets; aircraft engine retainer plates; aircraft engine fan stator assemblies; aircraft engine fan case assemblies; aircraft engine booster assemblies; aircraft engine hub assemblies; aircraft engine combustor diffuser nozzle assemblies; aircraft engine high pressure compressor rotor assemblies; aircraft engine high pressure nozzle assemblies; base metal aircraft engine blades; base metal aircraft engine disks; aircraft engine high pressure turbine rotor assemblies; base metal aircraft engine nozzles; aircraft engine turbine center frame assemblies; aircraft engine interstage seals; aircraft engine rear rotating seals; aircraft engine front rotating seals; aircraft engine heat shields; aircraft engine boroscope plugs; aircraft engine plugs; base metal aircraft engine blisks; aircraft engine weights; aircraft engine balances; aircraft engine shrouds; aircraft engine manifolds; aircraft engine retainer tube assemblies; aircraft engine rings; aircraft engine connector links; aircraft engine clevis; aircraft engine tube assemblies; aircraft engine ducts; aircraft engine cowl assemblies; aircraft engine fuel nozzles; aircraft engine spools; aircraft engine fairings; aircraft engine panels; aircraft engine air ducts; aircraft engine sectors; aircraft engine fan cowls; aircraft engine fan cowls; aircraft engine inlet assemblies; aircraft engine module assemblies; aircraft engine base assemblies; aircraft engine spool assemblies; linear acting hydraulic cylinders; rotary power replacement pumps; heat exchangers; fuel filters; oil separators; fuel separators; engine fluid filters; machine work holders; data processing machines; magnetic hard disk drives; automatic data processing machines; regulator valves; bodies of valves; aircraft engine gears; multilayered metal gaskets; AC alternator generators; motor stator rings; generator stator rings; power supplies; engine igniters; engine exciters; switching machines; routing machines; electric amplifiers; video recording machines; solid state storage media; transmission machines; digital cameras; computer monitors; electrical terminals; electrical plugs; junction boxes; electric terminals; programmable controllers; flight recorders; flight sensors; flight recorders speed sensor; coaxial cables; wiring harnesses; electrical cables with fitting; electrical cables; shipping containers; transportation carriers;

transportation carriers bracket; aircraft propellers; aircraft nacelles; aircraft thrust reversers; thermometers; flow meters; pressure meters; measuring meters; measuring multimeter; electrical measuring instrument; optical measuring instruments; testing equipment; vibration sensors; hydro-mechanical units; hydro-mechanical units sensors; masques; embroidered emblems; and engine cloth covers (duty rate ranges from duty-free to 20%).

The request indicates that certain materials/components are subject to duties under section 1702(a)(1)(B) of the International Emergency Economic Powers Act (section 1702), section 232 of the Trade Expansion Act of 1962 (section 232), or section 301 of the Trade Act of 1974 (section 301), depending on the country of origin. The applicable section 1702, section 232, and section 301 decisions require subject merchandise to be admitted to FTZs in privileged foreign (PF) status (19 CFR 146.41). The Board's regulations (15 CFR 400.13(c)(2)) require that merchandise subject to AD/CVD orders, or items which would be otherwise subject to suspension of liquidation under AD/CVD procedures if they entered U.S. customs territory, be admitted to the zone in PF status (19 CFR 146.41).]

Public comment is invited from interested parties. Submissions shall be addressed to the Board's Executive Secretary and sent to: ftz@trade.gov. The closing period for their receipt is March 23, 2026.

A copy of the notification will be available for public inspection in the "Online FTZ Information System" section of the Board's website.

For further information, contact Brian Warnes at brian.warnes@trade.gov.

Dated: February 6, 2026.

Elizabeth Whiteman,
Executive Secretary.

[FR Doc. 2026-02775 Filed 2-10-26; 8:45 am]

BILLING CODE 3510-DS-P

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[B-14-2026]

Foreign-Trade Zone (FTZ) 72, Notification of Proposed Production Activity; General Electric Company; (Commercial Aerospace Propulsion Parts and Engine Cores); Lafayette, Indiana

General Electric Company submitted a notification of proposed production activity to the FTZ Board (the Board) for

its facility in Lafayette, Indiana within FTZ 72. The notification conforming to the requirements of the Board's regulations (15 CFR 400.22) was received on February 3, 2026.

Pursuant to 15 CFR 400.14(b), FTZ production activity would be limited to the specific foreign-status material(s)/component(s) and specific finished product(s) described in the submitted notification (summarized below) and subsequently authorized by the Board. The benefits that may stem from conducting production activity under FTZ procedures are explained in the background section of the Board's website—accessible via www.trade.gov/ftz.

The proposed finished products include: aircraft engine cores; aircraft engine seal assemblies; base metal aircraft engine thermal blankets; aircraft engine retainer plates; aircraft engine fan stator assemblies; aircraft engine fan case assemblies; aircraft engine booster assemblies; aircraft engine hub assemblies; aircraft engine combustor diffuser nozzle assemblies; aircraft engine high pressure compressor rotor assemblies; aircraft engine high pressure nozzle assemblies; base metal aircraft engine blades; base metal aircraft engine disks; aircraft engine high pressure turbine rotor assemblies; base metal aircraft engine nozzles; aircraft engine turbine center frame assemblies; aircraft engine interstage seals; aircraft engine rear rotating seals; aircraft engine front rotating seals; aircraft engine heat shields; aircraft engine boroscope plugs; aircraft engine plugs; base metal aircraft engine blisks; aircraft engine weights; aircraft engine balances; aircraft engine shrouds; aircraft engine manifolds; aircraft engine retainer tube assemblies; aircraft engine rings; aircraft engine connector links; aircraft engine clevises; aircraft engine tube assemblies; aircraft engine ducts; aircraft engine cowl assemblies; aircraft engine fuel nozzles; aircraft engine spools; aircraft engine fairings; aircraft engine panels; aircraft engine air ducts; aircraft engine sectors; aircraft engine fan cowls; aircraft engine module assemblies; aircraft engine base assemblies; aircraft engine spool assemblies; and aircraft engine vane assemblies (duty rate of duty-free).

The proposed foreign-status materials/components include: polyester adhesive decals; plastic washers; plastic o-rings; plastic gaskets; plastic seals; plastic retainers; plastic blocks; plastic clamps; plastic bushings; plastic spacers; plastic straps; plastic strips; plastic sleeves; plastic covers; plastic grommets; plastic isolators; plastic dampers; plastic connectors; rubber seals; rubber washers; rubber

gaskets; rubber pipe fittings; rubber flange connectors; rubber grommets; rubber blocks; wood packing boxes; wood packing cases; slag wool insulation; slag wool shields; carbon fiber bushings; carbon fiber clamps; carbon fiber gaskets; carbon fiber seals; carbon fiber spacers; carbon fiber vanes; carbon fibers blades; glass fiber insulation blankets; glass wool insulation blankets; glass fiber reinforced fasteners (fiber); glass fiber reinforced fasteners (woven); stainless steel flanges; stainless steel threaded elbows; stainless steel threaded couplings; stainless steel threaded bends; stainless steel threaded sleeves; stainless steel pipe fittings; stainless steel tube fittings; steel oil tanks; non-stainless alloy threaded fasteners; base metal threaded fasteners; carbon steel threaded fasteners; stainless steel threaded fasteners; iron nuts; steel nuts; iron threaded inserts; steel threaded inserts; steel locking washers; steel spring washers; steel flat washers; steel rivets; steel cotter pins; steel retaining rings; steel non threaded hardware; steel springs; steel safety spring wires; steel connectors for hoses; steel general purpose plugs; steel general purpose spacers; steel general purpose clamps; steel general purpose bushings; steel general purpose caps; steel general purpose sleeves; refined copper wires; copper stranded wires; nickel alloy cold formed wires; nickel tubes; nickel pipes; nickel tube fittings; nickel pipe fittings; stranded wire of nickel; nickel screws; nickel bolts; nickel conduits; nickel couplings; nickel pins; nickel enclosures; nickel seals; nickel washers; nickel fittings; nickel connectors; nickel gears; nickel lockwires; nickel lugs; nickel nuts; nickel joints; nickel rings; nickel rivets; nickel rotors; nickel spacers; nickel springs; nickel studs; nickel clips; nickel thermocouples; nickel inserts; nickel tubes; nickel vanes; aluminum screws; aluminum caps; aluminum pins; aluminum washers; aluminum clamps; aluminum general purpose spacers; aluminum general purpose plugs; titanium bolts; titanium screws; titanium pins; titanium seals; titanium spacers; titanium nuts; titanium washers; titanium connectors; base metal hinges; base metal mounting fixtures; base metal brackets; steel flexible tubing; iron flexible tubing; base metal blind rivets; base metal tubular rivets; base metal bifurcated rivets; base metal identification plates; power engines spools; power engine nozzle assemblies; base metal power engine supports; base metal power engines weights; power engines disks; power engines dampers; base metal power

engine shims; power engine tube assemblies; power engine shrouds; base metal power engine sleeves; base metal power engine seals; base metal power engine segments; base metal power engine rings; base metal power engine blade retainers; base metal power engine vane retainers; base metal power engine retainer seals; base metal power engine plugs; power engine blades; power engine manifolds; power engine fuel nozzle assemblies; linear acting hydraulic cylinders; pneumatic power engines; pneumatic power motors; reciprocating positive replacing pumps; axial fans; centrifugal fans; cooling fan; blower assembly; heat exchangers; fuel filters; oil separators; fuel separators; engine fluid filters; oleo hydraulic vales; oleo pneumatic valves; check valves; safety relief valves; regulator valves; bodies of valves; ball bearings; spherical roller bearings; cylindrical roller bearings; roller bearing rings; roller bearing races; ball bearing rings; ball bearing races; transmission shafts; crank shafts; cam shafts; plain shaft bearings; aircraft engine gears; gearboxes tubes; gearboxes drains; gearbox covers; gearbox housings; multilayered metal gaskets; mechanical seals; base metal sheeting joints; AC alternator generators; motor stator rings generator stator rings; engine igniters; engine exciters; electronic engine control software; electrical plugs; junction boxes; electric terminals; programmable controllers; electrical switching apparatuses; flight recorders; flight sensors; copper winding wire; winding wire; coaxial cables; wiring harnesses; electrical cables with fitting; electrical cables; aircraft nacelles; aircraft thrust reversers; thermometers; flow meters; electrical pressure meters; measuring meters; checking meters; liquid heat pressure meters; pressure probes; measuring probes; checking probes; testing equipment; vibration sensors; testing probes; hydro-mechanical units; and hydro-mechanical units sensors (duty rate ranges from duty-free to 15%).

The request indicates that certain materials/components are subject to duties under section 1702(a)(1)(B) of the International Emergency Economic Powers Act (section 1702), section 232 of the Trade Expansion Act of 1962 (section 232), or section 301 of the Trade Act of 1974 (section 301), depending on the country of origin. The applicable section 1702, section 232, and section 301 decisions require subject merchandise to be admitted to FTZs in privileged foreign status (19 CFR 146.41).

Public comment is invited from interested parties. Submissions shall be

addressed to the Board's Executive Secretary and sent to: ftz@trade.gov. The closing period for their receipt is March 23, 2026.

A copy of the notification will be available for public inspection in the "Online FTZ Information System" section of the Board's website.

For further information, contact Brian Warnes at brian.warnes@trade.gov.

Dated: February 6, 2026.

Elizabeth Whiteman,
Executive Secretary.

[FR Doc. 2026-02773 Filed 2-10-26; 8:45 am]

BILLING CODE 3510-DS-P

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[B-15-2026]

Foreign-Trade Zone (FTZ) 93, Notification of Proposed Production Activity; General Electric Company; (Commercial Aerospace Propulsion Parts and Engine Cores); Durham, North Carolina

General Electric Company submitted a notification of proposed production activity to the FTZ Board (the Board) for its facility in Durham, North Carolina within FTZ 93. The notification conforming to the requirements of the Board's regulations (15 CFR 400.22) was received on February 3, 2026.

Pursuant to 15 CFR 400.14(b), FTZ production activity would be limited to the specific foreign-status material(s)/ component(s) and specific finished product(s) described in the submitted notification (summarized below) and subsequently authorized by the Board. The benefits that may stem from conducting production activity under FTZ procedures are explained in the background section of the Board's website—accessible via www.trade.gov/ftz.

The proposed finished products include: aircraft engine cores; aircraft engine seal assemblies; base metal aircraft engine thermal blankets; aircraft engine retainer plates; aircraft engine fan stator assemblies; aircraft engine fan case assemblies; aircraft engine booster assemblies; aircraft engine hub assemblies; aircraft engine combustor diffuser nozzle assemblies; aircraft engine high pressure compressor rotor assemblies; aircraft engine high pressure nozzle assemblies; base metal aircraft engine blades; base metal aircraft engine disks; aircraft engine high pressure turbine rotor assemblies; aircraft engine interstage seals; aircraft engine rear rotating seals; aircraft engine front

rotating seals; aircraft engine heat shields; aircraft engine boroscope plugs; aircraft engine plugs; base metal aircraft engine blisks; aircraft engine weights; aircraft engine balances; aircraft engine shrouds; aircraft engine manifolds; aircraft engine retainer tube assemblies; aircraft engine rings; aircraft engine connector links; aircraft engine clevises; aircraft engine tube assemblies; aircraft engine ducts; aircraft engine cowl assemblies; aircraft engine fuel nozzles; aircraft engine spools; aircraft engine fairings; aircraft engine panels; aircraft engine air ducts; aircraft engine sectors; aircraft engine fan cowls; aircraft engine inlet assemblies; aircraft engine module assemblies; aircraft engine base assemblies; aircraft engine spool assemblies; and, aircraft engine vane assemblies (duty rate is duty-free).

The proposed foreign-status materials/components include: plastic tubing, plastic pipes; plastic hoses; polyester adhesive decals; plastic caps; plastic stoppers; plastic handles; plastic knobs; plastic washers; plastic o-rings; plastic seals; plastic retainers; plastic blocks; plastic clamps; plastic bushings; plastic spacers; plastic straps; plastic strips; plastic sleeves; plastic covers; plastic grommets; plastic isolators; plastic dampers; plastic connectors; rubber seals; rubber washers; rubber gaskets; rubber pipe fittings; rubber flange connectors; rubber grommets; rubber blocks; wood packing boxes; wood packing cases; slag wool insulation blankets; slag wool insulation; slag wool shields; carbon fiber bushings; carbon fiber clamps; carbon fiber gaskets; carbon fiber seals; carbon fiber spacers; carbon fiber vanes; carbon fibers blades; graphite gaskets; graphite vanes; glass fiber insulation blankets; glass wool insulation blankets; glass fiber reinforced fasteners (fiber), glass fiber reinforced fasteners (woven), stainless steel rods; stainless steel bars; stainless steel threaded elbows; stainless steel threaded couplings; stainless steel threaded bends; stainless steel threaded sleeves; stainless steel pipe fittings; stainless steel tube fittings; steel oil tanks; iron nuts; steel nuts; iron threaded inserts; steel threaded inserts; steel locking washers; steel spring washers; steel flat washers; steel rivets; steel cotter pins; steel retaining rings; steel retaining rings; steel non threaded hardware; steel springs; steel safety spring wires; steel connectors for hoses; steel general purpose plugs; steel general purpose spacers; steel general purpose clamps; steel general purpose bushings; steel general purpose caps; steel general purpose sleeves; refined copper wires; copper stranded wires;

nickel alloy cold formed wires; nickel tubes; nickel pipes; nickel tube fittings; nickel pipe fittings; nickel stranded wires; nickel screws; nickel bolts; nickel conduits; nickel couplings; nickel pins; nickel enclosures; nickel seals; nickel washers; nickel fittings; nickel connectors; nickel gears; nickel lockwire; nickel lugs; nickel nuts; nickel joints; nickel rings; nickel rivets; nickel rotors; nickel spacers; nickel springs; nickel studs; nickel clips; nickel thermocouples; nickel inserts; nickel tubes; nickel vanes; aluminum tube fittings; aluminum pipe fittings; aluminum oil tank; aluminum box; aluminum container; aluminum screws; aluminum caps; aluminum pins; aluminum washers; aluminum clamps; aluminum general purpose spacers; aluminum general purpose plugs; cobalt bolts; cobalt screws; cobalt pins; cobalt seals; cobalt spacers; titanium bolts; titanium screws; titanium pins; titanium seals; titanium spacers; titanium nuts; titanium washers; titanium connectors; base metal hinges; base metal mounting fixtures; base metal brackets; steel flexible tubing; iron flexible tubing; base metal blind rivets; base metal tubular rivets; base metal bifurcated rivets; base metal identification plates; power engines pools; power engine nozzle assemblies; base metal power engine supports; base metal power engine weights; power engines disks; power engines dampers; base metal power engine shims; power engine tube assemblies; power engine shrouds; base metal power engine sleeves; base metal power engine seals; base metal power engine segments; base metal power engine rings; base metal power engine blade retainers; base metal power engine vane retainers; base metal engine retainer seals; base metal power engine plugs; power engine blades; power engine manifolds; power engine fuel nozzle assemblies; linear acting hydraulic cylinders; pneumatic power engines; pneumatic power motors; reciprocating positive replacing pumps; rotary power replacement pumps; pump housings; pump covers; pump bodies; axial fans; centrifugal fans; cooling fans; blower assemblies; heat exchangers; fuel filters; oil separators; fuel separators; engine fluid filters; air filters; filter bodies; filter elements; filter cartridges; filter strainers; filter housings; lifting machine rings; lifting machine hooks; mechanical machines; oleo hydraulic valves; oleo pneumatic valves; check valves; safety relief valves; regulator valves; bodies of valves; ball bearings; spherical roller bearings; cylindrical roller bearings; roller bearing rings; roller bearing races; ball bearing rings;

ball bearing races; transmission shafts; crank shafts; cam shafts; plain shaft bearings; aircraft engine gears; gearboxes tubes; gearboxes drain; gearbox covers; gearbox housings; multilayered metal gaskets; mechanical seals; base metal sheeting joints; electric motors; torque motors; torque generators; AC alternator generators; moto stator rings; generator stator rings; engine igniters; starter generators; electric fire alarms; electric smoke alarms; electronic engine control software; electrical circuit protectors; electrical switches; electrical plugs; junction boxes; electric terminals; programmable controllers; electrical switching apparatuses; flight recorders; flight sensors; flight recorders speed sensors; copper winding wires; coaxial cables; wiring harnesses; electrical cable with fitting; electrical cables; plastic insulating fittings; aircraft nacelles; aircraft thrust reversers; boroscope plugs; boroscope inspection tools; borescopes; navigation equipment; thermometers; flow meters; electrical pressure meters; measuring meters; checking meters; liquid heat pressure meters; pressure probes; measuring probes; checking probes; aircraft engine speedometers; aircraft engine tachometers; testing equipment; vibration sensors; testing probes automatic regulating instruments; controlling instruments; hydro-mechanical units; and, hydro-mechanical units sensors (duty rate ranges from duty-free to 15%).

The request indicates that certain materials/components are subject to duties under section 1702(a)(1)(B) of the International Emergency Economic Powers Act (section 1702), section 232 of the Trade Expansion Act of 1962 (section 232), or section 301 of the Trade Act of 1974 (section 301), depending on the country of origin. The applicable section 1702, section 232, and section 301 decisions require subject merchandise to be admitted to FTZs in privileged foreign status (19 CFR 146.41).

Public comment is invited from interested parties. Submissions shall be addressed to the Board's Executive Secretary and sent to: ftz@trade.gov. The closing period for their receipt is March 23, 2026.

A copy of the notification will be available for public inspection in the "Online FTZ Information System" section of the Board's website.

For further information, contact Brian Warnes at brian.warnes@trade.gov.

Dated: February 6, 2026.

Elizabeth Whiteman,
Executive Secretary.

[FR Doc. 2026-02774 Filed 2-10-26; 8:45 am]

BILLING CODE 3510-DS-P

DEPARTMENT OF COMMERCE

International Trade Administration

[A-570-992]

Monosodium Glutamate From the People's Republic of China: Preliminary Results of Antidumping Duty Administrative Review; 2023-2024

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: The U.S. Department of Commerce (Commerce) preliminarily finds that Ajinoriki MSG (Malaysia) Sdn Bhd (Ajinoriki), the sole company subject to the administrative review of the antidumping duty order on monosodium glutamate (MSG) from the People's Republic of China (China) covering the period of review (POR) November 1, 2023, through October 31, 2024, is not eligible to receive a separate rate and is, therefore, considered part of the China-wide entity. Furthermore, Commerce finds that, because no party requested a review of the China-wide entity for the POR, the China-wide entity is not under review, and the China-wide entity's rate (*i.e.*, 40.41 percent) is not subject to change.

DATES: Applicable February 11, 2026.

FOR FURTHER INFORMATION CONTACT: Thomas Cloyd, AD/CVD Operations, Office VII, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482-1246.

SUPPLEMENTARY INFORMATION:

Background

On January 6, 2015, Commerce published the *Order*¹ in the **Federal Register**. On November 1, 2024, Commerce notified interested parties of the opportunity to request an

¹ See *Monosodium Glutamate from the People's Republic of China: Second Amended Final Determination of Sales at Less Than Fair Value and Amended Antidumping Duty Order*, 80 FR 487 (January 6, 2015) (*Order*); see also *Monosodium Glutamate from the People's Republic of China, and the Republic of Indonesia: Antidumping Duty Orders*; and *Monosodium Glutamate from the People's Republic of China: Amended Final Determination of Sales at Less Than Fair Value*, 79 FR 70505 (November 26, 2014).

administrative review of the *Order*.² Pursuant to section 751(a)(1) of the Tariff Act of 1930, as amended (the Act), and 19 CFR 351.213(b)(2), Ajinoriki timely filed a request for an administrative review.³ On December 18, 2024, in accordance with 19 CFR 351.221(c)(1)(i), Commerce published a notice of initiation of this administrative review.⁴

In the *Initiation Notice*, Commerce stated that exporters in a proceeding involving a non-market economy (NME) country must timely file a Separate Rate Application (SRA) or Separate Rate Certification (SRC) “if they want to be considered for *individual* examination,” and provided an opportunity for interested parties to file SRCs or SRAs.⁵ We received no SRA or SRC from Ajinoriki, the only company under review. Because we received no SRA or SRC, and, as discussed below, Commerce finds that Ajinoriki, the only company subject to this review, is part of the China-wide entity and is not eligible for individual examination. Further, because the China-wide entity is not subject to this review, there are no calculations for these preliminary results of review and no decision memorandum accompanies this notice.

Scope of the Order

The product covered by the *Order* is MSG from China. For a complete description of the scope of the *Order*, see the appendix to this notice.

Methodology

Commerce considers China to be an NME country.⁶ In accordance with section 771(18)(C)(i) of the Act, any determination that a foreign country is an NME country shall remain in effect until revoked by the administering authority. Therefore, for these preliminary results, we treated China as an NME country and applied our

current NME methodology in accordance with section 773(c) of the Act.

Separate Rate Determinations

In a proceeding involving an NME country, Commerce maintains a rebuttable presumption that all companies within the country are subject to government control and, therefore, should be assessed a single weighted-average dumping margin.⁷ Commerce notified parties in the *Initiation Notice* that “[t]he 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.”⁸ Also in the *Initiation Notice*, Commerce notified parties of the application process by which exporters may obtain separate rate status in this administrative review.⁹ This process requires exporters to submit an SRA¹⁰ and to demonstrate the absence of both *de jure* and *de facto* government control over their export activities. In the *Initiation Notice*, Commerce required that all firms listed in the notice “that wish to qualify for separate rates status in the administrative reviews involving NME countries must complete, as appropriate, either a {SRA} or {SRC}”¹¹

Commerce’s policy is to assign all exporters of merchandise under consideration that are 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.¹² Commerce analyzes whether each entity exporting the merchandise under consideration is sufficiently independent under a test established in *Sparklers from China*¹³ and further developed in *Silicon Carbide from China*.¹⁴ In accordance with this separate rate test, Commerce

will assign a separate rate in an NME proceeding if a respondent can demonstrate the absence of both *de jure* and *de facto* government control over its export activities. If, however, Commerce determines that a company is wholly foreign owned, then a separate rate analysis is not necessary to determine whether that company is independent from government control and eligible for a separate rate.

Commerce continues to evaluate its practice with regard to the separate rates analysis in light of the *Diamond Sawblades from China*¹⁵ proceedings and its determinations therein. In particular, in litigation involving the *Diamond Sawblades from China* proceeding, the U.S. Court of International Trade (CIT) found Commerce’s existing separate rates analysis deficient in the circumstances of that case, in which a government-owned and controlled entity exercised control over the respondent exporter.¹⁶

¹⁴ See *Notice of Final Determination of Sales at Less Than Fair Value: Silicon Carbide from the People’s Republic of China*, 59 FR 22585 (May 2, 1994) (*Silicon Carbide from China*).

¹⁵ See *Final Results of Redetermination Pursuant to Court Remand, Diamond Sawblades and Parts Thereof from the People’s Republic of China*, Consol. Court No. 09–00511, Slip Op. 12–147 (CIT November 30, 2012), dated May 6, 2013, available at <https://enforcement.trade.gov/remands/12-147.pdf>, in *Advanced Technology & Materials Co., Ltd., et al. v. United States*, 885 F.Supp.2d 1343 (CIT 2012) (*Advanced Technology I*), *aff’d* *Advanced Technology & Materials Co. v. United States*, 938 F.Supp.2d 1342 (CIT 2013), *aff’d* *Advanced Technology & Materials Co. v. United States*, Court No. 2014–1154 (Fed. Cir. 2014); see also *Diamond Sawblades and Parts Thereof from the People’s Republic of China: Preliminary Results of Antidumping Duty Administrative Review; 2011–2012*, 78 FR 77098 (December 20, 2013), and accompanying Preliminary Decision Memorandum (PDM) at 7, unchanged in *Diamond Sawblades and Parts Thereof from the People’s Republic of China: Final Results of Antidumping Duty Administrative Review; 2011–2012*, 79 FR 35723 (June 24, 2014), and accompanying Issues and Decision Memorandum at Comment 1 (collectively, *Diamond Sawblades from China*).

¹⁶ See, e.g., *Advanced Technology I*, 885 F.Supp.2d at 1349 (CIT 2012) (“The court remains concerned that Commerce has failed to consider important aspects of the problem and offered explanations that run counter to the evidence before it.”); *Id.*, 885 F.Supp.2d at 1351 (“Further substantial evidence of record does not support the inference that SASAC’s {state-owned assets supervision and administration commission} ‘management’ of its ‘state-owned assets’ is restricted to the kind of passive-investor *de jure* ‘separation’ that Commerce concludes.”) (footnotes omitted); *Id.*, 885 F.Supp.2d at 1355 (“The point here is that ‘government control’ in the context of the separate rate test appears to be a fuzzy concept, at least to this court, since a ‘degree’ of it can obviously be traced from the controlling shareholder, to the board, to the general manager, and so on along the chain to ‘day-to-day decisions of export operations,’ including terms, financing, and inputs into finished product for export.”); *Id.*, 885 F.Supp.2d at 1357 (“AT&M itself identifies its ‘controlling shareholder’ as CISRI {owned by SASAC} in its

² See *Antidumping or Countervailing Duty Order, Finding, or Suspended Investigation; Opportunity to Request Administrative Review and Join Annual Inquiry Service List*, 89 FR 87338 (November 1, 2024).

³ See Ajinoriki’s Letter, “Request for Administrative Review,” dated December 2, 2024.

⁴ See *Initiation of Antidumping and Countervailing Duty Administrative Reviews*, 89 FR 102856 (December 18, 2024) (*Initiation Notice*).

⁵ *Id.*, 89 FR at 102857–8 (emphasis added).

⁶ See *Antidumping Duty Investigation of Certain Aluminum Foil from the People’s Republic of China: Affirmative Preliminary Determination of Sales at Less-Than-Fair-Value and Postponement of Final Determination*, 82 FR 50858, 50861 (November 2, 2017), and accompanying Preliminary Decision Memorandum (PDM) at 7–8 (citing Memorandum, “China’s Status as a Non-Market Economy,” dated October 26, 2017), unchanged in *Certain Aluminum Foil from the People’s Republic of China: Final Determination of Sales at Less Than Fair Value*, 83 FR 9282 (March 5, 2018).

⁷ See, e.g., *Polyethylene Terephthalate Film, Sheet, and Strip from the People’s Republic of China: Final Determination of Sales at Less Than Fair Value*, 73 FR 55039, 55040 (September 24, 2008).

⁸ See *Initiation Notice*.

⁹ See *Initiation Notice*, 89 FR at 102857.

¹⁰ For a description of our practice, see Enforcement and Compliance’s Policy Bulletin No. 05.1, regarding “Separate-Rates Practice and Application of Combination Rates in Antidumping Investigations Involving Non-Market Economy Countries,” (April 5, 2005), available on Commerce’s website at <https://access.trade.gov/Resources/policy/bull05-1.pdf>.

¹¹ See *Initiation Notice*, 89 FR at 102858.

¹² See *Final Determination of Sales at Less Than Fair Value: Sparklers from the People’s Republic of China*, 56 FR 20588, 20589 (May 6, 1991) (*Sparklers from China*).

¹³ *Id.*

Following the CIT's reasoning, in recent proceedings, we have concluded that where a government entity holds a majority equity ownership, either directly or indirectly, in the respondent exporter, this interest in and of itself means that the government exercises or has the potential to exercise control over the company's operations generally.¹⁷ This may include control over, for example, the selection of board members and management, key factors in determining whether a company has sufficient independence in its export activities to merit a separate rate. Consistent with our normal separate rate practice, any ability to control, or possess an interest in controlling, the operations of the company including the selection of board members, management, and the profit distribution of the company by a government entity is subject to Commerce's rebuttable presumption that all companies within the NME country are subject to government control.

In order to demonstrate eligibility for separate rate status, Commerce normally requires an exporter for which a review was requested, and which was assigned a separate rate in a previous completed segment of the proceeding and which remains active for that exporter, to submit an SRC stating that it continues to meet the criteria for obtaining a separate rate.¹⁸ For an exporter that was not assigned a separate rate in a previously completed segment of the proceeding and which remains active for that exporter, to demonstrate eligibility, Commerce requires an SRA.¹⁹ A company that submits an SRA or SRC and which is subsequently selected for examination must respond to all parts of Commerce's questionnaire in order to be eligible for a separate rate.²⁰

In the *Initiation Notice*, Commerce stated that submission of SRAs and SRCs were due 30 days after publication of the notice, *i.e.*, January 17, 2025.²¹ Moreover, Commerce specifically noted that “[t]he deadline and requirement for submitting a Separate Rate Application applies equally to NME-owned firms, wholly foreign-owned firms, and foreign sellers who purchase

and export subject merchandise to the United States.”²² Ajinoriki, the sole company subject to this review, failed to submit an SRA as it did not have separate rate status. As such, consistent with Commerce's practice for when a party fails to submit an SRA or SRC, we preliminarily find that Ajinoriki is not eligible for a separate rate, and, therefore, is part of the China-wide entity.²³ Commerce's practice with respect to an exporter that fails to submit an SRA or SRC has been upheld by the U.S. Court of Appeals for the Federal Circuit.²⁴ Commerce further notes that, because this review was initiated with respect to only one company (*i.e.*, Ajinoriki), there are no remaining companies subject to review, including the China-wide entity.²⁵ As a result, Commerce did not need to limit examination or select respondents and therefore did not place U.S. Customs and Border Protection (CBP) data on the record for that purpose. Furthermore, because no company or the China-wide entity were eligible for examination, Commerce did not issue a questionnaire.

China-Wide Entity

Under Commerce's policy regarding the conditional review of the China-wide entity,²⁶ the China-wide entity will not be under review unless a party specifically requests, or Commerce self-initiates, a review of the entity. Because no party requested a review of the

China-wide entity during this POR, the China-wide entity is not under review, and the China-wide entity's rate (*i.e.*, 40.41 percent) is not subject to change.²⁷

Preliminary Results of Review

Because Ajinoriki failed to timely file an SRA in this review, we preliminarily find that it is ineligible for a separate rate and is considered part of the China-wide entity.

Disclosure

Normally, Commerce will disclose to the parties in a proceeding the calculations performed in connection with preliminary results of review within five days of any public announcement or, if there is no public announcement, within five days of the date of publication of the notice of preliminary results in the **Federal Register**, in accordance with 19 CFR 351.224(b). However, because Commerce finds that the sole exporter of MSG subject to review is part of the China-wide entity and Commerce has not initiated a review of the China-wide entity, there are no calculations to disclose for these preliminary results of review.

Public Comment

Case briefs and other written comments may be submitted to the Assistant Secretary for Enforcement and Compliance. Pursuant to 19 CFR 351.309(c), we have modified the deadline for interested parties to submit case briefs to Commerce to no later than 21 days after the date of publication of this notice. Rebuttal briefs, limited to issues raised in the case briefs, may be filed not later than five days after the date for filing case briefs.²⁸ Interested parties who submit case briefs or rebuttal briefs in this proceeding must submit: (1) a table of contents listing each issue; and (2) a table of authorities.²⁹ An electronically filed document must be received successfully in its entirety in ACCESS by 5:00 p.m. Eastern Time (ET) on the established deadline.

As provided under 19 CFR 351.309(c)(2)(iii) and (d)(2)(iii), we request that interested parties provide at the beginning of their briefs a public, executive summary for each issue raised in their briefs.³⁰ Further, we request that

²² *Id.*, 89 FR at 102858.

²³ See *e.g.*, *Crystalline Silicon Photovoltaic Cells, Whether or Not Assembled Into Modules, from the People's Republic of China: Final Results of Antidumping Duty Administrative Review and Final Determination of No Shipments; 2012–2013*, 80 FR 40998 (July 14, 2015) (treating a company as part of the China-wide entity for failure to submit an SRA, and explaining that “[t]he failure to provide a separate rate certification is not a ministerial error, but rather, a failure to comply with [Commerce's] well established separate rate methodology.”); see also, *e.g.*, *Hydrofluorocarbon Blends from the People's Republic of China: Final Results of the Antidumping Duty Administrative Review; 2019–2020*, 86 FR 49516, 49517 (September 3, 2021) (finding that PureMann, Inc. (PureMann), the sole company subject to the review, did not file an SRA and did not demonstrate its eligibility for separate rate status and that, therefore, PureMann was part of the China-wide entity).

²⁴ See *Repwire LLC v. United States*, 628 F.Supp.3d 1288 (CIT 2023), *aff'd* 2025 WL 2399398 (Fed. Cir. Aug. 19, 2025) (finding that “Commerce's actions were reasonable and supported by substantial evidence” in a case in which Commerce rescinded an initial questionnaire and found that Jin Tiong Electrical Materials Manufacturer PTE. Ltd. (Jin Tiong) was part of the China wide entity due to its failure to submit a timely SRA).

²⁵ See *Initiation Notice*, 89 FR at 102862.

²⁶ See *Antidumping Proceedings: Announcement of Change in Department Practice for Respondent Selection in Antidumping Duty Proceedings and Conditional Review of the Nonmarket Economy Entity in NME Antidumping Duty Proceedings*, 78 FR 65963 (November 4, 2013).

²⁷ See *Order*.

²⁸ See 19 CFR 351.309(d); see also *Administrative Protective Order, Service, and Other Procedures in Antidumping and Countervailing Duty Proceedings*, 88 FR 67069, 67077 (September 29, 2023) (*APO and Service Final Rule*).

²⁹ See 19 CFR 351.309(c)(2) and (d)(2).

³⁰ We use the term “issue” here to describe an argument that Commerce would normally address

financial statements and the power to veto nomination does not equilibrate the power of control over nomination.”) (footnotes omitted).

¹⁷ See *Carbon and Certain Alloy Steel Wire Rod from the People's Republic of China: Preliminary Determination of Sales at Less Than Fair Value and Preliminary Affirmative Determination of Critical Circumstances, in Part*, 79 FR 53169 (September 8, 2014), and accompanying PDM at 5–9.

¹⁸ See *Initiation Notice*.

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

interested parties limit their public executive summary of each issue to no more than 450 words, not including citations. We intend to use the public executive summaries as the basis of the comment summaries included in the issues and decision memorandum that will accompany the final results in this administrative review. We request that interested parties include footnotes for relevant citations in the public executive summary of each issue. Note that Commerce has amended certain of its requirements pertaining to the service of documents in 19 CFR 351.303(f).³¹

Pursuant to 19 CFR 351.310(c), interested parties who wish to request a hearing must submit a written request to the Assistant Secretary for Enforcement and Compliance, filed electronically via ACCESS. An electronically filed hearing request must be received successfully in its entirety by Commerce's electronic records system, ACCESS, by 5:00 p.m. ET within 30 days after the date of publication of this notice.³² Hearing requests should contain: (1) the party's name, address and telephone number; (2) the number of participants; (3) whether any participant is a foreign national; and (4) a list of issues to be discussed. Issues raised in the hearing will be limited to those raised by each party in their respective case and rebuttal briefs. An electronically filed request must be received successfully in its entirety by ACCESS by 5:00 p.m. Eastern Time, within 30 days of the publication date of this notice. If a request for a hearing is made, parties will be notified of the time and date of the hearing.³³

Assessment Rates

In accordance with section 751(a)(2)(C) of the Act, the final results of this review shall be the basis for assessment of antidumping duties on entries of merchandise covered by this review.³⁴ Upon issuance of the final results, Commerce shall determine, and CBP shall assess, antidumping duties on all appropriate entries covered by this review.³⁵ Commerce intends to issue assessment instructions to CBP no earlier than 35 days after the date of

publication of the final results of this review in the **Federal Register**. If a timely summons is filed at the U.S. Court of International Trade, the assessment instructions will direct CBP not to liquidate relevant entries until the time for parties to file a request for a statutory injunction has expired (*i.e.*, within 90 days of publication).

For the final results of this review, if we continue to find that Ajinoriki is not eligible for a separate rate and treat it as part of the China-wide entity, we will instruct CBP to apply the *ad valorem* weighted-average dumping margin for the China-wide entity, *i.e.*, 40.41 percent,³⁶ to assess antidumping duties for all entries of subject merchandise during the POR which was exported by Ajinoriki.

Cash Deposit Requirements

The following cash deposit requirements for estimated antidumping duties will be effective upon publication of the final results of this administrative review for all shipments of the subject merchandise from China entered, or withdrawn from warehouse, for consumption on or after the publication date, as provided for by section 751(a)(2)(C) of the Act: (1) for subject merchandise exported by a company with a separate rate from a previously completed segment of this proceeding, the cash deposit rate will continue to be the existing exporter-specific rate, or produced-exporter-specific rate, for that exporter, (2) for all exporters of subject merchandise that have not been found to be entitled to a separate rate, *i.e.*, the China-wide entity, the cash deposit rate will continue to be 40.41 percent.

These cash deposit requirements, when imposed, shall remain in effect until further notice.

Final Results of Review

Unless otherwise extended, Commerce intends to issue the final results of this administrative review, including the results of its analysis of issues raised in case and rebuttal briefs, within 120 days of publication of these preliminary results of review in the **Federal Register**, pursuant to section 751(a)(3)(A) of the Act.

Notification to Importers

This notice serves as a preliminary reminder to importers of their responsibility under 19 CFR 351.402(f) to file a certificate regarding the

reimbursement of antidumping duties prior to liquidation of the relevant entries during this POR. Failure to comply with this requirement could result in Commerce's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of double antidumping duties.

Notification to Interested Parties

We are issuing and publishing these preliminary results of review in accordance with sections 751(a)(1) and 777(i)(1) of the Act, and 19 CFR 351.213 and 351.221(b)(4).

Dated: February 6, 2026.

Christopher Abbott,

Deputy Assistant Secretary for Policy and Negotiations, performing the non-exclusive functions and duties of the Assistant Secretary for Enforcement and Compliance.

Appendix

Scope of the Order

The products covered by this order are monosodium glutamate (MSG), whether or not blended or in solution with other products. Specifically, MSG that has been blended or is in solution with other product(s) is included in this order when the resulting mix contains 15 percent or more of MSG by dry weight. Products with which MSG may be blended include, but are not limited to, salts, sugars, starches, maltodextrins, and various seasonings.

Further, MSG is included in this order regardless of physical form (including, but not limited to, in monohydrate or anhydrous form, or as substrates, solutions, dry powders of any particle size, or unfinished forms such as MSG slurry), end-use application, or packaging. MSG in monohydrate form has a molecular formula of C₅H₈NO₄Na·H₂O, a Chemical Abstract Service (CAS) registry number of 6106-04-3, and a Unique Ingredient Identifier (UNII) number of W81N5U6R6U. MSG in anhydrous form has a molecular formula of C₅H₈NO₄Na, a CAS registry number of 142-47-2, and a UNII number of C3C196L9FG.

Merchandise covered by this order is currently classified in the Harmonized Tariff Schedule (HTS) of the United States at subheading 2922.42.10.00. Merchandise covered by this order may also enter under HTS subheadings 2922.42.50.00, 2103.90.72.00, 2103.90.74.00, 2103.90.78.00, 2103.90.80.00, and 2103.90.90.91. These tariff classifications, CAS registry numbers, and UNII numbers are provided for convenience and customs purposes; however, the written description of the scope is dispositive.

[FR Doc. 2026-02778 Filed 2-10-26; 8:45 am]

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in a comment of the Issues and Decision Memorandum.

³¹ See *APO and Service Final Rule*.

³² See 19 CFR 351.301(c).

³³ See 19 CFR 351.310(d).

³⁴ See 19 CFR 351.212(b)(1).

³⁵ *Id.*

³⁶ See *Order*.

DEPARTMENT OF COMMERCE

International Trade Administration

[A-560-848, A-557-834, C-560-849, C-557-835]

Notice of Extension of the Deadline for Determining the Adequacy of the Antidumping Duty and Countervailing Duty Petitions: Certain Fatty Acids From Indonesia and Malaysia

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

DATES: Applicable February 9, 2026.

FOR FURTHER INFORMATION CONTACT: John Conniff at (202) 482-1009 (Indonesia AD); Paul Kebker at (202) 482-2254 (Indonesia CVD); Dennis McClure at (202) 482-5973 (Malaysia AD); Rachel Accorsi at (202) 482-3149 (Malaysia CVD), AD/CVD Operations, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230.

Extension of Initiation of Investigations

The Petitions

On January 28, 2026, the U.S. Department of Commerce (Commerce) received antidumping duty (AD) and countervailing duty (CVD) petitions on imports of certain fatty acids from Indonesia and Malaysia, filed in proper form on behalf of Vantage Specialty Chemicals, Inc. (the petitioner), a domestic producer of certain fatty acids.¹

Determination of Industry Support for the Petitions

Sections 702(b)(1) and 732(b)(1) of the Tariff Act of 1930, as amended (the Act), require that a petition be filed by or on behalf of the domestic industry. To determine that the petition has been filed by or on behalf of the industry, sections 702(c)(4)(A) and 732(c)(4)(A) of the Act require that the domestic producers or workers who support the petition account for: (i) at least 25 percent of the total production of the domestic like product; and (ii) more than 50 percent of the production of the domestic like product produced by that portion of the industry expressing support for, or opposition to, the petition. Moreover, sections 702(c)(4)(D) and 732(c)(4)(D) of the Act provide that, if the petition does not establish support of domestic producers or workers accounting for more than 50 percent of

the total production of the domestic like product, Commerce shall: (i) poll the industry or rely on other information in order to determine if there is support for the petition, as required by subparagraph (A); or (ii) if there is a large number of producers, determine industry support using a statistically valid sampling method to poll the industry.

Extension of Time

Sections 702(c)(1)(A) and 732(c)(1)(A) of the Act provide that within 20 days of the filing of an AD or CVD petition, Commerce will determine, *inter alia*, whether the petition has been filed by or on behalf of the U.S. industry producing the domestic like product. Sections 702(c)(1)(B) and 732(c)(1)(B) of the Act provide that the deadline for the initiation determination, in exceptional circumstances, may be extended by 20 days in any case in which Commerce must “poll or otherwise determine support for the petition by the industry.”

Accordingly, because the Petitions have not established that the domestic producers or workers accounting for more than 50 percent of total production support the Petitions, in accordance with sections 702(c)(1)(B) and 732(c)(4)(D) of the Act, Commerce has determined it would be appropriate in this case to poll the industry and extend the time period for determining whether to initiate the investigations in order to further examine the issue of industry support.

Commerce will need additional time to gather and analyze additional information regarding industry support. Therefore, it is necessary to extend the deadline for determining the adequacy of the Petitions by an additional 20 days. As a result, in accordance with sections 702(c)(1)(B) and 732(c)(1)(B) of the Act, Commerce’s initiation determination will now be due no later than March 9, 2026.

International Trade Commission Notification

Commerce will contact the International Trade Commission (ITC) and will make this extension notice available to the ITC.

Dated: February 9, 2026.

Scot Fullerton,

Acting Deputy Assistant Secretary for Antidumping and Countervailing Duty Operations.

[FR Doc. 2026-02777 Filed 2-10-26; 8:45 am]

BILLING CODE 3510-DS-P

DEPARTMENT OF COMMERCE

International Trade Administration

[A-552-801]

Certain Frozen Fish Fillets From the Socialist Republic of Vietnam: Preliminary Results of Antidumping Duty Administrative Review; Preliminary Recission of Administrative Review; and Recission of Administrative Review, in Part; 2023-2024

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: The U.S. Department of Commerce (Commerce) preliminarily determines that Bien Dong Seafood Co., Ltd. (Bien Dong) and NTSF Seafoods Joint Stock Company (NTSF), made sales of certain frozen fish fillets (fish fillets) at less than normal value (NV) during the period of review (POR) August 1, 2023, through July 31, 2024. Additionally, Commerce determines that four companies are eligible for a separate rate. Finally, Commerce is rescinding this review with respect to 16 companies and preliminarily rescinding this review with respect to 24 companies and the Vietnam-wide entity. Commerce invites interested parties to comment on the preliminary results of this review.

DATES: Applicable February 11, 2026.

FOR FURTHER INFORMATION CONTACT: Blair Hood or Gemma Larsen, AD/CVD Operations, Office I, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482-8329 or (202) 482-8125, respectively.

SUPPLEMENTARY INFORMATION:

Background

On August 12, 2003, Commerce published in the **Federal Register** the antidumping duty (AD) order on fish fillets from the Socialist Republic of Vietnam (Vietnam).¹ On August 1, 2024, Commerce published in the **Federal Register** a notice of opportunity to request an administrative review of the Order.² On September 20, 2024, based on timely requests for an administrative review, Commerce published the notice of initiation of this administrative

¹ See Notice of Antidumping Duty Order: Certain Frozen Fish Fillets from the Socialist Republic of Vietnam, 68 FR 47909 (August 12, 2003) (Order).

² See Antidumping or Countervailing Duty Order, Finding, or Suspended Investigation; Opportunity To Request Administrative Review and Join Annual Inquiry Service List, 89 FR 62714 (August 1, 2024).

¹ See Petitioner’s Letter, “Petitions for the Imposition of Antidumping and Countervailing Duties,” dated January 28, 2026 (Petitions).

review of the *Order* with respect to 148 companies and the Vietnam-wide entity.³ On October 7 and 18, 2024, Commerce received 23 timely no-shipment certifications, four timely separate rate certifications (SRCs), and one separate rate application (SRA). On December 19, 2024, and January 24, 2025, the petitioners⁴ withdrew its requests for review of certain companies.⁵ On January 24, 2025, Commerce published a partial revocation of Vinh Hoan Corporation (Vinh Hoan) from the *Order*.⁶ On February 11, 2025, Commerce rescinded this review with respect to entries that were produced and exported by Vinh Hoan as a result of this partial revocation.⁷ On April 8 and November 20, 2025, Commerce stated its intent to rescind the review for certain companies with no entries of subject merchandise over the POR.⁸ Thus, as noted below, we are rescinding this review with respect to 16 companies with separate rates and no reviewable entries and preliminarily rescinding this review with respect to 24 companies and the Vietnam-wide entity. As such, these preliminary results cover four companies, including the mandatory respondents, Bien Dong and NTSF.

On December 9, 2024, Commerce tolled certain deadlines in this administrative proceeding by 90 days.⁹ Due to the lapse in appropriations and Federal Government shutdown, on November 14, 2025, Commerce tolled all deadlines in administrative

proceedings by 47 days.¹⁰ Additionally, due to a backlog of documents that were electronically filed via Enforcement and Compliance's Antidumping and Countervailing Duty Centralized Electronic Service System (ACCESS) during the Federal Government shutdown, on November 24, 2025, Commerce tolled all deadlines in administrative proceedings by an additional 21 days.¹¹ Accordingly, the deadline for these preliminary results are now February 5, 2026.

For a complete description of the events that followed the initiation of this review, *see* the Preliminary Decision Memorandum.¹² The Preliminary Decision Memorandum is a public document and is on file electronically via ACCESS. ACCESS is available to registered users at <https://access.trade.gov>. In addition, a complete version of the Preliminary Decision Memorandum can be accessed directly at <https://access.trade.gov/public/FRNoticesListLayout.aspx>.

Scope of the Order

The products covered by the *Order* are fish fillets from Vietnam. For a complete description of the scope of this review, *see* Preliminary Decision Memorandum.¹³

Standing

Based on the analysis of information gathered from initial and supplemental questionnaires, we find that the evidence supports a determination that Maritime Products International and QMC Foods Inc. have standing in this segment of the proceeding to request administrative review as wholesalers of domestic like product pursuant to section 771(9)(C) of the Act. We find that the evidence on record does not support Luscious Seafood LLC's claim to be a wholesaler of domestic like product pursuant to section 771(9)(C) of the Act during the POR. For additional information regarding these findings, *see* the Preliminary Decision Memorandum and the separate

memorandum addressing Luscious Seafood LLC.¹⁴

Separate Rates

Commerce preliminarily determines that information placed on the record by mandatory respondents Bien Dong and NTSF, and two additional companies seeking a separate rate (Cantho Import Export Seafood Joint Stock Company and Nam Viet Corporation,) demonstrates that these companies are preliminarily entitled to separate rate status. For additional information, *see* the Preliminary Decision Memorandum.

Vietnam-Wide Entity

The Vietnam-wide entity will not be under review unless a party specifically requests, or Commerce self-initiates, a review of the entity. Because there was no valid request for review of the Vietnam-wide entity, we are preliminarily rescinding our review of the entity; if this decision becomes final, the entity's rate (*i.e.*, \$2.39 per kilogram (kg)) will not be subject to change. Except for the four companies which established their eligibility for a separate rate, Commerce considers all companies currently under review to be part of the Vietnam-wide entity.¹⁵ For additional information, *see* the Preliminary Decision Memorandum and the "Dumping Margin for Exporters Not Selected for Individual Review" section below.

Rescission of Administrative Review, in Part

There we no suspended entries of subject merchandise for 16 companies with active separate rates for which the administrative review was initiated. On April 8 and November 20, 2025, Commerce notified all interested parties of its intent to rescind the administrative review, in part, with respect to these companies.¹⁶ In the absence of suspended entries of subject merchandise during the POR, for the companies listed in Appendix II, we are hereby rescinding this administrative review, in part, with respect to those companies, in accordance with 19 CFR 351.213(d)(3).

Further, pursuant to 19 CFR 351.213(d)(1), Commerce will rescind an administrative review, in whole or part, if the party that requested a review withdraws its request within 90 days of the date of publication of the notice of initiation. The only remaining review

³ *See Initiation of Antidumping and Countervailing Duty Administrative Reviews*, 89 FR 77079 (September 20, 2024).

⁴ The petitioners are the Catfish Farmers of America and individual U.S. catfish processors America's Catch, Inc., Alabama Catfish, LLC d/b/a Harvest Select Catfish, Inc., Consolidated Catfish Companies, LLC d/b/a Country Select Catfish, Delta Pride Catfish, Inc., Guidry's Catfish, Inc., Heartland Catfish Company, Magnolia Processing, Inc. d/b/a Pride of the Pond, and Simmons Farm Raised Catfish Inc. (collectively, the petitioners).

⁵ *See* Petitioners' Letters, "Withdrawal of Request for Administrative Review of Antidumping Order," dated December 19, 2024; and "Withdrawal of Request for Administrative Review of Antidumping Duty Order as to the Vinh Hoan Corporation and Vinh Hoan Collapsed Entity Companies," dated January 24, 2025.

⁶ *See Certain Frozen Fish Fillets from the Socialist Republic of Vietnam: Notice of Partial Revocation of the Antidumping Duty Order*, 90 FR 8120 (January 24, 2025).

⁷ *See Certain Frozen Fish Fillets from the Socialist Republic of Vietnam Administrative Review: Notice of Partial Rescission; 2023–2024*, 90 FR 9310 (February 11, 2025).

⁸ *See* Memoranda, "Notice of Intent to Rescind Review, In Part," dated April 8, 2025 (Notice of Intent to Rescind); and "Second Notice of Intent to Rescind Review, In Part," dated November 20, 2025 (Second Notice of Intent to Rescind).

⁹ *See* Memorandum, "Tolling of Deadlines for Antidumping and Countervailing Duty Proceedings," dated December 9, 2024.

¹⁰ *See* Memorandum, "Deadlines Affected by the Shutdown of the Federal Government," dated November 14, 2025.

¹¹ *See* Memorandum, "Tolling of all Case Deadlines," dated November 24, 2025.

¹² *See* Memorandum, "Decision Memorandum for the Preliminary Results and Partial Rescission of the 2023–2024 Antidumping Duty Administrative Review of Certain Frozen Fish Fillets from the Socialist Republic of Vietnam," dated concurrently with, and hereby adopted by, this notice (Preliminary Decision Memorandum).

¹³ *See* Preliminary Decision Memorandum at the "Scope" section for more details.

¹⁴ *See* Memorandum "Luscious Seafood LLC's Standing to Request Review," dated concurrently with this notice.

¹⁵ *See* Appendix IV.

¹⁶ *See* Notice of Intent to Rescind; and Second Notice of Intent to Rescind.

request for the Vietnam-wide entity and 23 other companies is from Luscious Seafood. As noted above, we have preliminarily determined that Luscious Seafood was not a U.S. wholesaler of domestic like product during the POR, and, thus, it does not have standing to request an administrative review in this segment of the proceeding. Accordingly, we are preliminarily rescinding the administrative review of the Vietnam-wide entity and the companies listed in Appendix III because all other requests for review from interested parties have been withdrawn. Further, we are preliminarily rescinding the review with respect to Indian Ocean One Member Company Limited because it demonstrated that it did not have shipments of subject merchandise during the POR.¹⁷

In sum, Commerce is rescinding the review with respect to 16 companies with an active separate rate that had no shipments of subject merchandise during the POR and preliminarily rescinding on 24 companies and the Vietnam-wide entity.¹⁸

Methodology

Commerce is conducting this review in accordance with section 751(a)(1)(B) of the Act. We have calculated constructed export price in accordance with section 772 of the Act. Because Vietnam is a non-market economy country within the meaning of section 771(18) of the Act, we have calculated NV in accordance with section 773(c) of the Act. For a full description of the methodology underlying our conclusions, see the Preliminary Decision Memorandum.

Dumping Margin for Exporters Not Selected for Individual Review

The Act and Commerce’s regulations do not address the establishment of a rate to apply to exporters not selected for individual examination when Commerce limits its examination in an administrative review pursuant to section 777A(c)(2) of the Act. Generally, Commerce looks to section 735(c)(5) of the Act, which provides instructions for calculating the all-others rate in an investigation, for guidance when calculating the rate for respondents that are not individually examined in an administrative review. Section 735(c)(5)(A) of the Act provides that the all-others rate should be calculated by averaging the weighted-average dumping margins that are zero, *de minimis*, or based entirely on facts

available.¹⁹ For the preliminary results of this review, Commerce determined the estimated dumping margins for Bien Dong and NTSF to be \$0.29/kg and \$0.07/kg, respectively. For the reasons explained in the Preliminary Decision Memorandum, we are assigning a \$0.23/kg rate to the non-examined respondents that qualify for a separate rate in this review, consistent with Commerce’s practice and section 735(c)(5)(A) of the Act.²⁰

Preliminary Results of Review

Commerce preliminarily determines that the following estimated weighted-average dumping margins exist for the period August 1, 2023, through July 31, 2024:

Exporter	Weighted-average dumping margin (dollars per kilogram)
Bien Dong Seafood Co., Ltd	0.29
NTSF Seafoods Joint Stock Company	0.07
Cantho Import Export Seafood Joint Stock Company	0.23
Nam Viet Corporation	0.23

Disclosure

Commerce intends to disclose to parties to the proceeding the calculation performed for these preliminary results of review within five days of any public announcement of these preliminary results, or if there is no public announcement, within five days of the date of publication of this notice in the **Federal Register**, in accordance with 19 CFR 351.224(b).

Public Comment

Commerce will establish the briefing schedule at a later time and will notify parties of the schedule in accordance with 19 CFR 351.309. Rebuttal briefs, limited to issues raised in the case briefs, may be filed not later than five days after the date for filing case briefs.²¹ Parties who submit case briefs or rebuttal briefs in this proceeding are encouraged to submit with each argument: (1) a statement of the issue; and (2) a table of authorities.²² All briefs

must be filed electronically using ACCESS. An electronically filed document must be received successfully in its entirety in ACCESS by 5:00 p.m. Eastern Time on the established deadline.

As provided under 19 CFR 351.309(c)(2)(iii) and (d)(2)(iii), we request that interested parties provide at the beginning of their briefs a public, executive summary for each issue raised in their briefs.²³ Further, we request that interested parties limit their executive summary of each issue to no more than 450 words, not including citations. We intend to use the executive summaries as the basis of the comment summaries included in the issues and decision memorandum that we will issue for the final results in this administrative review. We request that interested parties include footnotes for relevant citations in the executive summary of each issue. Note that Commerce has amended certain of its requirements pertaining to the service of documents in 19 CFR 351.303(f).²⁴

Pursuant to 19 CFR 351.310(c), interested parties who wish to request a hearing, limited to issues raised in the case and rebuttal briefs, must submit a written request to the Assistant Secretary for Enforcement and Compliance, U.S. Department of Commerce, within 30 days after the publication of this notice. Hearing requests should contain: (1) the party’s name, address and telephone number; (2) the number of participants; (3) whether any participant is a foreign national; and (4) a list of issues to be discussed. If a request for a hearing is made, Commerce intends to hold the hearing at a time and date to be determined. Parties should confirm by telephone the date, time, and location of the hearing two days before the scheduled date.

Final Results of Review

Unless otherwise extended, Commerce intends to issue the final results of this administrative review, which will include the results of its analysis of issues raised in case and rebuttal briefs, within 120 days of these preliminary results of review in the **Federal Register**, pursuant to 751(a)(3)(A) of the Act.

Assessment Rates

Upon issuing the final results, Commerce will determine, and U.S.

¹⁷ See Preliminary Decision Memorandum at 7.
¹⁸ See Appendixes II and III.

¹⁹ See Statement of Administrative Action Accompanying the Uruguay Round Agreements Act, H.R. Doc. 103–316, Vol. 1 (1994), at 873.
²⁰ See Preliminary Decision Memorandum at the “Calculation of the Separate Rate” section for more details.
²¹ See 19 CFR 351.309(d); see also *Administrative Protective Order, Service, and Other Procedures in Antidumping and Countervailing Duty Proceedings*, 88 FR 67069, 67077 (September 29, 2023) (*APO and Final Service Rule*).
²² See 19 CFR 351.309(c)(2) and (d)(2).

²³ We use the term “issue” here to describe an argument that Commerce would normally address in a comment of the Issues and Decision Memorandum.
²⁴ See *APO and Final Service Rule*, 88 FR at 67077.

Customs and Border Protection (CBP) shall assess, antidumping duties on all appropriate entries covered by this review.²⁵ If the preliminary results are unchanged for the final results, we will instruct CBP to apply a per-unit assessment rate of 2.39 dollars per kilogram to all entries of subject merchandise during the POR which were exported by the companies considered to be a part of the Vietnam-wide entity listed in Appendix IV.

Commerce intends to issue assessment instructions to CBP no earlier than 35 days after the date of publication of the final results of this review in the **Federal Register**. If a timely summons is filed at the U.S. Court of International Trade, the assessment instructions will direct CBP not to liquidate relevant entries until the time for parties to file a request for statutory injunction has expired (*i.e.*, within 90 days of publication).

For Bien Dong and NTSF, Commerce intends to calculate importer or customer-specific assessment rates, in accordance with 19 CFR 351.212(b)(1).²⁶ Where the respondent reported reliable entered values, Commerce intends to calculate importer or customer-specific per unit assessment rates by aggregating the amount of dumping calculated for all U.S. sales to the importer or customer and dividing this amount by the total entered value of the merchandise sold to the importer or customer.²⁷ Where the respondent did not report entered values, Commerce will calculate importer or customer-specific assessment rates by dividing the amount of dumping for reviewed sales to the importer or customer by the total quantity of those sales. Commerce will calculate an estimated per unit importer or customer-specific assessment rate to determine whether the per-unit assessment rate is *de minimis*; however, Commerce will use the per-unit assessment rate where entered values were not reported.²⁸ Where an importer or customer-specific per unit assessment rate is not zero or *de minimis*, Commerce will instruct CBP to collect the appropriate duties at the time of liquidation. Where either the respondent's weighted average dumping margin is zero or *de minimis*, Commerce will instruct CBP to liquidate

appropriate entries without regard to antidumping duties.²⁹

Pursuant to a refinement to Commerce's assessment practice, where sales of subject merchandise exported by an individually examined respondent were not reported in the U.S. sales data submitted by the respondent, but the merchandise was entered into the United States during the POR, Commerce will instruct CBP to liquidate any entries of such merchandise at the AD assessment rate for the Vietnam-wide entity.³⁰

For the respondents that were not selected for individual examination in this administrative review, but which qualified for a separate rate, the assessment rate will be based on the weighted-average dumping margins assigned to the respondents selected for individual examination, as appropriate, in the final results of this review.³¹

For the companies for which this review is rescinded with these preliminary results, we will instruct CBP to assess antidumping duties on all appropriate entries at a rate equal to the cash deposit of estimated antidumping duties required at the time of entry, or withdrawal from warehouse, for consumption, during the period August 1, 2023, through July 31, 2024, in accordance with 19 CFR 351.212(c)(1)(i).

Cash Deposit Requirements

The following cash deposit requirements will be effective for all shipments of the subject merchandise entered, or withdrawn from warehouse, for consumption on or after the publication date of the final results of this administrative review, as provided by section 751(a)(2)(C) of the Act: (1) for the exporters listed above, the cash deposit rate will be equal to the weighted-average dumping margins established in the final results of this review, except if the rate is *de minimis*, in which case the cash deposit rate will be zero; (2) for previously-examined Vietnamese and non-Vietnamese exporters not listed above that at the time of entry are eligible for a separate

rate based on a prior completed segment of this proceeding, the cash deposit rate will continue to be the existing exporter-specific cash deposit rate; (3) for all non-Vietnamese exporters of subject merchandise which at the time of entry do not have a separate rate, the cash deposit rate will be the rate applicable to the Vietnamese exporter that supplied the non-Vietnamese exporter; and (4) for all Vietnamese exporters of subject merchandise that have not been found to be entitled to a separate rate at the time of entry, the cash deposit rate will be that for the Vietnam-wide entity (*i.e.*, \$2.39 per kilogram). These cash deposit requirements, when imposed, shall remain in effect until further notice.

Notification to Importers

This notice serves as a preliminary reminder to importers of their responsibility under 19 CFR 351.402(f)(2) to file a certificate regarding the reimbursement of antidumping and/or countervailing duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in Commerce's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of double antidumping duties.

Notification to Interested Parties

Commerce is issuing and publishing the preliminary results of this review in accordance with sections 751(a)(1)(B), 751(a)(3), and 777(i) of the Act, and 19 CFR 351.213(d)(4) and 351.221(b)(4).

Dated: February 5, 2026.

Christopher Abbott,

Deputy Assistant Secretary for Policy and Negotiations, performing the non-exclusive functions and duties of the Assistant Secretary for Enforcement and Compliance.

Appendix I

List of Topics Discussed in the Preliminary Decision Memorandum

- I. Summary
- II. Background
- III. Scope of the Order
- IV. Standing
- V. Rescission of Administrative Review, In Part
- VI. Discussion of the Methodology
- VII. Currency Conversion
- VIII. Recommendation

Appendix II

Companies for Which Commerce Is Rescinding the Review

1. C.P. Vietnam Corporation
2. Can Tho Animal Fishery Products Processing Export Enterprise (also known as Cafatex Corporation, or Cafatex)

²⁵ See 19 CFR 351.212(b)(1).

²⁶ See *Antidumping Proceedings: Calculation of the Weighted Average Dumping Margin and Assessment Rate in Certain Antidumping Proceedings: Final Modification*, 77 FR 8101 (February 12, 2012) (*Final Modification*).

²⁷ See 19 CFR 351.212(b)(1).

²⁸ *Id.*

²⁹ See *Final Modification*, 77 FR at 8103.

³⁰ For a full discussion of this practice, see *Non-Market Economy Antidumping Proceedings: Assessment of Antidumping Duties*, 76 FR 65694 (October 24, 2011).

³¹ See *Drawn Stainless Steel Sinks from the People's Republic of China: Preliminary Results of the Antidumping Duty Administrative Review and Preliminary Determination of No Shipments: 2014–2015*, 81 FR 29528 (May 12, 2016), and accompanying Preliminary Decision Memorandum at 10–11, unchanged in *Drawn Stainless Steel Sinks from the People's Republic of China: Final Results of Antidumping Duty Administrative Review; Final Determination of No Shipments: 2014–2015*, 81 FR 54042 (August 15, 2016).

3. Co May Import Export Company Limited (aka Co May Imp. Exp. Co)
4. Dai Thanh Seafoods Company Limited (also known as DATHACO, Dai Thanh Seafoods or Dai Thanh Seafoods Co., Ltd.)
5. Dong A Seafood One Member Company Limited (also known as Dong A Seafood Co.)
6. East Sea Seafoods LLC (also known as euSea Seafoods Limited Liability Company, ESS LLC, ESS, ESS JVC, or East Sea Seafoods Joint Venture Co., Ltd.)
7. Fatifish Company Limited (also known as FATIFISH or FATIFISHCO or Fatfish Co., Ltd.)
8. GODACO Seafood Joint Stock Company (also known as GODACO, GODACO Seafood, GODACO SEAFOOD, GODACO SEAFOOD, or GODACO Seafood J.S.C.)
9. Green Farms Seafood Joint Stock Company (also known as Green Farms, Green Farms Seafood JSC, GreenFarm SeaFoods Joint Stock Company, or Green Farms Seafoods Joint Stock Company)
10. Hai Huong Seafood Joint Stock Company (also known as HHFish, HH Fish, or Hai Huong Seafood)
11. HungCa 6 Corporation
12. Hung Vuong Corporation; Hung Vuong Joint Stock Company, HVC or HV Corp.; An Giang Fisheries Import and Export Joint Stock Company (also known as Agifish, An Giang Fisheries Import and Export, An Giang Fisheries Import & Export Joint Stock Company); Asia Pangasius Company Limited (also known as ASIA); Europe Joint Stock Company (also known as Europe, Europe JSC or EJS CO.); Hung Vuong Ben Tre Seafood Processing Company Limited (also known as Ben Tre, HVB, or HVB Seafood Processing); Hung Vuong Mascato Company Limited (also known as Mascato); Hung Vuong—Sa Dec Co., Ltd. (also known as Sa Dec or Hung Vuong Sa Dec Company Limited); Hung Vuong—Vinh Long Co., Ltd. (also known as Vinh Long or Hung Vuong Vinh Long Company Limited)
13. I.D.I International Development and Investment Corporation (also known as IDI, International Development & Investment Corporation, International Development and Investment Corporation, or IDI International Development & Investment Corporation)
14. Loc Kim Chi Seafood Joint Stock Company (also known as Loc Kim Chi)
15. QVD Food Co., Ltd.; QVD Dong Thap Food Co., Ltd. (also known as Dong Thap or QVD DT); Thuan Hung Co., Ltd. (also known as THUFICO)
16. Vinh Quang Fisheries Corporation (also known as Vinh Quang, Vinh Quang Fisheries Corp., Vinh Quang Fisheries Joint Stock Company, or Vinh Quang Fisheries Co., Ltd.)

- (also known as Binh An or Binh An Seafood Joint Stock Co.)
3. Binh Dinh Garment Joint Stock Co
4. Binh Phu Seafood Co. Ltd
5. Ca Mau Frozen Seafood Processing Import Export Corporation
6. Cantho Imp. Exp. Seafood
7. Cantho Import Export Fishery Limited
8. Hapag Lloyd (America) Inc
9. Hogiya Seafoods Inc
10. Hong Hai International
11. Hung Vuong
12. Indian Ocean One Member Company Limited (also known as Indian Ocean Co., Ltd.)
13. Jk Fish Jsc
14. Mechanics Construction and Foodstuff
15. Pecheries Oceanic Fisheries Inc
16. Phi Long Food Manufacturing Co. Ltd
17. Phuong Ngoc Cai Be Ltd. Liability
18. Seagate Logistics Co., Ltd
19. Thuan Nhan Phat Co., Ltd
20. Tran Thai Food Joint Stock
21. Trinity Vietnam Co., Ltd
22. Trong Nhan Seafood Co., Ltd
23. Van
24. Viet World Co., Ltd
25. Vietnam-wide Entity

Appendix IV

Vietnam-Wide Entity

1. An Chau Co., Ltd
2. An Giang Agriculture and Food Import-Export Joint Stock Company (also known as Afieh or An Giang Agriculture and Foods Import-Export Joint Stock Company)
3. An Hai Fishery Ltd. Co
4. An My Fish Joint Stock Company (also known as Anmyfish, Anmyfishco or An My Fish Joint Stock)
5. An Phat Import-Export Seafood Co., Ltd. (also known as An Phat Seafood Co. Ltd. or An Phat Seafood, Co., Ltd.)
6. An Phu Seafood Corp. (also known as ASEAFood or An Phu Seafood Corp.)
7. Anchor Seafood Corp
8. Anvifish Joint Stock Company (also known as Anvifish, Anvifish JSC, or Anvifish Co., Ltd.)
9. Asia Commerce Fisheries Joint Stock Company (also known as Acomfish JSC or Acomfish)
10. Basa Joint Stock Company (also known as BASACO)
11. Ben Tre Aquaprocess Import and Export Joint Stock Company (also known as Bentre Aquaprocess, Bentre Aquaprocess Import & Export Joint Stock Company or Aquatex Bentre)
12. Bentre Forestry and Aquaprocess Import Export Joint Stock Company (also known as Bentre Forestry and Aquaprocess Import and Export Joint Stock Company, Ben Tre Forestry and Aquaprocess Import-Export Company, Ben Tre Forestry Aquaprocess Import-Export Company, Ben Tre Frozen Aquaprocess Export Company or Faquimex)
13. Bentre Seafood Jsc
14. Binh Dinh Fisheries Joint Stock
15. Binh Dinh Import Export Company (also known as Binh Dinh Import Export Joint Stock Company, or Binh Dinh)
16. Bien Dong Hau Giang Seafood Joint Stock Company (also known as Bien Dong HG

- or Bien Dong Hau Giang Seafood Joint Stock Co.)
17. Cadovimex II Seafood Import-Export and Processing Joint Stock Company (also known as Cadovimex II, Cadovimex II Seafood Import Export and Processing Joint Stock Company, or Cadovimex II Seafood Import-Export)
18. Cavina Seafood Joint Stock Company (also known as Cavina Fish or Cavina Seafood Jsc)
19. Cds Overseas Vietnam Co., Ltd
20. Colorado Boxed Beef Company (also known as CBBC)
21. Coral Triangle Processors (dba Mowi Vietnam Co., Limited (Dong Nai))
22. Cuu Long Fish Import-Export Corporation (also known as CL Panga Fish or Cuu Long Fish Imp. Exp. Corporation)
23. Cuu Long Fish Joint Stock Company (also known as CL-Fish, CL-FISH CORP, or Cuu Long Fish Joint Stock Company)
24. Cuu Long Seapro
25. Da Nang Seaproducts Import-Export Corporation (also known as SEADANANG, Da Nang or Da Nang Seaproducts Import/Export Corp.)
26. Dai Tien Vinh Co., Ltd
27. Dong Phuong Co., Ltd
28. Dong Phuong Import Export Seafood Company Limited (also known as Dong Phuong Export Seafood Limited, Dong Phuong Seafood Company Limited, or aFishDeal)
29. Dragonwaves Frozen Food Factory Co., Ltd
30. Europe Trading Co., Ltd
31. GF Seafood Corp
32. Gia Minh Co. Ltd
33. Go Dang An Hiep One Member Limited Company
34. Go Dang Ben Tre One Member Limited Liability Company
35. Gold Future Imp. Exp/Gold Future Imp. Exp. Development Co. Ltd
36. Golden Quality Seafood Corporation (also known as Golden Quality, GoldenQuality, GOLDENQUALITY, or GoldenQuality Seafood Corporation)
37. GreenFeed Vietnam Corporation
38. Ha Noi Can Tho Seafood Jsc
39. Hai Thuan Nam Co Ltd
40. Hai Trieu Co., Ltd
41. Hasa Seafood Corp. (Hasaco)
42. Hiep Thanh Seafood Joint Stock Company (also known as Hiep Thanh or Hiep Thanh Seafood Joint Stock Co.)
43. Hoa Phat Seafood Import-Export and Processing J.S.C. (also known as HOPAFISH, Hoa Phat Seafood Import-Export and Processing Joint Stock Company, Hoa Phat Seafood Import-Export and Processing JSC, or Hoa Phat Seafood Imp. Exp. And Processing)
44. Hoang Long Seafood Processing Company Limited (also known as HLS, Hoang Long, Hoang Long Seafood, HoangLong Seafood, or Hoang Long Seafood Processing Co., Ltd.)
45. Hong Ngoc Seafood Co., Ltd
46. Hung Phuc Thinh Food Jsc
47. Hung Vuong—Mien Tay Aquaculture Corporation (HVMT or Hung Vuong Mien Tay Aquaculture Joint Stock Company)
48. Hung Vuong Seafood Joint Stock

Appendix III

Companies for Which Commerce Is Preliminarily Rescinding the Review

1. Anh Vu Seafoods Corporation
2. Binh An Seafood Joint Stock Company

- Company
49. Hungca Co., Ltd
 50. I.D.I International Development
 51. Lian Heng Trading Co. Ltd. (also known as Lian Heng, Lian Heng Trading, Lian Heng Investment Co. Ltd., or Lian Heng Investment)
 52. Mekong Seafood Connection Co., Ltd
 53. Minh Phu Hau Giang Seafood Corp
 54. Minh Phu Seafood Corp
 55. Minh Qui Seafood Co., Ltd
 56. Nam Phuong Seafood Co., Ltd. (also known as Nam Phuong, NAFISHCO, Nam Phuong Seafood, or Nam Phuong Seafood Company Ltd.)
 57. New Food Import, Inc
 58. Ngoc Ha Co. Ltd. Food Processing and Trading (also known as Ngoc Ha or Ngoc Ha Co., Ltd. Foods Processing and Trading)
 59. Ngoc Tri Seafood Joint Stock
 60. Nguyen Tran Seafood Company (also known as Nguyen Tran J-S Co)
 61. Nha Trang Seafoods, Inc. (also known as Nha Trang Seafoods-F89, Nha Trang Seafoods, or Nha Trang Seaproduct Company)
 62. NTACO Corporation (also known as NTACO or NTACO Corp.)
 63. Phu Thanh Co., Ltd
 64. Phu Thanh Hai Co. Ltd. (also known as PTH Seafood)
 65. Phuc Tam Loi Fisheries Imp
 66. PREFCO Distribution, LLC
 67. Pufong Trading And Service Co
 68. QMC Foods, Inc
 69. Qn Seafood Co., Ltd
 70. Quang Minh Seafood Company Limited (also known as Quang Minh, Quang Minh Seafood Co., Ltd., or Quang Minh Seafood Co.)
 71. Quirch Foods, LLC
 72. Riptide Foods
 73. Saigon-Mekong Fishery Co., Ltd. (also known as SAMEFICO or Saigon Mekong Fishery Co., Ltd.)
 74. Seafood Joint Stock Company No. 4 (also known as SEAPRIEXCO No. 4)
 75. Seafood Joint Stock Company No. 4 Branch Dongtam Fisheries Processing Company (also known as DOTASEAFOODCO or Seafood Joint Stock Company No. 4—Branch Dong Tam Fisheries Processing Company)
 76. Seavina Joint Stock Company (also known as Seavina)
 77. Sobi Co., Ltd
 78. Song Bien Co., Ltd
 79. Southern Fishery Industries Company, Ltd. (also known as South Vina, South Vina Co., Ltd., Southern Fishery Industries Co., Ltd., Southern Fisheries Industries Company, Ltd., or Southern Fisheries Industries Company Limited)
 80. Sunrise Corporation
 81. Tam Le Food Co., Ltd
 82. Tan Thanh Loi Frozen Food Co., Ltd
 83. TG Fishery Holdings Corporation (also known as TG or Tg Fishery Holdings Corp.)
 84. Thanh Dat Food Service And Trading
 85. Thanh Hung Co., Ltd. (also known as Thanh Hung Frozen Seafood Processing Import Export Co., Ltd. or Thanh Hung)
 86. Thanh Phong Fisheries Corp
 87. The Great Fish Company, LLC

88. Thien Ma Seafood Co., Ltd. (also known as THIMACO, Thien Ma, Thien Ma Seafood Company, Ltd., or Thien Ma Seafoods Co., Ltd.)
89. Thinh Hung Co., Ltd
90. Thuan An Production Trading and Service Co., Ltd. (also known as TAFISHCO, Thuan An Production Trading and Services Co., Ltd., or Thuan An Production Trading & Service Co., Ltd.)
91. Thuan Phuoc Seafoods and Trading Corporation
92. To Chau Joint Stock Company (also known as TOCHAU, TOCHAU JSC, or TOCHAU Joint Stock Company)
93. Trang Thuy Seafood Co., Ltd
94. Truong Phat Seafood Jsc
95. Van Y Corp
96. Viet Hai Seafood Company Limited (also known as Viet Hai, Viet Hai Seafood Co., Ltd., Viet Hai Seafood Co., Vietnam Fish-One Co., Ltd., or Fish One)
97. Viet Long Seafood Co., Ltd
98. Viet Phat Aquatic Products Co., Ltd
99. Viet Phu Foods & Fish Co., Ltd
100. Viet Phu Foods and Fish Corporation (also known as Vietphu, Viet Phu, Viet Phu Food and Fish Corporation, or Viet Phu Food & Fish Corporation)
101. Vietnam Seaproducts Joint Stock Company (also known as Seaproduct or Vietnam Seafood Corporation—Joint Stock Company)
102. Vif Seafood Factory
103. Vinh Long Import-Export Company (also known as Vinh Long, Imex Cuu Long, Vinh Long Import/Export Company)

[FR Doc. 2026–02772 Filed 2–10–26; 8:45 am]

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DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–016]

Certain Passenger Vehicle and Light Truck Tires From the People's Republic of China: Preliminary Results and Partial Rescission of Antidumping Duty Administrative Review; 2023–2024

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: The U.S. Department of Commerce (Commerce) preliminarily finds that certain exporters of passenger vehicle and light truck tires (passenger tires) from the People's Republic of China (China) made sales of subject merchandise at prices below normal value (NV) during the period of review (POR) August 1, 2023, through July 31, 2024. We are also rescinding this administrative review for 16 companies because either all requests for review were withdrawn or these companies had no reviewable entries during the POR. We invite interested parties to comment on these preliminary results.

DATES: Applicable February 11, 2026.

FOR FURTHER INFORMATION CONTACT: Lilit Astvatsatryan, AD/CVD Operations, Office IX, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482–6412.

SUPPLEMENTARY INFORMATION:

Background

On August 10, 2015, Commerce published in the **Federal Register** an antidumping duty (AD) order on passenger tires from China.¹ On September 20, 2024, based on timely requests for review from the petitioner² and other interested parties,³ in accordance with 19 CFR 351.221(c)(1)(i), we initiated an administrative review of the *Order* covering 20 exporters of the subject merchandise.⁴

On December 9, 2024, Commerce tolled certain deadlines in this administrative proceeding by 90 days.⁵ On July 16, 2025, Commerce extended the deadline for the preliminary results of this administrative review by 90 days.⁶ Due to the lapse in

¹ See *Certain Passenger Vehicle and Light Truck Tires from the People's Republic of China: Amended Final Affirmative Antidumping Duty Determination and Antidumping Duty Order; and Amended Final Affirmative Countervailing Duty Determination and Countervailing Duty Order*, 80 FR 47902 (August 10, 2015) (*Order*).

² The petitioner is the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL–CIO, CLC.

³ See Pirelli Tyre Co., Ltd.'s (Pirelli's) Letter, "Pirelli's Request for AD Review," dated August 5, 2024; Petitioner's Letter, "Request for Administrative Reviews," dated August 28, 2024; Jiangsu General Science Technology Co., Ltd.'s (Jiangsu General's) and Qingdao Keter International Co., Limited's (Keter's) Letter, "Request for Administrative Review," dated August 30, 2024; Hankook Tire China Co., Ltd.'s (Hankook Tire's) and Jiangsu Hankook Tire Co., Ltd.'s (Jiangsu Hankook's) Letter, "Request for Administrative Review," dated August 30, 2024; Giti Tire Global Trading Pte. Ltd.'s (Giti's) Letter, "Request for Administrative Review," dated September 3, 2024; Qingdao Lakesea Tyre Co., Ltd.'s (Qingdao Lakesea's) Letter, "Request for Administrative Review," dated September 3, 2024; Sailun Group Co. Ltd.'s (Sailun Group's) Letter, "Sailun and Linglong Request for Administrative Review," dated September 3, 2024; Sumitomo Rubber (Hunan) Co., Ltd.'s (Sumitomo's) Letter, "Request for Administrative Review," dated September 3, 2024; and Qingdao Transamerica Tire Industrial Co., Ltd.'s (Transamerica's) Letter, "Request for Administrative Review," dated August 30, 2024.

⁴ See *Initiation of Antidumping and Countervailing Duty Administrative Reviews*, 89 FR 77079 (September 20, 2024).

⁵ See Memorandum, "Tolling of Deadlines for Antidumping and Countervailing Duty Proceedings," dated December 9, 2024.

⁶ See Memorandum, "Extension of Deadline for Preliminary Results of 2023–2024 Antidumping Duty Administrative Review," dated July 16, 2025.

appropriations and Federal Government shutdown, on November 14, 2025, Commerce tolled all deadlines in administrative proceedings by 47 days.⁷ Additionally, due to a backlog of documents that were electronically filed via Enforcement and Compliance's Antidumping and Countervailing Duty Centralized Electronic Service System (ACCESS) during the Federal Government shutdown, on November 24, 2025, Commerce tolled all deadlines in administrative proceedings by an additional 21 days.⁸ Finally, on December 17, 2025, Commerce extended the deadline for the preliminary results by 30 days.⁹ Accordingly, the deadline for these preliminary results is now February 5, 2026.

For a complete description of the events that followed the initiation of this administrative review, *see* the Preliminary Decision Memorandum.¹⁰ A list of topics discussed in the Preliminary Decision Memorandum is included in Appendix I. The Preliminary Decision Memorandum is a public document and is on file electronically via ACCESS. ACCESS is available to registered users at <https://access.trade.gov>. In addition, a complete version of the Preliminary Decision Memorandum can be accessed directly at <https://access.trade.gov/public/FRNoticesListLayout.aspx>.

Scope of the Order

The products covered by the *Order* are passenger tires from China. For a full description of the scope of the *Order*, *see* the Preliminary Decision Memorandum.

Partial Rescission of Administrative Review

Pursuant to 19 CFR 351.213(d)(1), Commerce will rescind an administrative review, in whole or in part, if a party who requested the review withdraws the request within 90 days of the date of publication of notice of initiation of the requested review in the **Federal Register**. For the companies

identified in Appendix II,¹¹ all parties timely withdrew their requests for review by the 90-day withdrawal deadline. Because all parties timely withdrew their requests for a review of these exporters, consistent with 19 CFR 351.213(d)(1), Commerce is rescinding this review, in part, with respect to these companies.

Furthermore, pursuant to 19 CFR 351.213(d)(3), Commerce will rescind an administrative review when there are no entries of subject merchandise during the POR for which liquidation is suspended.¹² Normally, upon completion of an administrative review, the suspended entries are liquidated at the AD assessment rate calculated for the review period.¹³ Therefore, for an administrative review of a company to be conducted, there must be a suspended entry that Commerce can instruct U.S. Customs and Border Protection (CBP) to liquidate at the AD assessment rate calculated for the POR.¹⁴

In February 2025, we notified interested parties of our intent to rescind this administrative review, in part, with respect to three companies because there were no suspended entries of subject merchandise produced or exported by these companies during the POR, and we invited interested parties to comment.¹⁵ The petitioner submitted comments on the Intent to

Rescind Memorandum, alleging that there were entries from both Shandong Yongsheng Rubber Group Co., Ltd. (Yongsheng) and Qingdao Fullrun Tech Tyre Corp., Ltd. (Fullrun Tech).¹⁶ In response to these concerns, we obtained entry documents for Yongsheng, which we placed on the record.¹⁷ This information shows that, while Yongsheng was the manufacturer of the entries at issue, there is no indication that it had knowledge that this merchandise was destined for the United States.¹⁸ Therefore, we are rescinding this administrative review for Yongsheng, in accordance with 19 CFR 351.213(d)(3).

Further, in the absence of any suspended entries of subject merchandise from Shandong Duratti Rubber Corporation Co., Ltd. (Duratti), we are rescinding the administrative review for Duratti, in accordance with 19 CFR 351.213(d)(3). However, with respect to Fullrun Tech, as discussed below, we preliminarily determine that this company is part of the China-wide entity.

Methodology

Commerce is conducting this review in accordance with section 751(a)(1)(B) of the Tariff Act of 1930, as amended (the Act), and 19 CFR 351.213. We calculated constructed export prices in accordance with section 772(b) of the Act. Because China is a non-market economy (NME) country, within the meaning of section 771(18) of the Act, we calculated NV in accordance with section 773(c) of the Act. In addition, Commerce has relied on partial adverse facts available under sections 776(a) and (b) of the Act for Transamerica and Shandong Haohua Tire Co., Ltd. (Haohua). For a full description of the methodology underlying our conclusions, *see* the Preliminary Decision Memorandum.

Separate Rates

As discussed in the Preliminary Decision Memorandum, Commerce preliminarily finds that Fullrun Tech has not established its eligibility for a separate rate. As such, we preliminarily determine that Fullrun Tech is part of the China-wide entity.

Commerce preliminarily determines that the following companies have demonstrated their eligibility for a

⁷ See Memorandum, "Deadlines Affected by the Shutdown of the Federal Government," dated November 14, 2025.

⁸ See Memorandum, "Tolling of all Case Deadlines," dated November 24, 2025.

⁹ See Memorandum, "Extension of Deadline for Preliminary Results of 2023–2024 Antidumping Duty Administrative Review," dated December 17, 2025.

¹⁰ See Memorandum, "Decision Memorandum for the Preliminary Results of the Antidumping Duty Administrative Review of Certain Passenger Vehicle and Light Truck Tires from the People's Republic of China; 2023–2024," dated concurrently with, and hereby adopted by, this notice (Preliminary Decision Memorandum).

¹¹ See Pirelli's Letter, "Pirelli's Withdrawal Request for AD Review," dated October 16, 2024; Sailun Group's Letter, "Sailun, Sailun Tire America's, and Linglong Withdrawal Request of Administrative Review," dated October 20, 2024; Sumitomo's Letter, "Withdrawal of Request for Administrative Review," dated November 25, 2024, and "Letter to Confirm Withdrawal of Request for Administrative Review and Request to Deselect Companies as Mandatory Respondents or Suspend the Deadlines to Respond to the Initial Questionnaire," dated December 4, 2024; Zhaoqing Junhong Co., Ltd.'s Letter, "Withdrawal of Request for Administrative Review," dated December 4, 2024; Giti's Letter, "Withdrawal of Request for Administrative Review," dated December 5, 2024; Petitioner's Letter, "Withdrawal of Requests for Administrative Review," dated December 17, 2024; Jiangsu General's and Keter's Letter, "Withdrawal of Request for Administrative Review," dated December 17, 2024; Jiangsu Hankook's and Hankook Tire's Letter, "Withdrawal of Request for Administrative Review," dated December 18, 2024; and Qingdao Lakesea's Letter, "Withdrawal of Request for Administrative Review," dated December 19, 2024.

¹² See, e.g., *Diocetyl Terephthalate from the Republic of Korea: Rescission of Antidumping Administrative Review; 2021–2022*, 88 FR 24758 (April 24, 2023); *see also Certain Carbon and Alloy Steel Cut-to-Length Plate from the Federal Republic of Germany: Rescission of Antidumping Administrative Review; 2020–2021*, 88 FR 4157 (January 24, 2023).

¹³ See 19 CFR 351.212(b)(2).

¹⁴ See 19 CFR 351.213(d)(3).

¹⁵ See Memorandum, "Notice of Intent to Rescind Review, In Part," dated February 13, 2025 (Intent to Rescind Memorandum).

¹⁶ See Petitioner's Letter, "Petitioner's Comments on Commerce's Intent to Rescind," dated February 20, 2025.

¹⁷ See Memorandum, "Release of U.S. Customs and Border Protection Entry Documents," dated December 4, 2025.

¹⁸ *Id.*

separate rate in this review:¹⁹ (1) Transamerica; (2) Haohua; and (3) Triangle Tyre Co., Ltd. (Triangle Tyre).

The Act and Commerce's regulations do not address the establishment of a rate to apply to companies not selected for individual examination when Commerce limits its examination in an administrative review pursuant to section 777A(c)(2) of the Act. Generally, Commerce looks to section 735(c)(5) of the Act, which provides instructions for calculating the all-others rate in an investigation, for guidance when determining the dumping margin for respondents that are not individually examined in an administrative review. Section 735(c)(5)(A) of the Act states that the all-others rate should be calculated by averaging the weighted-average dumping margins for individually-examined respondents, excluding dumping margins that are zero, *de minimis*, or based entirely on facts available. For these preliminary results, we preliminarily determined a dumping margin for the separate rate respondent, Triangle Tyre, as the weighted average of the calculated rate of the mandatory respondents, Transamerica and Haohua, which are not zero or *de minimis*, or determined entirely on the basis of facts available.

China-Wide Entity

Commerce's policy regarding conditional review of the China-wide entity applies to this administrative review.²⁰ Because no party requested a review of the China-wide entity, the China-wide entity is not under review. Therefore, the rate previously established for the China-wide entity (*i.e.*, 76.46 percent) remains the China-wide entity rate this review.²¹

Preliminary Results of Review

We preliminarily determine that the following estimated weighted-average dumping margins exist for the POR August 1, 2023, through July 31, 2024:

Exporter	Weighted-average dumping margin (percent)
Qingdao Transamerica Tire Industrial Co., Ltd	61.43
Shandong Haohua Tire Co., Ltd	62.56

¹⁹ See Preliminary Decision Memorandum at "Separate Rates."

²⁰ See *Antidumping Proceedings: Announcement of Change in Department Practice for Respondent Selection in Antidumping Duty Proceedings and Conditional Review of the Nonmarket Economy Entity in NME Antidumping Duty Proceedings*, 78 FR 65963 (November 4, 2013).

²¹ See *Order*, 80 FR at 47904, n.19.

Exporter	Weighted-average dumping margin (percent)
Triangle Tyre Co., Ltd	61.47

Disclosure

Commerce intends to disclose its calculations and analysis performed to interested parties in these preliminary results within five days of any public announcement or, if there is no public announcement, within five days of the date of publication of this notice in the **Federal Register**, in accordance with 19 CFR 351.224(b).

Public Comment

Case briefs and other written comments may be submitted to the Assistant Secretary for Enforcement and Compliance. Pursuant to 19 CFR 351.309(c), we have modified the deadline for interested parties to submit case briefs to Commerce to no later than 21 days after the date of publication of this notice. Rebuttal briefs, limited to issues raised in the case briefs, may be filed not later than five days after the date for filing case briefs.²² Interested parties who submit case briefs or rebuttal briefs in this proceeding must submit: (1) a table of contents listing each issue; and (2) a table of authorities.²³ An electronically filed document must be received successfully in its entirety in ACCESS by 5:00 p.m. Eastern Time (ET) on the established deadline. As provided under 19 CFR 351.309(c)(2)(iii) and (d)(2)(iii), we request that interested parties provide at the beginning of their briefs a public, executive summary for each issue raised in their briefs.²⁴ Further, we request that interested parties limit their public executive summary of each issue to no more than 450 words, not including citations. We intend to use the public executive summaries as the basis of the comment summaries included in the issues and decision memorandum that will accompany the final results in this administrative review. We request that interested parties include footnotes for relevant citations in the public executive summary of each issue. Note that Commerce has amended certain of its requirements pertaining to the

²² See 19 CFR 351.309(d); see also *Administrative Protective Order, Service, and Other Procedures in Antidumping and Countervailing Duty Proceedings*, 88 FR 67069, 67077 (September 29, 2023) (*APO and Service Final Rule*).

²³ See 19 CFR 351.309(c)(2) and (d)(2).

²⁴ We use the term "issue" here to describe an argument that Commerce would normally address in a comment of the Issues and Decision Memorandum.

service of documents in 19 CFR 351.303(f).²⁵

Pursuant to 19 CFR 351.310(c), interested parties who wish to request a hearing must submit a written request to the Assistant Secretary for Enforcement and Compliance, filed electronically via ACCESS. An electronically filed hearing request must be received successfully in its entirety by Commerce's electronic records system, ACCESS, by 5:00 p.m. ET within 30 days after the date of publication of this notice.²⁶ Hearing requests should contain: (1) the party's name, address and telephone number; (2) the number of participants; (3) whether any participant is a foreign national; and (4) a list of issues to be discussed. Issues raised in the hearing will be limited to those raised by each party in their respective case and rebuttal briefs. An electronically filed request must be received successfully in its entirety by ACCESS by 5:00 p.m. Eastern Time, within 30 days of the publication date of this notice. If a request for a hearing is made, parties will be notified of the time and date of the hearing.²⁷

Assessment Rates

Pursuant to section 751(a)(2)(A), upon completion of this administrative review, Commerce shall determine, and CBP shall assess, antidumping duties on all appropriate entries covered by this review.²⁸ Pursuant to 19 CFR 351.212(b)(1), because Haohua and Transamerica reported the entered value for their U.S. sales, we calculated importer-specific *ad valorem* duty assessment rates based on the ratio of the total amount of dumping calculated for the importer's examined sales to the total entered value of those sales. Where either a respondent's weighted-average dumping margin is zero or *de minimis* within the meaning of 19 CFR 351.106(c)(1), or an importer-specific rate is zero or *de minimis*, we will instruct CBP to liquidate the appropriate entries without regard to antidumping duties.²⁹

Pursuant to Commerce's assessment practice,³⁰ for entries that were not reported in the U.S. data submitted by Haohua and Transamerica, we will instruct to CBP to liquidate such entries at the China-wide rate. Additionally, where Commerce determines that an

²⁵ See *APO and Service Final Rule*.

²⁶ See 19 CFR 351.301(c).

²⁷ See 19 CFR 351.310(d).

²⁸ See 19 CFR 351.212(b)(1).

²⁹ *Id.*

³⁰ See *Non-Market Economy Antidumping Proceedings: Assessment of Antidumping Duties*, 76 FR 65694 (October 24, 2011), for a full discussion of this practice.

exporter under review had no shipments of subject merchandise to the United States during the POR, any suspended entries of subject merchandise that entered under that exporter's CBP case number during the POR will be liquidated at the dumping margin assigned to the China-wide entity.

For Triangle Tyre, the separate rate respondent, the assessment rate will be equal to the weighted-average dumping margin calculated using the rates assigned to Haohua and Transamerica in the final results of this review.³¹ Finally, we intend to liquidate entries containing subject merchandise exported by the companies under review that we determine in the final results to be part of the China-wide entity at the China-wide rate of 76.46 percent.

In accordance with section 751(a)(2)(C) of the Act, the final results of this review shall be the basis for the assessment of antidumping duties on entries of merchandise covered by the final results of this review and for future deposits of estimated antidumping duties, where applicable. Commerce intends to issue assessment instructions to CBP no earlier than 35 days after the date of publication of the final results of this review in the **Federal Register**. If a timely summons is filed at the U.S. Court of International Trade, the assessment instructions will direct CBP not to liquidate relevant entries until the time for parties to file a request for a statutory injunction has expired (*i.e.*, within 90 days of publication).

Finally, for the companies for which we are rescinding this review, Duratti and Yongsheng, we intend to instruct CBP to assess antidumping duties on all appropriate entries at a rate equal to the cash deposit rate of estimated antidumping duties required at the time of entry, or withdrawal from warehouse, for consumption in accordance with 19 CFR 351.212(c)(1)(i). Commerce intends to issue assessment instructions to CBP for these companies no earlier than 35 days after the date of publication of this notice in the **Federal Register**.

Cash Deposit Requirements

The following cash deposit requirements will be effective upon

publication of the final results of this administrative review for all shipments of the subject merchandise from China entered, or withdrawn from warehouse, for consumption on or after the publication date, as provided for by section 751(a)(2)(C) of the Act: (1) for the companies listed above that have a separate rate, the cash deposit rate will be that rate established in the final results of this review (except, if the rate is zero or *de minimis*, then a cash deposit rate of zero will be established for that company); (2) for previously investigated or reviewed exporters not listed in the final results of review that have separate rates, the cash deposit rate will continue to be the exporter's weighted-average dumping margin published of the most recently-completed segment of this proceeding; (3) for all Chinese exporters of subject merchandise that have not been found to be entitled to a separate rate, the cash deposit rate will be the rate for the China-wide entity (*i.e.*, 76.46 percent);³² and (4) for all exporters of subject merchandise which are not located in China and are not eligible for a separate rate, the cash deposit rate will be the rate applicable to Chinese exporter(s) that supplied that non-Chinese exporter. These deposit requirements, when imposed, shall remain in effect until further notice.

Final Results

Unless the deadline is extended pursuant to section 751(a)(3)(A) of the Act and 19 CFR 351.213(h)(2), Commerce intends to issue the final results of this administrative review, including the results of our analysis of the issues raised in any case briefs, not later than 120 days after the date of publication of this notice.

Notification to Importers

This notice also serves as a reminder to importers of their responsibility under 19 CFR 351.402(f)(2) to file a certificate regarding the reimbursement of antidumping and/or countervailing duties prior to liquidation of the relevant entries during this POR. Failure to comply with this requirement could result in Commerce's presumption that reimbursement of antidumping and/or countervailing duties occurred and the subsequent assessment of double antidumping duties and/or an increase in the amount of antidumping duties by the amount of the countervailing duties.

Notification to Interested Parties

We are issuing and publishing these results in accordance with sections

751(a)(1) and 777(i)(1) of the Act, and 19 CFR 351.213 and 19 CFR 351.221(b)(4).

Dated: February 5, 2026.

Christopher Abbott,

Deputy Assistant Secretary for Policy and Negotiations, performing the non-exclusive functions and duties of the Assistant Secretary for Enforcement and Compliance.

Appendix I

List of Topics Discussed in the Preliminary Decision Memorandum

- I. Summary
- II. Background
- III. Scope of the Order
- IV. Use of Facts Available and Adverse Inferences
- V. Discussion of the Methodology
- VI. Currency Conversion
- VII. Recommendation

Appendix II

Companies Rescinded Based on Timely Withdrawals of Requests for Review

1. Giti Radial Tire (Anhui) Company, Ltd.; Giti Tire (Anhui) Company, Ltd.; Giti Tire (Chongqing) Company, Ltd.; Giti Tire (Fujian) Company, Ltd.; Giti Tire Global Trading Pte. Ltd.; Giti Tire Greatwall Company, Ltd.; Giti Tire (Hualin) Company, Ltd.; Giti Tire (Yinchuan) Company, Ltd.
2. Hankook Tire China Co., Ltd.
3. Jiangsu General Science Technology Co., Ltd.
4. Jiangsu Hankook Tire Co., Ltd.
5. Pirelli Tyre Co., Ltd.
6. Qingdao Fullrun Tyre Corp., Ltd.
7. Qingdao Keter International Co., Limited
8. Qingdao Lakesea Tyre Co., Ltd.
9. Qingdao Powerich Tyre Co., Ltd.
10. Dynamic Tire Corp.; Shandong Jinyu Industrial Co.; Sailun Tire International Corp.; Husky Tire Corp.; Seatex PTE. Ltd.; Seatex International Inc.; Sailun Group (HongKong) Co., Limited; Sailun HK; Sailun Jinyu HK; Sailun Group Co., Ltd.; Sailun Group; Sailun Jinyu Group Co., Ltd.; and Sailun Jinyu
11. Sailun Tire Americas Inc.
12. Shandong Linglong Tyre Co., Ltd.
13. Sumitomo Rubber (Changshu) Co., Ltd.; Sumitomo Rubber (Hunan) Co., Ltd.; and Sumitomo Rubber Industries, Ltd.
14. Zhaoqing Junhong Co., Ltd.

[FR Doc. 2026-02779 Filed 2-10-26; 8:45 am]

BILLING CODE 3510-DS-P

DEPARTMENT OF COMMERCE

International Trade Administration

[A-823-816]

Carbon and Alloy Steel Wire Rod From Ukraine: Rescission of Antidumping Duty Administrative Review; 2024-2025

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

³¹ See *Drawn Stainless Steel Sinks from the People's Republic of China: Preliminary Results of the Antidumping Duty Administrative Review and Preliminary Determination of No Shipments: 2014-2015*, 81 FR 29528 (May 12, 2016), and accompanying PDM at 10-11, unchanged in *Drawn Stainless Steel Sinks from the People's Republic of China: Final Results of Antidumping Duty Administrative Review; Final Determination of No Shipments: 2014-2015*, 81 FR 54042 (August 15, 2016).

³² See *Order*, 80 FR at 47904, n.19.

SUMMARY: The U.S. Department of Commerce (Commerce) is rescinding the administrative review of the antidumping duty (AD) order on carbon and alloy steel wire rod (steel wire rod) from Ukraine, covering the period of review (POR) March 1, 2024, though February 28, 2025.

DATES: Applicable February 11, 2026.

FOR FURTHER INFORMATION CONTACT: Brittany Bauer, AD/CVD Operations, Office V, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482-3860.

SUPPLEMENTARY INFORMATION:

Background

On March 14, 2018, Commerce published in the **Federal Register** the AD order on steel wire rod from Ukraine.¹ On March 4, 2025, Commerce published in the **Federal Register** a notice of opportunity to request an administrative review of the *Order* for the POR.² On March 31, 2025, Commercial Metals Company and Nucor Corporation (collectively, the petitioners) submitted a timely request that Commerce conduct an administrative review.³

On April 28, 2025, Commerce published in the **Federal Register** a notice of initiation of an administrative review with respect to imports of steel wire rod from Ukraine in accordance with section 751(a) of the Tariff Act of 1930, as amended (the Act).⁴ On June 5, 2025, Commerce placed on the record U.S. Customs and Border Protection (CBP) entry data for the companies subject to the review, showing no reviewable POR entries, and invited interested parties to comment.⁵ No party filed comments with respect to the CBP data.

On July 8, 2025, Commerce issued a notice of intent to rescind the 2024–2025 administrative review and invited interested parties to comment.⁶ No party

filed comments with respect to the Notice of Intent to Rescind.

Due to a lapse in appropriations and federal government shutdown, on November 14, 2025, Commerce tolled all deadlines in administrative proceedings by 47 days.⁷ Additionally, due to a backlog of documents that were electronically filed via Enforcement and Compliance's Antidumping and Countervailing Duty Centralized Electronic Service System (ACCESS) during the Federal Government shutdown, on November 24, 2025, Commerce tolled all deadlines in administrative proceedings by an additional 21 days.⁸ Accordingly the deadline for the preliminary results of this review is now February 9, 2026.

Rescission of Review

Pursuant to 19 CFR 351.213(d)(3), it is Commerce's practice to rescind an administrative review of an AD order when there are no reviewable entries of subject merchandise during the POR for which liquidation is suspended.⁹ Normally, upon completion of an administrative review, the suspended entries are liquidated at the AD assessment rate for the review period.¹⁰ Therefore, for an administrative review to be conducted, there must be a reviewable, suspended entry that Commerce can instruct CBP to liquidate at the calculated AD assessment rate for the review period.¹¹

As noted above, there were no entries of subject merchandise for the companies subject to this review during the POR. Accordingly, in the absence of suspended entries of subject merchandise during the POR, we are hereby rescinding this administrative review, in its entirety, in accordance with 19 CFR 351.213(d)(3).

Cash Deposit Requirements

As Commerce has proceeded to a final rescission of this administrative review, no cash deposit rates will change. Accordingly, the current cash deposit requirements shall remain in effect until further notice.

Assessment Rates

Commerce will instruct CBP to assess antidumping duties on all appropriate entries. Antidumping duties shall be

assessed at rates equal to the cash deposit of estimated antidumping duties required at the time of entry, or withdrawal from warehouse, for consumption, in the United States, in accordance with 19 CFR 351.212(c)(1)(i). Commerce intends to issue assessment instructions to CBP no earlier than 35 days after the date of publication of this rescission notice in the **Federal Register**.

Administrative Protective Order (APO)

This notice serves as a final reminder to parties subject to an APO of their responsibility concerning the return or destruction of proprietary information disclosed under APO in accordance with 19 CFR 351.305(a)(3), which continues to govern business proprietary information in this segment of the proceeding. Timely written notification of the return or destruction of the APO materials, or conversion to judicial protective order is hereby requested. Failure to comply with regulations and terms of an APO is a violation, which is subject to sanction.

Notification to Interested Parties

This notice is issued and published in accordance with sections 751(a)(1) and 777(i)(1) of the Act, and 19 CFR 351.213(d)(4).

Dated: February 9, 2026.

Scot Fullerton,

Acting Deputy Assistant Secretary for Antidumping and Countervailing Duty Operations.

[FR Doc. 2026-02780 Filed 2-10-26; 8:45 am]

BILLING CODE 3510-DS-P

DEPARTMENT OF DEFENSE

Department of the Air Force

Notice of 2026 Public Interface Control Working Group (PICWG) and Open Public Forum

AGENCY: Space Systems Command, United States Space Force, Department of the Air Force, Department of Defense.
ACTION: Meeting notice.

SUMMARY: This notice informs the public that the Space Systems Command (SSC), System Delta 831 (SYD 831) NAVWAR & Position, Navigation, and Timing (PNT) will host the 2026 Public Interface Control Working Group (PICWG) and Open Public Forum on June 16, 2026 for the following NAVSTAR GPS public documents: IS-GPS-200 (Navigation User Interfaces), IS-GPS-705 (User Segment L5 Interfaces), IS-GPS-800 (User Segment L1C Interface), and ICD-GPS-870

¹ See *Carbon and Alloy Steel Wire Rod from the Republic of South Africa and Ukraine: Antidumping Duty Orders*, 83 FR 11175 (March 14, 2018) (*Order*).

² See *Antidumping and Countervailing Duty Order, Finding or Suspended Investigation; Opportunity to Request Administrative Review and Join Annual Inquiry Service List*, 90 FR 11155 (March 4, 2025).

³ See Petitioner's Letter, "Request for Administrative Review," dated March 31, 2025.

⁴ See *Initiation of Antidumping and Countervailing Duty Administrative Reviews*, 90 FR 17568, 17572 (April 28, 2025).

⁵ See Memorandum, "Release of Customs and Border Protection Data," dated June 5, 2025.

⁶ See Memorandum, "Notice of Intent to Rescind Review," dated July 8, 2025 (Notice of Intent to Rescind).

⁷ See Memorandum, "Deadlines Affected by the Shutdown of the Federal Government," dated November 14, 2025.

⁸ See Memorandum, "Tolling of all Case Deadlines," dated November 24, 2025.

⁹ See, e.g., *Certain Carbon and Alloy Steel Cut-to-Length Plate from the Federal Republic of Germany: Rescission of Antidumping Administrative Review; 2020–2021*, 88 FR 4154 (January 24, 2023).

¹⁰ See 19 CFR 351.212(b)(1).

¹¹ See 19 CFR 351.213(d)(3).

(NAVSTAR Next Generation GPS Control Segment (OCX) to User Support Community Interface).

DATES: Open to the public Tuesday, June 16, 2026, from 8:30 a.m. to 4:00 p.m. (Pacific Time).

ADDRESSES: This virtual meeting can be accessed via the following URLs and dial-in numbers:

MS Teams https://dod.teams.microsoft.us/l/meetup-join/19%3adod%3ameeting_aa4774f66ff44ad6b5f2099643665195%40thread.v2/0?context=%7b%22id%22%3a%228331b18d-2d87-48ef-a35f-ac8818ebf9b4%22%2c%22oid%22%3a%2287a32064-cfb0-4c32-867b-0f7cf2dd1434%22%7d.

Meeting ID: 993 250 433 301 |

Passcode: Gt2o45Ea.

Dial in by phone: +1 410-874-6750 United States, Odenton | Phone conference ID: 764 408 612#.

If you wish to attend, please place a request via the for **FURTHER INFORMATION CONTACT** listed below.

FOR FURTHER INFORMATION CONTACT: Mr. Daniel Stevenson, PNT Systems Delta 831/S5 SEIT Director, by email at SSC.CG.PICWG@spaceforce.mil or by phone at 310-653-3531.

SUPPLEMENTARY INFORMATION: The purpose of this meeting is to update the public on proposed GPS public document changes, collect issues/ comments for analysis and adjudicate subject comments for possible incorporation into future GPS public document revisions. The 2026 Public Interface Control Working Group and Open Forum are open to the general public.

Comments to the proposed changes will be collected, catalogued, and adjudicated for potential inclusion. If accepted, these changes will be processed through the government change management process for IS-GPS-200, IS-GPS-705, IS-GPS-800, and ICD-GPS-870. All comments must be submitted in a Comments Resolution Matrix. This form along with the proposed change notices, public document baseline documents and the official meeting notice are posted at: <https://www.gps.gov/meetings/icwg/public-interface-control-working-group-picwg-2026>.

Please submit comments to the Space Systems Command GPS Requirements Section (SSC/SYD 831/S5) workflow at SSC.CG.PICWG@spaceforce.mil by March 13, 2026. Special topics may also be considered for the Public Open Forum. If you wish to present a special topic, please submit your topic title, briefer name, and organization by April 1, 2026.

For those who would like to attend and participate online, we request that you register no later than May 29, 2026. Please send the registration information to SSC.CG.PICWG@spaceforce.mil, providing your name, organization, telephone number, email address, and country of citizenship. Meeting is being held virtually. Additional logistical details can be found below.

Crystle C. Poge,

Air Force Federal Register Liaison.

[FR Doc. 2026-02691 Filed 2-10-26; 8:45 am]

BILLING CODE 3911-44-P

DEPARTMENT OF DEFENSE

Department of the Air Force

Notice of Intent To Prepare an Environmental Impact Statement (EIS) for Basing F-16 Fighting Falcon Fighter Squadron at Gowen Field—Idaho Air National Guard Base, Ada County, Boise, Idaho

AGENCY: Department of the Air Force, Department of Defense.

ACTION: Notice of intent.

SUMMARY: The Department of the Air Force (DAF) is issuing this Notice of Intent (NOI) to prepare an Environmental Impact Statement (EIS) to assess the potential social, economic, and environmental impacts associated with basing an F-16 Fighting Falcon Fighter Squadron at Gowen Field in Boise, Idaho, as well as the required facility improvements and construction necessary to support the mission. The squadron would consist of up to 21 F-16 Block 40 aircraft (18 primary and three backup/reserve) to replace the fleet of 21 A-10C aircraft (18 primary and three backup/reserve) currently operating.

DATES: A public scoping period of 30 days will take place starting from the date of this NOI publication in the **Federal Register**. Comments on alternatives or impacts and on relevant information, studies, or analyses with respect to the proposed agency action are requested and will be accepted at any time during the EIS process. To ensure sufficient time to consider public input in the preparation of the Draft EIS, scoping comments should be submitted in writing to the website or the address listed below within the 30-day scoping period. The Draft EIS is anticipated in Summer 2026 and the Final EIS is anticipated in Spring 2027.

ADDRESSES: The project website, www.gowenfieldf16eis.com, provides information on the EIS and the scoping

process and can be used to submit scoping comments online. Scoping comments may also be submitted by email to NGB.CCA4F.NEPACOMMENTSorg@us.af.mil, including “F-16 Gowen Field EIS” in the subject line, or by mail to Ms. Kristi Kucharek, National Guard Bureau, NGB/A4FR, 3501 Fetchet Avenue, Joint Base Andrews, MD 20762. EIS inquiries and requests for digital or print copies of scoping materials are available upon request to Ms. Kucharek at the email or mailing address provided. For printed material requests, the standard U.S. Postal Service shipping timeline will apply. Members of the public who want to receive future communications informing them about the availability of the Draft and Final EIS are encouraged to submit the contact form on the project website.

FOR FURTHER INFORMATION CONTACT: For inquiries regarding accommodations under the Americans with Disabilities Act or questions regarding the Proposed Action, scoping, and EIS development please contact Ms. Kristi Kucharek, NEPA Project Manager at NGB.CCA4F.NEPACOMMENTSorg@us.af.mil or by phone at (208) 422-5028.

SUPPLEMENTARY INFORMATION: The DAF is the lead agency and the Federal Aviation Administration (FAA) is serving as a cooperating agency. The purpose of the Proposed Action is to effectively maintain combat capability and mission readiness for the 124th Fighter Wing (124 FW) based at the Idaho Air National Guard (IDANG) Base at the Boise Air Terminal/Gowen Field (BOI) in Boise, Idaho by transitioning the 124 FW from an A-10C Thunderbolt II mission to an F-16 Fighting Falcon mission. The Proposed Action is needed because the A-10C fleet is reaching the end of its service life and is consistent with DAF plans to divest all A-10 aircraft by FY2029. The EIS will assess the potential environmental consequences of the proposed beddown, operation, and associated infrastructure construction supporting one squadron of F-16 Fighting Falcon aircraft at IDANG Base. The squadron would consist of up to 21 F-16 Block 40 aircraft (18 primary and three backup/reserve). The EIS will also assess a No Action Alternative.

Resource areas to be analyzed include airspace, noise, air quality, biological and natural resources, cultural resources, water resources, geological resources, land use/noise compatible land use, socioeconomic, hazardous materials/waste, infrastructure and utilities, transportation and parking, community services, and aesthetics.

Potential significant impacts include those related to aircraft noise, air quality, and land use. Should any permits or other authorizations be required for the Proposed Action, the NGB and DAF will identify and obtain each.

Scoping and Agency Coordination: Consultation will include, but not necessarily be limited to, Section 7 of the Endangered Species Act, Section 106 of the National Historic Preservation Act, and will include consultations with federally recognized Native American Tribes. The scoping process will be used to involve the public early in the planning and development of the EIS to assist in identifying issues and information to be addressed in the analysis. To effectively define the full range of issues to be evaluated, DAF and NGB will determine the scope of the analysis by requesting comments, including potential alternatives, information, and analyses from interested local, State, and Federal elected officials and agencies, Tribes, members of the public, and others. Comments may be submitted at any time during the process, however, to ensure consideration in the Draft EIS, comments should be received within 30 days of the publication of this notice in the **Federal Register**. Comments received via email, on the website, or by U.S. mail will be considered equally.

Crystle C. Poge,

Air Force Federal Register Liaison.

[FR Doc. 2026-02688 Filed 2-10-26; 8:45 am]

BILLING CODE 3911-44-P

DEPARTMENT OF DEFENSE

Department of the Air Force

Notice of Intent To Grant a Partially Exclusive Patent License

AGENCY: Department of the Air Force, Department of Defense.

ACTION: Notice of intent.

SUMMARY: Pursuant to the Bayh-Dole Act and implementing regulations, the Department of the Air Force hereby gives notice of its intent to grant a partially exclusive (the field to include imaging and communication using infrared wavelengths) patent license to Ravee Optics Inc., a Delaware corporation having a place of business at 406 Greenmount Blvd., Oakwood, OH 45419.

DATES: Written objections must be filed no later than fifteen (15) calendar days after the date of publication of this notice.

ADDRESSES: Submit written objections to John DePinto, Air Force Research Laboratory, Manufacturing Directorate, Attn: Office of Technology Transfer & Applications, 2977 Hobson Way, Bldg. 653, Room 105; Phone: (937) 255-3637; or Email: afrl.rx.t2@us.af.mil. Include Docket No. 25-0005890-AFRL/RX in the subject line of the message.

FOR FURTHER INFORMATION CONTACT: John DePinto, Air Force Research Laboratory, Manufacturing Directorate, Attn: Office of Technology Transfer & Applications, 2977 Hobson Way, Bldg. 653, Room 105; Phone: (937) 255-3637; or Email: afrl.rx.t2@us.af.mil.

SUPPLEMENTARY INFORMATION:

Abstract of Patent Application(s)

A wafer-scale metamaterial structure and a method for forming is provided. The metamaterial structure has a number of reticles each having meta-atoms in which a number of dual-function meta-atoms form an alignment mark at an interior zone of the reticle. The alignment mark of the reticle is configured to align with a corresponding alignment mark at an interior zone of another reticle at a lithographic divide between the reticles that together form a metamaterial component. Misalignment between dual-function meta-atoms of the alignment mark and the dual-function meta-atoms of the corresponding alignment mark creates a plurality of malformed meta-atoms at the lithographic divide indicative of misalignment between the reticles.

Intellectual Property

U.S. Application No. 19/452,480, filed on January 19, 2026, and entitled Methodology to Realize Wafer-Scale Metamaterials Components.

The Department of the Air Force may grant the prospective license unless a timely objection is received that sufficiently shows the grant of the license would be inconsistent with the Bayh-Dole Act or implementing regulations. A competing application for a patent license agreement, completed in compliance with 37 CFR 404.8 and received by the Air Force within the period for timely objections, will be treated as an objection and may be considered as an alternative to the proposed license.

(Authority: 35 U.S.C. 209; 37 CFR 404)

Crystle C. Poge,

Air Force Federal Register Liaison Officer.

[FR Doc. 2026-02686 Filed 2-10-26; 8:45 am]

BILLING CODE 3911-44-P

DEPARTMENT OF DEFENSE

Department of the Army

[Docket ID: USA-2026-HQ-0134]

Proposed Collection; Comment Request

AGENCY: Department of the Army, Department of Defense (DoD).

ACTION: 60-Day information collection notice.

SUMMARY: In compliance with the *Paperwork Reduction Act of 1995*, the Department of the Army (USA) announces a proposed public information collection and seeks public comment on the provisions thereof. Comments are invited on: whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; the accuracy of the agency's estimate of the burden of the proposed information collection; ways to enhance the quality, utility, and clarity of the information to be collected; and ways to minimize the burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology.

DATES: Consideration will be given to all comments received by April 13, 2026.

ADDRESSES: You may submit comments, identified by docket number and title, by any of the following methods:

Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.

Mail: Department of Defense, Office of the Director of Administration and Management, Privacy, Civil Liberties, and Transparency Directorate, Regulatory Division, 4800 Mark Center Drive, Mailbox #24, Suite 05F16, Alexandria, VA 22350-1700.

Instructions: All submissions received must include the agency name, docket number and title for this **Federal Register** document. 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: To request more information on this proposed information collection or to obtain a copy of the proposal and associated collection instruments, please write to Department of the Army, Office of the Deputy Chief of Staff G-1

(DAIN-PR), 2530 Crystal Dr., 6th Floor Taylor Bldg., Arlington, VA 22202-394, Ms. Dorie Hickson, 571-256-8682.

SUPPLEMENTARY INFORMATION:

Title; Associated Form; and OMB Number: Army Youth Program Evaluation Survey; OMB Control Number 0702-CYSS.

Needs and Uses: The USA is seeking public comment on a proposed information collection designed to conduct an outcome evaluation of its Child, Youth, and School Services (CYSS) Youth Program. This evaluation will formally assess the program's impacts on Soldier mission focus, as well as overall family and youth well-being. To gather this information, a confidential online survey will be administered to two distinct groups of Army parents: those with children participating in the CYSS program and a comparison group with non-participating children. The resulting data will be used to analyze and compare outcomes between the two groups, providing an evidence-based assessment of program effectiveness and guiding future improvements to these critical family support services.

Affected Public: Individuals or households.

Annual Burden Hours: 100.

Number of Respondents: 300.

Responses per Respondent: 2.

Annual Responses: 600.

Average Burden per Response: 10 minutes.

Frequency: Twice. This is planned as a two-timepoint study, with data collections occurring approximately four months apart.

Dated: February 9, 2026.

Stephanie J. Bost,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2026-02728 Filed 2-10-26; 8:45 am]

BILLING CODE 6001-FR-P

DEPARTMENT OF DEFENSE

Office of the Secretary

[Docket ID: DOD-2026-OS-0199]

Proposed Collection; Comment Request

AGENCY: Office of the Under Secretary of Defense for Personnel and Readiness (OUSD(P&R)), Department of Defense (DoD).

ACTION: 60-Day information collection notice.

SUMMARY: In compliance with the *Paperwork Reduction Act of 1995*, the OUSD(P&R) announces a proposed

public information collection and seeks public comment on the provisions thereof. Comments are invited on: whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; the accuracy of the agency's estimate of the burden of the proposed information collection; ways to enhance the quality, utility, and clarity of the information to be collected; and ways to minimize the burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology.

DATES: Consideration will be given to all comments received by April 13, 2026.

ADDRESSES: You may submit comments, identified by docket number and title, by any of the following methods:

Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.

Mail: Department of Defense, Office of the Director of Administration and Management, Privacy, Civil Liberties, and Transparency Directorate, Regulatory Division, 4800 Mark Center Drive, Mailbox #24, Suite 05F16, Alexandria, VA 22350-1700.

Instructions: All submissions received must include the agency name, docket number and title for this **Federal Register** document. 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: To request more information on this proposed information collection or to obtain a copy of the proposal and associated collection instruments, please write to Defense Human Resources Activity, 4800 Mark Center Drive, Suite 08F05, Alexandria, VA 22350, LaTarsha Yeargins, 571-372-2089.

SUPPLEMENTARY INFORMATION:

Title; Associated Form; and OMB Number: Military Spouse Priority Placement Program Self-Certification Checklist; DD Form 3145-4; OMB Control Number 0704-0667.

Needs and Uses: The Military Spouse Priority Placement Program Self-Certification Checklist must be completed by military spouses when applying for appropriated funds GS-15 and below (or equivalent positions in other pay systems) in the competitive

service or excepted service in order to receive priority consideration for competitive service and excepted service positions at DoD activities in the United States (U.S.), and in U.S. territories and possessions. The military spouses must provide evidence of their appointment eligibility, and evidence of marriage to a current active-duty military member of the U.S. Armed Forces (including the U.S. Coast Guard and full-time National Guard or Military Reservist) with a copy of the permanent-change-of-station orders. This collection will be used by gaining DoD activities to certify preference eligibility for the possible appointment of the military spouse into their vacancy.

Affected Public: Individuals or households.

Annual Burden Hours: 138,724 hours.

Number of Respondents: 69,362.

Responses per Respondent: 4.

Annual Responses: 277,448.

Average Burden per Response: 30 minutes.

Frequency: On occasion.

Dated: February 9, 2026.

Stephanie J. Bost,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2026-02733 Filed 2-10-26; 8:45 am]

BILLING CODE 6001-FR-P

DEPARTMENT OF DEFENSE

Office of the Secretary

[Docket ID: DOD-2026-OS-0200]

Proposed Collection; Comment Request

AGENCY: Office of the Under the Secretary of Defense for Personnel and Readiness OUSD(P&R)), Department of Defense (DoD).

ACTION: 60-Day information Collection Notice.

SUMMARY: In compliance with the *Paperwork Reduction Act of 1995*, the OUSD(P&R) announces a proposed public information collection and seeks public comment on the provisions thereof. Comments are invited on: whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; the accuracy of the agency's estimate of the burden of the proposed information collection; ways to enhance the quality, utility, and clarity of the information to be collected; and ways to minimize the burden of the information collection on respondents, including through the use

of automated collection techniques or other forms of information technology.

DATES: Consideration will be given to all comments received by April 13, 2026.

ADDRESSES: You may submit comments, identified by docket number and title, by any of the following methods:

Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.

Mail: Department of Defense, Office of the Director of Administration and Management, Privacy, Civil Liberties, and Transparency Directorate, Regulatory Division, 4800 Mark Center Drive, Mailbox #24, Suite 05F16, Alexandria, VA 22350-1700.

Instructions: All submissions received must include the agency name, docket number and title for this **Federal Register** document. 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.

Any associated form(s) for this collection may be located within this same electronic docket and downloaded for review/testing. Follow the instructions at <http://www.regulations.gov> for submitting comments. Please submit comments on any given form identified by docket number, form number, and title.

FOR FURTHER INFORMATION CONTACT: To request more information on this proposed information collection or to obtain a copy of the proposal and associated collection instruments, please write to the Department of Defense Education Activity (Executive Services Division), ATTN: Christina Suarez, 4800 Mark Center Drive, Alexandria, VA 22350 or call at (571) 372-1891.

SUPPLEMENTARY INFORMATION:

Title; Associated Form; and OMB Number: Student Registration, DoDEA Form 600, and Sure Start Medical/Dental Examination, DoDEA Form 1307; OMB Control Number 0704-0495.

Needs and Uses: This information collection requirement is necessary to obtain information on Department of War military and civilian sponsors and their dependents. The information obtained from sponsors is used to determine their dependents' enrollment eligibility to attend the Department of Defense Education Activity (DoDEA) schools. This includes determination of enrollment categories, whether tuition-free or tuition-paying, space-required or space-available. Information gathered

for students is used for age verification, class and transportation schedules, record attendance, absence and withdrawal, record and monitor student progress, grades, course and grade credits, educational services and placement, activities, student awards, special interest, and accomplishments.

Affected Public: Individuals or households.

Annual Burden Hours: 27,356.

Number of Respondents: 72,950.

Responses per Respondent: 1.

Annual Responses: 72,950.

Average Burden per Response: 22.5 minutes.

Frequency: Annual.

Student Registration: Respondents are sponsors of students enrolled in DoDEA Schools. All students are required to be registered to attend a DoDEA school.

Sure Start Medical/Dental Examination: Respondents are sponsors of students enrolled in the DoDEA Sure Start Program.

Dated: February 9, 2026.

Stephanie J. Bost,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2026-02732 Filed 2-10-26; 8:45 am]

BILLING CODE 6001-FR-P

DEPARTMENT OF DEFENSE

Department of the Navy

[Docket ID: USN-2026-HQ-0068]

Proposed Collection; Comment Request

AGENCY: Department of the Navy, Department of Defense (DoD).

ACTION: 60-Day information collection notice.

SUMMARY: In compliance with the *Paperwork Reduction Act of 1995*, Navy Personnel Command announces the proposed reinstatement of a previously approved public information collection and seeks public comment on the provisions thereof. Comments are invited on: whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; the accuracy of the agency's estimate of the burden of the proposed information collection; ways to enhance the quality, utility, and clarity of the information to be collected; and ways to minimize the burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology.

DATES: Consideration will be given to all comments received by April 13, 2026.

ADDRESSES: You may submit comments, identified by docket number and title, by any of the following methods:

Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.

Mail: Department of Defense, Office of the Director of Administration and Management, Privacy, Civil Liberties, and Transparency Directorate, Regulatory Division, 4800 Mark Center Drive, Mailbox #24, Suite 05F16, Alexandria, VA 22350-1700.

Instructions: All submissions received must include the agency name, docket number and title for this **Federal Register** document. 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: To request more information on this proposed information collection or to obtain a copy of the proposal and associated collection instruments, please write to OPNAV Forms/Information Collections Office (DNS-14), 2000 Navy Pentagon, Room 4E563, Washington, DC 20350-2000, ATTN: Ms. Ashley Alford, or call 703-614-7585.

SUPPLEMENTARY INFORMATION:

Title; Associated Form; and OMB Number: Navy Casualty Assistance Forms; OPNAV Form 1770/1, OPNAV Form 1770/2, OPNAV Form 1770/3; OMB Control Number 0703-0076.

Needs and Uses: The Department of the Navy must collect information to administer casualty assistance and survivor benefits for the Next of Kin of Sailors who are deceased, missing, or have suffered a serious illness or injury. This collection is necessary to comply with federal laws, such as 10 United States Code (U.S.C.) section 1475 (Death Gratuity) and 37 U.S.C. 452 (Travel Allowances), which direct the payment of benefits and other entitlements to eligible family members.

The information is collected by a Casualty Assistance Calls Officer using OPNAV Forms 1770/1, 1770/2, and 1770/3. It is used to process claims for the Death Gratuity, Service Members' Group Life Insurance, and the Survivor Benefit Plan. The data is also used to arrange travel for eligible family members to attend burial ceremonies or the bedside of an ill or injured Sailor, and, with consent, to provide contact

information to members of Congress for condolence purposes.

The respondents are the Next of Kin and designated beneficiaries of the affected Sailor. Without this information collection, the Navy would be unable to execute its legal mandate to pay critical benefits, arrange authorized travel, and provide other essential support to the families of Sailors during a time of need.

Affected Public: Individuals or households.

Annual Burden Hours: 1,300.

Number of Respondents: 800.

Responses per Respondent: 2.5.

Annual Responses: 2,000.

Average Burden per Response: 39 minutes.

Frequency: On occasion.

Dated: February 9, 2026.

Stephanie J. Bost,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2026-02730 Filed 2-10-26; 8:45 am]

BILLING CODE 6001-FR-P

DEPARTMENT OF DEFENSE

Department of the Navy

[Docket ID: USN-2026-HQ-0067]

Proposed Collection; Comment Request

AGENCY: Department of the Navy, Department of Defense (DoD).

ACTION: 60-Day information collection notice.

SUMMARY: In compliance with the *Paperwork Reduction Act of 1995*, Navy Personnel Command announces the proposed reinstatement of a previously approved public information collection and seeks public comment on the provisions thereof. Comments are invited on: whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; the accuracy of the agency's estimate of the burden of the proposed information collection; ways to enhance the quality, utility, and clarity of the information to be collected; and ways to minimize the burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology.

DATES: Consideration will be given to all comments received by April 13, 2026.

ADDRESSES: You may submit comments, identified by docket number and title, by any of the following methods:

Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.

Mail: Department of Defense, Office of the Director of Administration and Management, Privacy, Civil Liberties, and Transparency Directorate, Regulatory Division, 4800 Mark Center Drive, Mailbox #24, Suite 05F16, Alexandria, VA 22350-1700.

Instructions: All submissions received must include the agency name, docket number and title for this **Federal Register** document. 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: To request more information on this proposed information collection or to obtain a copy of the proposal and associated collection instruments, please write to OPNAV Forms/Information Collections Office (DNS-14), 2000 Navy Pentagon, Room 4E563, Washington, DC 20350-2000, ATTN: Ms. Ashley Alford, or call 703-614-7585.

SUPPLEMENTARY INFORMATION:

Title; Associated Form; and OMB Number: Burial at Sea Request and Checklist; OPNAV Forms 5360/1 and 5360/2; OMB Control Number 0703-0082.

Needs and Uses: The Department of the Navy must collect information to administer the Burial at Sea program, a time-honored tradition to honor the service of deceased veterans. This collection is necessary to confirm the deceased veteran's eligibility and to ensure the ceremony is conducted in compliance with environmental regulations, specifically 40 CFR 229.1.

The information is used in a two-part process. The OPNAV Form 5360/1, "Burial at Sea Request/Authorization," is used by the Person Authorized to Direct Disposition (PADD) to formally request the burial and provide the necessary documentation to verify the veteran's eligibility. For full casketed remains, the OPNAV Form 5360/2, "Burial at Sea Port Checklist," is used by the funeral home and the receiving Navy port to ensure the casket is properly prepared for safe transport, storage, and sinking, as required by law.

The respondents are the PADD and, in cases of casketed remains, the funeral home. Without this information collection, the Navy would be unable to verify eligibility, confirm the legal

authority of the requester, or ensure the safe and proper disposition of remains, thereby preventing it from carrying out this final honor for veterans.

Affected Public: Individuals or households; Businesses or other for-profit.

Burial at Sea Request/Authorization (OPNAV Form 5360/1)

Annual Burden Hours: 150.

Number of Respondents: 300.

Responses per Respondent: 1.

Annual Responses: 300.

Average Burden per Response: 30 minutes.

Burial at Sea Port Checklist (OPNAV Form 5360/2)

Annual Burden Hours: 30.

Number of Respondents: 20.

Responses per Respondent: 1.

Annual Responses: 20.

Average Burden per Response: 90 minutes.

Total

Annual Burden Hours: 180.

Number of Respondents: 320.

Annual Responses: 320.

Frequency: On occasion.

Dated: February 9, 2026.

Stephanie J. Bost,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2026-02731 Filed 2-10-26; 8:45 am]

BILLING CODE 6001-FR-P

DEPARTMENT OF DEFENSE

Department of the Navy

[Docket ID: USN-2026-HQ-0037]

Proposed Collection; Comment Request

AGENCY: Department of the Navy, Department of Defense (DoD).

ACTION: 60-Day information collection notice.

SUMMARY: In compliance with the *Paperwork Reduction Act of 1995*, the Department of the Navy (DoN) announces the revision of an approved public information collection and seeks public comment on the provisions thereof. Comments are invited on: 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; the accuracy of the agency's estimate of the burden of the proposed information collection; ways to enhance the quality, utility, and clarity of the information to be collected; and ways to minimize the

burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology.

DATES: Consideration will be given to all comments received by April 13, 2026

ADDRESSES: You may submit comments, identified by docket number and title, by any of the following methods:

Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.

Mail: Department of Defense, Office of the Director of Administration and Management, Privacy, Civil Liberties, and Transparency Directorate, Regulatory Division, 4800 Mark Center Drive, Mailbox #24, Suite 05F16, Alexandria, VA 22350-1700.

Instructions: All submissions received must include the agency name, docket number and title for this **Federal Register** document. 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: To request more information on this proposed information collection or to obtain a copy of the proposal and associated collection instruments, please write to the OPNAV Forms/Information Collections Office (DNS-14), 2000 Navy Pentagon, Room 4E563, Washington, DC 20350-2000, ATTN: Ms. Ashley Alford, or call 703-614-7585.

SUPPLEMENTARY INFORMATION:

Title; Associated Form; and OMB Number: Naval Reserve Officers Training Corps (NROTC) Programs Forms; OMB Control Number 0703-0026.

Needs and Uses: DON collects information to select the highest-quality candidates for the Naval Reserve Officers Training Corps (NROTC) program and its associated programs. This collection is necessary to assess an applicant's eligibility and qualifications for a commission in the U.S. Naval Reserve. The collection is authorized by various sections of Title 10, United States Code, and other federal regulations that govern the appointment of officers.

The information is used by selection boards to holistically evaluate an applicant's background, including their academic performance, leadership experience, physical fitness, and moral character. The application process is

primarily conducted online, where applicants provide information and request evaluations from school officials and teachers. The collection includes specialized forms for different program paths, such as tattoo screenings for Marine Corps applicants and specific agreements for SSMP participants. Data is also collected to manage participants in prerequisite programs like the NROTC, New Student Indoctrination and the NROTC Preparatory Program.

The respondents are prospective and current students applying to these programs, as well as the school officials and other adults providing evaluations on their behalf. Without this information, the ability of selection boards to effectively assess an applicant's potential for success as a future Naval officer would be severely limited, hindering the selection of the best-qualified candidates.

Affected Public: Individuals or households.

Annual Burden Hours: 70,000.

Number of Respondents: 14,000.

Responses per Respondent: 10.

Annual Responses: 140,000.

Average Burden per Response: 30 minutes.

Frequency: On occasion.

Dated: February 9, 2026.

Stephanie J. Bost,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2026-02729 Filed 2-10-26; 8:45 am]

BILLING CODE 6001-FR-P

DEPARTMENT OF DEFENSE

Department of the Navy

[Docket ID: USN-2026-HQ-0036]

Proposed Collection; Comment Request

AGENCY: Department of the Navy, Department of Defense (DoD).

ACTION: 60-Day information collection notice.

SUMMARY: In compliance with the *Paperwork Reduction Act of 1995*, the United States Marine Corps (USMC) announces the proposed extension of an approved public information collection and seeks public comment on the provisions thereof. Comments are invited on: 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; the accuracy of the agency's estimate of the burden of the proposed information collection; ways to enhance the quality, utility, and clarity of the information to

be collected; and ways to minimize the burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology.

DATES: Consideration will be given to all comments received by April 13, 2026.

ADDRESSES: You may submit comments, identified by docket number and title, by any of the following methods:

Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.

Mail: Department of Defense, Office of the Director of Administration and Management, Privacy, Civil Liberties, and Transparency Directorate, Regulatory Division, 4800 Mark Center Drive, Mailbox #24, Suite 05F16, Alexandria, VA 22350-1700.

Instructions: All submissions received must include the agency name, docket number and title for this **Federal Register** document. 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: To request more information on this proposed information collection or to obtain a copy of the proposal and associated collection instruments, please write to AR Division, Headquarters Marine Corps, 3000 Marine Corps., Pentagon Rm. 2B253, ATTN: Mr. Michael Moon, or call 703-571-7134.

SUPPLEMENTARY INFORMATION:

Title; Associated Form; and OMB Number: Camp Lejeune Notification Database; OMB Control Number 0712-0011.

Needs and Uses: The USMC is collecting this information to identify and notify individuals who may have been exposed to contaminated drinking water at Marine Corps Base Camp Lejeune between 1953 and 1987. This collection is necessary to comply with Section 315 of the 2008 Defense Authorization Act (Pub. L. 110-181), which mandates that the Secretary of the Navy notify all persons, including residents and workers, who were potentially affected.

The information is used to build and maintain the Camp Lejeune Notification Database. The Marine Corps uses this database to send an official notification letter and provide registrants with current information and research updates. The collected information may also be used by federal health agencies,

such as the Department of Veteran Affairs and the Agency for Toxic Substances and Diseases Registry, to assist with future health studies related to the exposure.

The respondents are former residents and workers of Camp Lejeune during the specified timeframe who voluntarily register for the database via the official website, email, or a toll-free number. Without this information collection, the Marine Corps would be unable to fulfill its legal obligation to directly contact and inform this population about their potential exposure and related health information.

Affected Public: Individuals or households.

Annual Burden Hours: 1,000.

Number of Respondents: 10,000.

Responses per Respondent: 1.

Annual Responses: 10,000.

Average Burden per Response: 6 minutes.

Frequency: On occasion.

Dated: February 9, 2026.

Stephanie J. Bost,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2026-02734 Filed 2-10-26; 8:45 am]

BILLING CODE 6001-FR-P

DEPARTMENT OF ENERGY

Environmental Management Site-Specific Advisory Board, Oak Ridge

AGENCY: Office of Environmental Management, Department of Energy.

ACTION: Notice of open meeting.

SUMMARY: This notice announces an in-person/virtual meeting of the Environmental Management Site-Specific Advisory Board (EM SSAB), Oak Ridge. The Federal Advisory Committee Act requires that public notice of this meeting be announced in the **Federal Register**.

DATES: Wednesday, March 11, 2026; 6–8 p.m. EST.

ADDRESSES: Department of Energy (DOE) Information Center, Office of Science and Technical Information, 1 Science.gov Way, Oak Ridge, Tennessee 37831. This meeting will be held in-person at the DOE Information Center and virtually. To receive the virtual access information, please send an email to: orssab@orem.doe.gov at least two days prior to the meeting.

FOR FURTHER INFORMATION CONTACT: Melyssa P. Noe, Deputy Designated Federal Officer, U.S. Department of Energy, Oak Ridge Office of Environmental Management (OREM), P.O. Box 4067, EM-94, Oak Ridge, TN

37831; Phone (865) 241-3315; or Email: Melyssa.Noe@orem.doe.gov.

SUPPLEMENTARY INFORMATION:

Purpose of the Board: The purpose of the Board is to provide advice and recommendations concerning the following EM site-specific issues: clean-up activities and environmental restoration; waste and nuclear materials management and disposition; excess facilities; future land use and long-term stewardship. The Board may also be asked to provide advice and recommendations on other EM program components. The Board also provides an avenue to fulfill public participation requirements outlined in the National Environmental Policy Act (NEPA), the Comprehensive Environmental Response, Compensation, and Liability Act (CERLA), the Resource Conservation and Recovery Act (RCRA), Federal Facility Agreements, Consent Orders, Consent Decrees and Settlement Agreements.

Tentative Agenda: (agenda topics are subject to change; please email orssab@orem.doe.gov for the most current agenda).

- OREM Presentation to the Board
- Discussion
- Public Comment Period
- Board Business

Public Participation: The meeting is open to the public and public comment can be given orally or in writing. Fifteen minutes are allocated during the meeting for public comment and those wishing to make oral comment will be given a minimum of two minutes to speak. Written comments received at least two working days prior to the meeting will be provided to the members and included in the meeting minutes. Written comments received within two working days after the meeting will be included in the minutes. For additional information on public comment and to submit written comment, please email orssab@orem.doe.gov. The EM SSAB, Oak Ridge, welcomes the attendance of the public at its meetings and will make every effort to accommodate persons with physical disabilities or special needs. If you require special accommodations due to a disability, please contact Melyssa P. Noe at least seven days in advance of the meeting.

Meeting conduct: The Designated Federal Officer is empowered to conduct the meeting in a fashion that will facilitate the orderly conduct of business. Questioning of board members or presenters by the public is not permitted.

Minutes: Minutes will be available at the following website: <https://>

www.energy.gov/orem/listings/oak-ridge-site-specific-advisory-board-meetings.

Signing Authority: This document of the Department of Energy was signed on February 6, 2026, by David Borak, Committee Management Officer, pursuant to delegated authority from the Secretary of Energy. That 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 February 6, 2026.

Jennifer Hartzell,

Alternate Federal Register Liaison Officer, U.S. Department of Energy.

[FR Doc. 2026-02655 Filed 2-10-26; 8:45 am]

BILLING CODE 6450-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. IC26-18-000]

Commission Information Collection Activities (Ferc-549B); Comment Request

AGENCY: Federal Energy Regulatory Commission.

ACTION: Notice of information collection and request for comments.

SUMMARY: In compliance with the requirements of the Paperwork Reduction Act of 1995, 44 U.S.C. 3506(c)(2)(A), the Federal Energy Regulatory Commission (Commission or FERC) is soliciting public comments on the previously approved information collection, FERC-549B (Gas Pipeline Rates: Annual Capacity Reports and Index of Customers).

DATES: Comments on the collections of information are due April 13, 2026.

ADDRESSES: Please submit comments via email to DataClearance@FERC.gov. You must specify the Docket No. (IC26-18-000) and the FERC Information Collection number (FERC-549B) in your email. If you are unable to file electronically, comments may be filed by USPS mail or by hand (including courier) delivery:

- Mail via U.S. Postal Service only, addressed to: Federal Energy Regulatory

Commission, Secretary of the Commission, 888 First Street NE, Washington, DC 20426.

• *Hand (including courier) delivery to:* Federal Energy Regulatory Commission, 12225 Wilkins Avenue, Rockville, MD 20852.

Docket: To view comments and issuances in this docket, please visit <https://elibrary.ferc.gov/eLibrary/search>.

FOR FURTHER INFORMATION CONTACT:

Kayla Williams may be reached by email at DataClearance@FERC.gov, or by telephone at (202)502-6468.

SUPPLEMENTARY INFORMATION:

Title: FERC-549B (Gas Pipeline Rates: Annual Capacity Reports and Index of Customers)

OMB Control No.: 1902-0169

Type of Request: Reinstatement of the FERC-549B information collection requirements with no changes to the reporting requirements.

Abstract: As described below, FERC-549B is comprised of information collection activities at 18 CFR 284.13(b)-(c) and 18 CFR 284.13(d)(1)-(d)(2). The purpose of these information collection activities is to provide reliable information about capacity availability and price that shippers need to make informed decisions in a competitive market, and to enable shippers and the Commission to monitor marketplace behavior to detect, and remedy anti-competitive behavior. The regulations at 18 CFR 284.13(b) and 18 CFR 284.13(d)(1) require each interstate pipeline to post information about firm and interruptible service on its internet website, and in downloadable file formats. The information required at 18 CFR 284.13(b) includes identification of the

shippers receiving service, and details about contracts for firm service, capacity release transactions,¹ and agreements for interruptible service. The pipeline must maintain access to that information for a period not less than 90 days from the date of posting. The regulation at 18 CFR 284.13(d)(1) requires equal and timely access to information relevant to the availability of all transportation services whenever capacity is scheduled. In addition, each interstate pipeline must provide information about the volumes of no-notice transportation² provided. This information collection activity enables shippers to release transportation and storage capacity to other shippers wanting to obtain capacity. The information results in reliable capacity information availability and price data that shippers need to make informed decisions in a competitive market and enable shippers and the Commission to monitor the market for potential abuses. The regulation at 18 CFR 284.13(c) requires each interstate pipeline to file with the Commission an index of all its firm transportation and storage customers under contract on the first business day of each calendar quarter. The index of customers also must be posted on the pipeline's own internet website, in downloadable file formats, and must be made available until the next quarterly index is posted. The

¹ As provided at 18 CFR 284.8, an interstate pipeline that offers transportation service on a firm basis must include in its tariff a mechanism for firm shippers to release firm capacity to the pipeline for resale.

² No-notice transportation allows for the reservation of pipeline capacity on demand without incurring any penalties.

requirements for the electronic index can be obtained at <https://www.ferc.gov/industries-data/natural-gas/industry-forms/form-549b-index-customers>. The regulation at 18 CFR 284.13(d)(2) requires an annual peak-day capacity report of all interstate pipelines, including natural gas storage-only companies. This report is generally a short report showing the peak day design capacity or the actual peak day capacity achieved, with a short explanation, if needed. The regulation provides that an interstate pipeline must make an annual filing by March 1 of each year showing the estimated peak day capacity of the pipeline's system, and the estimated storage capacity and maximum daily delivery capability of storage facilities under reasonably representative operating assumptions and the respective assignments of that capacity to the various firm services provided by the pipeline.

Types of Respondents: Respondents for this data collection are interstate pipelines and storage facilities subject to FERC regulation under the Natural Gas Act.

*Estimate of Annual Burden:*³ The Commission estimates the annual public reporting burden and cost for FERC-549B as shown in the following table: FERC-549B (Gas Pipeline Rates: Annual Capacity Reports and Index of Customers)

³ The Commission defines burden as the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal agency. For further explanation of what is included in the information collection burden, reference 5 Code of Federal Regulations 1320.3.

FERC-549B

[Gas pipeline rates: annual capacity reports and index of customers]

	Annual number of respondents	Annual number of responses per respondent	Total number of responses	Average burden & cost (\$) per response	Total annual burden & total annual cost (\$)	Cost per respondent (\$)
	(1)	(2)	(1) * (2) = (3)	(4) ⁴	(3) * (4) = (5)	(5) ÷ (1)
Capacity Reports under 284.13(b) & 284.13(d)(1).	168	6	1,008	145 hrs.; \$14,790	146,160 hrs.; \$14,908,320.	88,740
Peak Day Annual Capacity Report under 284.13(d)(2).	168	1	168	10 hrs.; \$1,020	1,680 hrs.; \$171,360.	1,020
Index of Customers under 284.13(c) ⁵ .	168	4	672	3 hrs.; \$306	2,016 hrs.; \$205,632.	1,224
Total .....	.....	1,848	.....	.....	149,856 hrs.; \$15,285,312.	.....

Comments: Comments are invited on: (1) whether the collection of information is necessary for the proper performance of the functions of the Commission, including whether the information will have practical utility; (2) the accuracy of the agency's estimate of the burden and cost of the collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility and clarity of the information collection; and (4) ways to minimize the burden of the collection of information on those who are to respond, including the use of automated collection techniques or other forms of information technology.

Dated: February 6, 2026.

Debbie-Anne A. Reese,
Secretary.

[FR Doc. 2026-02757 Filed 2-10-26; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 1403-000]

Yuba County Water Agency; Notice of Authorization for Continued Project Operation

The license for the Narrows Hydroelectric Project No. 1403 was issued for a period ending January 31, 2026.

⁴ The Commission staff estimates that the industry's hourly cost for wages plus benefits is similar to the Commission's \$102.00 FY 2026 average hourly cost for wages and benefits.

⁵ The burden per response is based on burden expended on similar forms and other similar FERC reporting requirements (e.g. capacity reports).

Section 15(a)(1) of the FPA, 16 U.S.C. 808(a)(1), requires the Commission, at the expiration of a license term, to issue from year-to-year an annual license to the then licensee(s) under the terms and conditions of the prior license until a new license is issued, or the project is otherwise disposed of as provided in section 15 or any other applicable section of the FPA. If the project's prior license waived the applicability of section 15 of the FPA, then, based on section 9(b) of the Administrative Procedure Act, 5 U.S.C. 558(c), and as set forth at 18 CFR 16.21(a), if the licensee of such project has filed an application for a subsequent license, the licensee may continue to operate the project in accordance with the terms and conditions of the license after the minor or minor part license expires, until the Commission acts on its application. If the licensee of such a project has not filed an application for a subsequent license, then it may be required, pursuant to 18 CFR 16.21(b), to continue project operations until the Commission issues someone else a license for the project or otherwise orders disposition of the project.

If the project is subject to section 15 of the FPA, notice is hereby given that an annual license for Project No. 1403 is issued to Yuba County Water Agency for a period effective February 1, 2026, through January 31, 2027, or until the issuance of a new license for the project or other disposition under the FPA, whichever comes first.

If issuance of a new license (or other disposition) does not take place on or before January 31, 2027, notice is hereby given that, pursuant to 18 CFR 16.18(c), an annual license under section 15(a)(1) of the FPA is renewed automatically

without further order or notice by the Commission, unless the Commission orders otherwise.

If the project is not subject to section 15 of the FPA, notice is hereby given that Yuba County Water Agency is authorized to continue operation of the Narrows Hydroelectric Project under the terms and conditions of the prior license until the issuance of a subsequent license for the project or other disposition under the FPA, whichever comes first.

For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, contact the Office of Public Participation at (202) 502-6595 or OPP@ferc.gov.

(Authority: 18 CFR 2.1)

Dated: February 6, 2026.

Debbie-Anne A. Reese,
Secretary.

[FR Doc. 2026-02756 Filed 2-10-26; 8:45 am]

BILLING CODE 6717-01-P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP26-75-000]

Texas Eastern Transmission, LP; Notice of Application and Establishing Intervention Deadline

Take notice that on January 23, 2026, Texas Eastern Transmission, LP (Texas Eastern), 915 N Eldridge Parkway, Suite 1100, Houston, Texas 77079, filed an application under section 7(c) of the Natural Gas Act (NGA) and Part 157 of the Commission's regulations requesting authorization for its Line 31 Expansion

Project (Project). The Project consists of: (i) extending Texas Eastern's existing 36-inch-diameter Line 31 by constructing 10.2 miles of new 36-inch-diameter pipeline loop (Line 31 Pipeline Loop) adjacent to Texas Eastern's Lines 14 and 18; (ii) constructing a new pipeline inspection gauge (pig) launcher/receiver, a receiver barrel, a mainline valve (MLV), and two new 30-inch-diameter crossover valves to connect the Line 31 Pipeline Loop to Texas Eastern's Lines 14 and 18; (iii) constructing a new 16-inch-diameter delivery lateral (Line 14-P Lateral) connecting to Lines 14 and 18 and extending southward for approximately 1.6 miles to a terminus at an interconnect with Entergy Mississippi, LLC's (Entergy) proposed Traceview Advanced Power Station (Traceview Power Station); (iv) constructing two sets of pig launcher/receivers for the Line 14-P Lateral; (v) constructing a new compressor station on the Line 14-P Lateral, including three new 1,500 horsepower (hp) natural gas-driven compressor units (Ridgeland Compressor Station); (vi) constructing a new delivery meter station on the Line 14-P Lateral at an interconnect with the proposed Traceview Power Station (Ridgeland M&R Station); and (vii) constructing other related appurtenances, all located in Madison County, Mississippi. The Project will provide up to an additional 125,000 dekatherms per day (Dth/d) of firm incremental natural gas transportation capacity on a segment of Texas Eastern's mainline pipeline system between its existing Kosciusko and Clinton Compressor Stations located in Attala County and Hinds County, Mississippi, respectively, and the Line 14-P Lateral to Entergy's proposed Traceview Power Station. Texas Eastern estimates the total cost of the Project to be \$131,000,000 and proposes a new incremental recourse rate to apply to the Project capacity, all as more fully set forth in the application which is on file with the Commission and open for public inspection.

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>). From the Commission'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 Commission'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.

Any questions regarding the proposed project should be directed to Brian Kim, Regulatory Manager, Texas Eastern Transmission, LP, P.O. Box 1642, Houston, Texas 77251, by phone at (713) 627-4059, or by email at brian.kim@enbridge.com.

Pursuant to section 157.9 of the Commission's Rules of Practice and Procedure,¹ within 90 days of this Notice the Commission staff will either: complete its environmental review and place it into the Commission's public record (eLibrary) for this proceeding; or issue a Notice of Schedule for Environmental Review. If a Notice of Schedule for Environmental Review is issued, it will indicate, among other milestones, the anticipated date for the Commission staff's issuance of the final environmental impact statement (FEIS) or environmental assessment (EA) for this proposal. The filing of an EA in the Commission's public record for this proceeding or the issuance of a Notice of Schedule for Environmental Review will serve to notify federal and state agencies of the timing for the completion of all necessary reviews, and the subsequent need to complete all federal authorizations within 90 days of the date of issuance of the Commission staff's FEIS or EA.

Public Participation

There are three ways to become involved in the Commission's review of this project: you can file comments on the project, you can protest the filing, and you can file a motion to intervene in the proceeding. There is no fee or cost for filing comments or intervening. The deadline for filing a motion to intervene is 5:00 p.m. Eastern Time on February 27, 2026. How to file protests, motions to intervene, and comments is explained below.

For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, contact the Office of Public Participation (OPP) at (202) 502-6595 or OPP@ferc.gov.

¹ 18 CFR 157.9.

Comments

Any person wishing to comment on the project may do so. Comments may include statements of support or objections, to the project as a whole or specific aspects of the project. The more specific your comments, the more useful they will be.

Protests

Pursuant to sections 157.10(a)(4)² and 385.211³ of the Commission's regulations under the NGA, any person⁴ may file a protest to the application. Protests must comply with the requirements specified in section 385.2001⁵ of the Commission's regulations. A protest may also serve as a motion to intervene so long as the protestor states it also seeks to be an intervenor.

To ensure that your comments or protests are timely and properly recorded, please submit your comments on or before 5:00 p.m. Eastern Time on February 27, 2026.

There are three methods you can use to submit your comments or protests to the Commission. In all instances, please reference the Project docket number CP26-75-000 in your submission.

(1) You may file your comments electronically by using the eComment feature, which is located on the Commission's website at www.ferc.gov under the link to Documents and Filings. Using eComment is an easy method for interested persons to submit brief, text-only comments on a project;

(2) You may file your comments or protests electronically by using the eFiling feature, which is located on the Commission's website (www.ferc.gov) under the link to Documents and Filings. With eFiling, you can provide comments in a variety of formats by attaching them as a file with your submission. New eFiling users must first create an account by clicking on "eRegister." You will be asked to select the type of filing you are making; first select "General" and then select "Comment on a Filing"; or

(3) You can file a paper copy of your comments or protests by mailing them to the following address below. Your written comments must reference the Project docket number (CP26-75-000).

To file via USPS: Debbie-Anne A. Reese, Secretary, Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426.

² 18 CFR 157.10(a)(4).

³ 18 CFR 385.211.

⁴ Persons include individuals, organizations, businesses, municipalities, and other entities. 18 CFR 385.102(d).

⁵ 18 CFR 385.2001.

To file via any other courier: Debbie-Anne A. Reese, Secretary, Federal Energy Regulatory Commission, 12225 Wilkins Avenue, Rockville, Maryland 20852.

The Commission encourages electronic filing of comments (options 1 and 2 above) and has eFiling staff available to assist you at (202) 502–8258 or FercOnlineSupport@ferc.gov.

Persons who comment on the environmental review of this project will be placed on the Commission's environmental mailing list, and will receive notification when the environmental documents (EA or EIS) are issued for this project and will be notified of meetings associated with the Commission's environmental review process.

The Commission considers all comments received about the project in determining the appropriate action to be taken. However, the filing of a comment alone will not serve to make the filer a party to the proceeding. To become a party, you must intervene in the proceeding. For instructions on how to intervene, see below.

Interventions

Any person, which includes individuals, organizations, businesses, municipalities, and other entities,⁶ has the option to file a motion to intervene in this proceeding. Only intervenors have the right to request rehearing of Commission orders issued in this proceeding and to subsequently challenge the Commission's orders in the U.S. Circuit Courts of Appeal.

To intervene, you must submit a motion to intervene to the Commission in accordance with Rule 214 of the Commission's Rules of Practice and Procedure⁷ and the regulations under the NGA⁸ by the intervention deadline for the project, which is 5:00 p.m. Eastern Time on February 27, 2026. As described further in Rule 214, your motion to intervene must state, to the extent known, your position regarding the proceeding, as well as your interest in the proceeding. For an individual, this could include your status as a landowner, ratepayer, resident of an impacted community, or recreationist. You do not need to have property directly impacted by the project in order to intervene. For more information about motions to intervene, refer to the FERC website at <https://www.ferc.gov/resources/guides/how-to/intervene.asp>.

There are two ways to submit your motion to intervene. In both instances,

please reference the Project docket number CP26–75–000 in your submission.

(1) You may file your motion to intervene by using the Commission's eFiling feature, which is located on the Commission's website (www.ferc.gov) under the link to Documents and Filings. New eFiling users must first create an account by clicking on "eRegister." You will be asked to select the type of filing you are making; first select "General" and then select "Intervention." The eFiling feature includes a document-less intervention option; for more information, visit <https://www.ferc.gov/docs-filing/efiling/document-less-intervention.pdf>; or

(2) You can file a paper copy of your motion to intervene, along with three copies, by mailing the documents to the address below. Your motion to intervene must reference the Project docket number CP26–75–000.

To file via USPS: Debbie-Anne A. Reese, Secretary, Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426.

To file via any other courier: Debbie-Anne A. Reese, Secretary, Federal Energy Regulatory Commission, 12225 Wilkins Avenue, Rockville, Maryland 20852.

The Commission encourages electronic filing of motions to intervene (option 1 above) and has eFiling staff available to assist you at (202) 502–8258 or FercOnlineSupport@ferc.gov.

Protests and motions to intervene must be served on the applicant either by mail at: Brian Kim, Regulatory Manager, Texas Eastern Transmission, LP, P.O. Box 1642, Houston, Texas 77251 or by email (with a link to the document) at brian.kim@enbridge.com. Any subsequent submissions by an intervenor must be served on the applicant and all other parties to the proceeding. Contact information for parties can be downloaded from the service list at the eService link on FERC Online. Service can be via email with a link to the document.

All timely, unopposed⁹ motions to intervene are automatically granted by operation of Rule 214(c)(1).¹⁰ Motions to intervene that are filed after the intervention deadline are untimely, and may be denied. Any late-filed motion to intervene must show good cause for being late and must explain why the time limitation should be waived and provide justification by reference to factors set forth in Rule 214(d) of the

Commission's Rules and Regulations.¹¹ A person obtaining party status will be placed on the service list maintained by the Secretary of the Commission and will receive copies (paper or electronic) of all documents filed by the applicant and by all other parties.

Tracking the Proceeding

Throughout the proceeding, additional information about the project will be available from OPP at (202) 502–6595 or on the FERC website at www.ferc.gov using the "eLibrary" link as described above. The eLibrary link also provides access to the texts of all formal documents issued by the Commission, such as orders, notices, and rulemakings.

In addition, the Commission offers a free service called eSubscription which allows you to keep track of all formal issuances and submittals in specific dockets. This can reduce the amount of time you spend researching proceedings by automatically providing you with notification of these filings, document summaries, and direct links to the documents. For more information and to register, go to www.ferc.gov/docs-filing/esubscription.asp.

Intervention Deadline: 5:00 p.m. Eastern Time on February 27, 2026.

(Authority: 18 CFR 2.1)

Dated: February 6, 2026.

Debbie-Anne A. Reese,
Secretary.

[FR Doc. 2026–02759 Filed 2–10–26; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 6904–000]

Battenkill Hydro Associates; Notice of Authorization for Continued Project Operation

The license for the Upper Greenwich Hydroelectric Project No. 6904 was issued for a period ending January 31, 2026.

Section 15(a)(1) of the FPA, 16 U.S.C. 808(a)(1), requires the Commission, at the expiration of a license term, to issue from year-to-year an annual license to the then licensee(s) under the terms and conditions of the prior license until a new license is issued, or the project is otherwise disposed of as provided in section 15 or any other applicable section of the FPA. If the project's prior license waived the applicability of

⁶ 18 CFR 385.102(d).

⁷ 18 CFR 385.214.

⁸ 18 CFR 157.10.

⁹ The applicant has 15 days from the submittal of a motion to intervene to file a written objection to the intervention.

¹⁰ 18 CFR 385.214(c)(1).

¹¹ 18 CFR 385.214(b)(3) and (d).

section 15 of the FPA, then, based on section 9(b) of the Administrative Procedure Act, 5 U.S.C. 558(c), and as set forth at 18 CFR 16.21(a), if the licensee of such project has filed an application for a subsequent license, the licensee may continue to operate the project in accordance with the terms and conditions of the license after the minor or minor part license expires, until the Commission acts on its application. If the licensee of such a project has not filed an application for a subsequent license, then it may be required, pursuant to 18 CFR 16.21(b), to continue project operations until the Commission issues someone else a license for the project or otherwise orders disposition of the project.

If the project is subject to section 15 of the FPA, notice is hereby given that an annual license for Project No. 6904 is issued to Battenkill Hydro Associates for a period effective February 1, 2026, through January 31, 2027, or until the issuance of a new license for the project or other disposition under the FPA, whichever comes first.

If issuance of a new license (or other disposition) does not take place on or before January 31, 2027, notice is hereby given that, pursuant to 18 CFR 16.18(c), an annual license under section 15(a)(1) of the FPA is renewed automatically without further order or notice by the Commission, unless the Commission orders otherwise.

If the project is not subject to section 15 of the FPA, notice is hereby given that Battenkill Hydro Associates is authorized to continue operation of the Upper Greenwich Hydroelectric Project under the terms and conditions of the prior license until the issuance of a subsequent license for the project or other disposition under the FPA, whichever comes first.

For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, contact the Office of Public Participation at (202) 502-6595 or OPP@ferc.gov.

(Authority: 18 CFR 2.1.)

Dated: February 6, 2026.

Debbie-Anne A. Reese,
Secretary.

[FR Doc. 2026-02754 Filed 2-10-26; 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: RP26-466-000.
Applicants: Northern Natural Gas Company.

Description: § 4(d) Rate Filing: 20260205 Negotiated Rate Filing to be effective 2/6/2026.

Filed Date: 2/5/26.

Accession Number: 20260205-5120.

Comment Date: 5 p.m. ET 2/17/26.

Docket Numbers: RP26-467-000.

Applicants: Gulf Run Transmission, LLC.

Description: § 4(d) Rate Filing: Housekeeping Filing on 2-6-26 to be effective 3/6/2026.

Filed Date: 2/6/26.

Accession Number: 20260206-5031.

Comment Date: 5 p.m. ET 2/18/26.

Docket Numbers: RP26-468-000.

Applicants: Florida Gas Transmission Company, LLC.

Description: § 4(d) Rate Filing: Housekeeping Filing on 2-6-26 to be effective 3/6/2026.

Filed Date: 2/6/26.

Accession Number: 20260206-5035.

Comment Date: 5 p.m. ET 2/18/26.

Docket Numbers: RP26-469-000.

Applicants: Florida Gas Transmission Company, LLC.

Description: § 4(d) Rate Filing: Housekeeping Filing on 2-6-26 (1-A) to be effective 3/6/2026.

Filed Date: 2/6/26.

Accession Number: 20260206-5037.

Comment Date: 5 p.m. ET 2/18/26.

Docket Numbers: RP26-470-000.

Applicants: Iroquois Gas Transmission System, L.P.

Description: § 4(d) Rate Filing: 2.6.26 Negotiated Rates—Macquarie Energy LLC H-4090-89 to be effective 2/6/2026.

Filed Date: 2/6/26.

Accession Number: 20260206-5048.

Comment Date: 5 p.m. ET 2/18/26.

Docket Numbers: RP26-471-000.

Applicants: National Fuel Gas Supply Corporation.

Description: § 4(d) Rate Filing: New PAL Rate Schedule to be effective 3/2/2026.

Filed Date: 2/6/26.

Accession Number: 20260206-5071.

Comment Date: 5 p.m. ET 2/18/26.

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: RP26-317-001.

Applicants: Midwestern Gas Transmission Company.

Description: Compliance filing: Compliance Filing for ROFR Provision Part 8, Section 16 to be effective 1/22/2026.

Filed Date: 2/5/26.

Accession Number: 20260205-5121.

Comment Date: 5 p.m. ET 2/17/26.

Any person desiring to protest in any of 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/fercensearch.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.

For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, contact the Office of Public Participation at (202) 502-6595 or OPP@ferc.gov.

Dated: February 6, 2026.

Carlos D. Clay,

Deputy Secretary.

[FR Doc. 2026-02738 Filed 2-10-26; 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 exempt wholesale generator filings:

Docket Numbers: EG26-147-000.

Applicants: Mayhew Lake Energy Storage, LLC.

Description: Mayhew Lake Energy Storage, LLC submits Notice of Self-

Certification of Exempt Wholesale Generator Status.

Filed Date: 2/6/26.

Accession Number: 20260206–5094.

Comment Date: 5 p.m. ET 2/27/26.

Take notice that the Commission received the following Complaints and Compliance filings in EL Dockets:

Docket Numbers: EL26–44–000; ER25–2145–000.

Applicants: American Transmission Systems, Incorporated, American Municipal Power, Inc. v. American Transmission Systems, Inc.

Description: Formal Challenge and Complaint of American Municipal Power, Inc. v. American Transmission Systems, Inc.

Filed Date: 2/5/26.

Accession Number: 20260205–5122.

Comment Date: 5 p.m. ET 2/25/26.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER14–199–007.

Applicants: Lakewood Cogeneration, L.P.

Description: Compliance filing: Informational Filing Pursuant to Schedule 2 of the PJM OATT to be effective N/A.

Filed Date: 2/6/26.

Accession Number: 20260206–5120.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER14–714–005.

Applicants: Essential Power Rock Springs, LLC.

Description: Compliance filing: Informational Filing Pursuant to Schedule 2 of the PJM OATT to be effective N/A.

Filed Date: 2/6/26.

Accession Number: 20260206–5108.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER14–715–005.

Applicants: Essential Power OPP, LLC.

Description: Compliance filing: Informational Filing Pursuant to Schedule 2 of the PJM OATT to be effective N/A.

Filed Date: 2/6/26.

Accession Number: 20260206–5114.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER18–2002–005.

Applicants: Essential Power Rock Springs, LLC.

Description: Compliance filing: Informational Filing Pursuant to Schedule 2 of the PJM OATT to be effective N/A.

Filed Date: 2/6/26.

Accession Number: 20260206–5112.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER20–2452–015.

Applicants: Hamilton Liberty LLC.

Description: Compliance filing: Informational Filing Pursuant to

Schedule 2 of the PJM OATT to be effective N/A.

Filed Date: 2/6/26.

Accession Number: 20260206–5129.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER20–2453–016.

Applicants: Hamilton Patriot LLC.

Description: Compliance filing: Informational Filing Pursuant to Schedule 2 of the PJM OATT to be effective N/A.

Filed Date: 2/6/26.

Accession Number: 20260206–5143.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER22–2359–005.

Applicants: PJM Interconnection, L.L.C.

Description: Compliance filing: PJM Clean-Up Filing re Order 881 to be effective 3/4/2026.

Filed Date: 2/5/26.

Accession Number: 20260205–5146.

Comment Date: 5 p.m. ET 2/26/26.

Docket Numbers: ER25–2680–001.

Applicants: New York Independent System Operator, Inc.

Description: Compliance filing: NYISO Compliance Errata: Order No. 676–K NAESB/WEQ to be effective 2/27/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5159.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–247–001.

Applicants: Southwest Power Pool, Inc.

Description: Compliance filing: Compliance Filing—High Impact Large Load Processes and Generation Assessment to be effective 1/15/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5017.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–766–001.

Applicants: Pelicans Jaw Solar, LLC.

Description: Tariff Amendment: Response to Request for Add'l Information and Req. for Shortened Comment Period to be effective 2/14/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5088.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1277–000.

Applicants: Southwest Power Pool, Inc.

Description: § 205(d) Rate Filing: 4266R1 Beeline Solar Energy GIA to be effective 1/26/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5004.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1278–000.

Applicants: American Transmission Systems, Incorporated.

Description: § 205(d) Rate Filing: ATSI submits a Construction Agmt—SA No. 7264 to be effective 4/8/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5006.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1279–000.

Applicants: Union Electric Company, Midcontinent Independent System Operator, Inc.

Description: § 205(d) Rate Filing: Union Electric Company submits tariff filing per 35.13(a)(2)(iii): 2026–02–06_SA 4177 Union Electric-CEC 1st Rev TIA to be effective 4/8/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5027.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1280–000.

Applicants: American Transmission Company LLC, Midcontinent Independent System Operator, Inc.

Description: § 205(d) Rate Filing: American Transmission Company LLC submits tariff filing per 35.13(a)(2)(iii): 2026–02–06_SA 4333 ATC-Degas 2nd Rev ESA to be effective 2/7/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5036.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1281–000.

Applicants: Southwestern Public Service Company.

Description: § 205(d) Rate Filing: 2026.02.06—Removal of 2026 Generation to be effective 4/1/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5040.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1282–000.

Applicants: Tri-State Generation and Transmission Association, Inc.

Description: § 205(d) Rate Filing: Initial Filing of Service Agreement FERC No. 932 to be effective 1/7/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5043.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1283–000.

Applicants: PJM Interconnection, L.L.C.

Description: § 205(d) Rate Filing: Original WMPA, Service Agreement No. 7820; AF2–296 to be effective 1/7/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5050.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1284–000.

Applicants: PJM Interconnection, L.L.C.

Description: § 205(d) Rate Filing: Amendment to ISA, Service Agreement No. 3325; Queue No. X1–038 to be effective 1/23/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5052.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1285–000.

Applicants: PJM Interconnection, L.L.C.

Description: § 205(d) Rate Filing: Rev'd WMPA Service Agreement SA No. 7261; Project Identifier No. AF1–238/AF1–239 to be effective 1/7/2026.
Filed Date: 2/6/26.

Accession Number: 20260206–5057.
Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1286–000.

Applicants: Southern California Edison Company.

Description: Tariff Amendment: Terminate City of Verson RS 531 536 to be effective 2/7/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5065.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1287–000.

Applicants: Southwest Power Pool, Inc.

Description: § 205(d) Rate Filing: Revisions to Attachment AA for RTO Expansion to be effective 4/8/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5083.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1288–000.

Applicants: Midcontinent Independent System Operator, Inc., Ameren Illinois Company.

Description: § 205(d) Rate Filing: Ameren Illinois Company submits tariff filing per 35.13(a)(2)(iii): 2026–02–06 – SA 4673 Ameren Illinois-PPI Reimbursement Agreement to be effective 2/7/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5087.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1289–000.

Applicants: Midcontinent Independent System Operator, Inc., American Transmission Company LLC.

Description: § 205(d) Rate Filing: American Transmission Company LLC submits tariff filing per 35.13(a)(2)(iii): 2026–02–06 SA 4556 ATC-Vantage 1st Rev PAA to be effective 2/7/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5091.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1290–000.

Applicants: PJM Interconnection, L.L.C.

Description: § 205(d) Rate Filing: Original GIA, SA No. 7825; Project Identifier No. AG1–433 to be effective 1/9/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5154.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1291–000.

Applicants: Western Interconnect LLC.

Description: § 205(d) Rate Filing: Amendments to TSA and LGIA Agreements to be effective 2/7/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5155.

Comment Date: 5 p.m. ET 2/27/26.

Docket Numbers: ER26–1292–000.

Applicants: PJM Interconnection, L.L.C.

Description: § 205(d) Rate Filing: Original GIA Service Agreement No. 7822; Project Identifier No. AG1–354 to be effective 1/8/2026.

Filed Date: 2/6/26.

Accession Number: 20260206–5163.

Comment Date: 5 p.m. ET 2/27/26.

The filings are accessible in the Commission's eLibrary system (<https://elibrary.ferc.gov/idmws/search/fercensearch.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.

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: February 6, 2026.

Carlos D. Clay,

Deputy Secretary.

[FR Doc. 2026–02737 Filed 2–10–26; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP26–77–000]

Southern Star Central Gas Pipeline, Inc.; Notice of Request Under Blanket Authorization and Establishing Intervention and Protest Deadline

Take notice that on January 27, 2026, Southern Star Central Gas Pipeline, Inc. (Southern Star), 4700 State Route 56, Owensboro, Kentucky 42301, filed in the above referenced docket, a prior notice request pursuant to sections 157.205, 157.208(b) and 157.213(c) of the Commission's regulations under the

Natural Gas Act (NGA), and Southern Star's blanket certificate issued in Docket No. CP82–479–000, for authorization to drill a vertical replacement well, Well No. 222, install a lateral pipeline connecting the well to existing infrastructure, and install associated appurtenant facilities at the existing Webb Storage Field in Grant County, Oklahoma (Replacement Well No. 222 at Webb Storage Field and Lateral Project). The project will allow Southern Star to maintain the safe, reliable, and compliant operation of the Webb Storage Field. The estimated cost for the project is \$8,500,000, all as more fully set forth in the request which is on file with the Commission and open to public inspection.

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>). From the Commission'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 Commission'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.

Any questions concerning this request should be directed to Jennifer Matthews, Manager, Regulatory, Southern Star Central Gas Pipeline, Inc., 4700 State Route 56, Owensboro, Kentucky 42301, by phone at (270) 316–2972, or by email at jennifer.matthews@southernstar.com.

Public Participation

There are three ways to become involved in the Commission's review of this project: you can file a protest to the project, you can file a motion to intervene in the proceeding, and you can file comments on the project. There is no fee or cost for filing protests, motions to intervene, or comments. The deadline for filing protests, motions to intervene, and comments is 5:00 p.m. Eastern Time on April 7, 2026. How to file protests, motions to intervene, and comments is explained below.

For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, contact the Office of Public Participation (OPP) at (202) 502-6595 or OPP@ferc.gov.

Protests

Pursuant to section 157.205 of the Commission's regulations under the NGA,¹ any person² or the Commission's staff may file a protest to the request. If no protest is filed within the time allowed or if a protest is filed and then withdrawn within 30 days after the allowed time for filing a protest, the proposed activity shall be deemed to be authorized effective the day after the time allowed for protest. If a protest is filed and not withdrawn within 30 days after the time allowed for filing a protest, the instant request for authorization will be considered by the Commission.

Protests must comply with the requirements specified in section 157.205(e) of the Commission's regulations,³ and must be submitted by the protest deadline, which is 5:00 p.m. Eastern Time on April 7, 2026. A protest may also serve as a motion to intervene so long as the protestor states it also seeks to be an intervenor.

Interventions

Any person has the option to file a motion to intervene in this proceeding. Only intervenors have the right to request rehearing of Commission orders issued in this proceeding and to subsequently challenge the Commission's orders in the U.S. Circuit Courts of Appeal.

To intervene, you must submit a motion to intervene to the Commission in accordance with Rule 214 of the Commission's Rules of Practice and Procedure⁴ and the regulations under the NGA⁵ by the intervention deadline for the project, which is 5:00 p.m. Eastern Time on April 7, 2026. As described further in Rule 214, your motion to intervene must state, to the extent known, your position regarding the proceeding, as well as your interest in the proceeding. For an individual, this could include your status as a landowner, ratepayer, resident of an impacted community, or recreationist. You do not need to have property

directly impacted by the project in order to intervene. For more information about motions to intervene, refer to the FERC website at <https://www.ferc.gov/resources/guides/how-to/intervene.asp>.

All timely, unopposed motions to intervene are automatically granted by operation of Rule 214(c)(1). Motions to intervene that are filed after the intervention deadline are untimely and may be denied. Any late-filed motion to intervene must show good cause for being late and must explain why the time limitation should be waived and provide justification by reference to factors set forth in Rule 214(d) of the Commission's Rules and Regulations. A person obtaining party status will be placed on the service list maintained by the Secretary of the Commission and will receive copies (paper or electronic) of all documents filed by the applicant and by all other parties.

Comments

Any person wishing to comment on the project may do so. The Commission considers all comments received about the project in determining the appropriate action to be taken. To ensure that your comments are timely and properly recorded, please submit your comments on or before 5:00 p.m. Eastern Time on April 7, 2026. The filing of a comment alone will not serve to make the filer a party to the proceeding. To become a party, you must intervene in the proceeding.

How To File Protests, Interventions, and Comments

There are two ways to submit protests, motions to intervene, and comments. In both instances, please reference the Project docket number CP26-77-000 in your submission.

(1) You may file your protest, motion to intervene, and comments by using the Commission's eFiling feature, which is located on the Commission's website (www.ferc.gov) under the link to Documents and Filings. New eFiling users must first create an account by clicking on "eRegister." You will be asked to select the type of filing you are making; first select "General" and then select "Protest", "Intervention", or "Comment on a Filing"; or⁶

(2) You can file a paper copy of your submission by mailing it to the address

below. Your submission must reference the Project docket number CP26-77-000.

To file via USPS: Debbie-Anne A. Reese, Secretary, Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426.

To file via any other method: Debbie-Anne A. Reese, Secretary, Federal Energy Regulatory Commission, 12225 Wilkins Avenue, Rockville, Maryland 20852.

The Commission encourages electronic filing of submissions (option 1 above) and has eFiling staff available to assist you at (202) 502-8258 or FercOnlineSupport@ferc.gov.

Protests and motions to intervene must be served on the applicant either by mail at: Jennifer Matthews, Manager, Regulatory, Southern Star Central Gas Pipeline, Inc., 4700 State Route 56, Owensboro, Kentucky 42301, or by email (with a link to the document) at jennifer.matthews@southernstar.com. Any subsequent submissions by an intervenor must be served on the applicant and all other parties to the proceeding. Contact information for parties can be downloaded from the service list at the eService link on FERC Online.

Tracking the Proceeding

Throughout the proceeding, additional information about the project will be available from OPP at (202) 502-6595 or on the FERC website at www.ferc.gov using the "eLibrary" link as described above. The eLibrary link also provides access to the texts of all formal documents issued by the Commission, such as orders, notices, and rulemakings.

In addition, the Commission offers a free service called eSubscription which allows you to keep track of all formal issuances and submittals in specific dockets. This can reduce the amount of time you spend researching proceedings by automatically providing you with notification of these filings, document summaries, and direct links to the documents. For more information and to register, go to www.ferc.gov/docs-filing/esubscription.asp.

(Authority: 18 CFR 2.1)

Dated: February 6, 2026.

Debbie-Anne A. Reese,
Secretary.

[FR Doc. 2026-02758 Filed 2-10-26; 8:45 am]

BILLING CODE 6717-01-P

¹ 18 CFR 157.205.

² Persons include individuals, organizations, businesses, municipalities, and other entities. 18 CFR 385.102(d).

³ 18 CFR 157.205(e).

⁴ 18 CFR 385.214.

⁵ 18 CFR 157.10.

⁶ Additionally, you may file your comments electronically by using the eComment feature, which is located on the Commission's website at www.ferc.gov under the link to Documents and Filings. Using eComment is an easy method for interested persons to submit brief, text-only comments on a project.

DEPARTMENT OF ENERGY

Federal Energy Regulatory
Commission

[Project No. 5737–032]

**Santa Clara Valley Water District;
Notice of Availability of the Final
Environmental Impact Statement for
Dam Retrofit and Surrender of the
Anderson Dam Project**

In accordance with the National Environmental Policy Act of 1969 (NEPA) and the Federal Energy Regulatory Commission's (Commission) regulations, 18 CFR part 380, Commission staff reviewed the Santa Clara Valley Water District's (exemptee) application to retrofit the Anderson Dam and to surrender the exemption for the Anderson Dam Project No. 5737 (Project) and has prepared a final environmental impact statement (EIS).¹ The Anderson Dam project consists of: a 240-foot-high, 1,385-foot-long dam; a reservoir with a maximum surface area of 1,240 acres and storage capacity of 89,278 acre-feet at a spillway elevation of 627.8 feet (North American Vertical Datum 1988); a 54-inch diameter, 2,800-foot-long penstock; a powerhouse with a total installed capacity of 800 kilowatts; and a 100-foot-long transmission line connecting the project to the electrical grid. The project is located on Coyote Creek in Santa Clara County, California, and does not occupy any federal lands.

The final EIS contains staff evaluations of the applicant's proposal and the alternatives to the proposed action. The final EIS documents the views of governmental agencies, non-governmental organizations, affected Native-American Tribes, the public, the applicant, and Commission staff.

In addition to publishing the full text of this document in the **Federal Register**, the Commission provides all interested persons with an opportunity to view and/or print the final EIS via the internet through the Commission's Home Page (<http://www.ferc.gov/>), using the "eLibrary" link. Enter the docket number (P–5737) in the docket number field to access the document. For assistance, contact FERC Online Support at FERCOnlineSupport@ferc.gov, or toll-free at (866) 208–3676, or for TTY, (202) 502–8659.

You may also register online at <https://ferconline.ferc.gov/FEROnline.aspx> to be notified via email of new filings and issuances

related to this or other pending projects. For assistance, contact FERC Online Support.

For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, contact the Office of Public Participation at (202) 502–6595 or OPP@ferc.gov.

For further information, contact Holly Frank at (202) 502–6833 or holly.frank@ferc.gov.

(Authority: 18 CFR 2.1)

Dated: February 6, 2026.

Debbie-Anne A. Reese,
Secretary.

[FR Doc. 2026–02755 Filed 2–10–26; 8:45 am]

BILLING CODE 6717–01–P

**ENVIRONMENTAL PROTECTION
AGENCY**

[EPA–HQ–OPP–2025–1906; FRL–12954–02–OCSPP]

**Agency Information Collection
Activities; Proposed New Collection
and Request for Comment; Process To
Become an EPA Qualified
Conservation Program (QCP) and
Qualified External Party (QEP); Draft
Pesticide Registration Notice;
Extension of Comment Period**

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice; extension of comment period.

SUMMARY: EPA issued a notice in the **Federal Register** on January 5, 2026, concerning a proposed new collection and draft Pesticide Registration (PR) Notice. This document extends the comment period for 30 days, from March 2, 2026, to April 6, 2026. EPA is extending the comment period to allow interested parties additional time to thoroughly review and analyze how this notice may impact them.

DATES: Comments, identified by docket identification (ID) number EPA–HQ–OPP–2025–1906, must be received on or before April 6, 2026.

ADDRESSES: Follow the detailed instructions provided under **ADDRESSES** in the **Federal Register** document of January 5, 2026 (91 FR 273 (FRL–12954–01)).

FOR FURTHER INFORMATION CONTACT: Natalie Bray, Pesticide Registration Division (Mail Code 7505T), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460–0001; telephone number: (202) 566–2222; email address: Conservation_Programs@epa.gov.

SUPPLEMENTARY INFORMATION: This document extends the comment period for an action published on January 5, 2026. Comments for notice FRL 12954–01–OCSPP (91 FR 273, January 5, 2026) now must be received on or by April 6, 2026. That document seeks to inform interested parties of (1) the proposed process of becoming an EPA QCP or EPA QEP and to solicit public comment on the proposed process, and (2) communicate the estimated paperwork burden that this process would create for the public and to solicit public comment on these estimates pursuant to the Paperwork Reduction Act.

To submit comments, or access the docket, please follow the detailed instructions provided under **ADDRESSES** in the **Federal Register** document of January 5, 2026. If you have questions, consult the person listed under **FOR FURTHER INFORMATION CONTACT**.

Authority: 44 U.S.C. 3501 *et seq.*

Dated: February 6, 2026.

Douglas M. Troutman,
*Assistant Administrator, Office of Chemical
Safety and Pollution Prevention.*

[FR Doc. 2026–02739 Filed 2–10–26; 8:45 am]

BILLING CODE 6560–50–P

**ENVIRONMENTAL PROTECTION
AGENCY**

[EPA–HQ–OPP–2025–2863; FRL–5992–04–OCSPP]

**Pesticides; Draft Guidance for
Pesticide Registrants on Notifications,
Non-Notifications, and Minor
Formulation Amendments; Extension
of Comment Period**

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice; extension of comment period.

SUMMARY: EPA issued a notice in the **Federal Register** of January 5, 2026, concerning a draft Pesticide Registration Notice (PR Notice) entitled "Pesticide Registration (PR) Notice 2026–NEW: Notifications, Non-Notifications, and Minor Formulation Amendments." The draft PR Notice adds several new minor modifications, moves some existing minor modifications to a more streamlined process (*e.g.*, from notification to non-notification), and provides more details in the minor modification and process descriptions to enhance clarity. EPA received a request to extend the comment period by 30 days due to the scope and significance of the proposed changes and is granting the request. The additional time will allow impacted

¹ The unique identification number for documents relating to this environmental review is EISX–019–20–000–1727256582.

stakeholders to provide robust and meaningful comments.

DATES: The comment period for the document published on January 5, 2026, at 91 FR 271 (FRL–5992–03–OCSPP) is extended. Comments must be received on or before March 23, 2026.

ADDRESSES: Follow the detailed instructions provided under **ADDRESSES** in the **Federal Register** document of January 5, 2026 (91 FR 271 (FRL–5992–03–OCSPP)).

FOR FURTHER INFORMATION CONTACT: Alexandra Boukedes, Registration Division (7505T), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460–0001; telephone number: (202) 566–1511; email address: boukedes.alexandra@epa.gov.

SUPPLEMENTARY INFORMATION: To give stakeholders most likely impacted by the proposed changes additional time to review materials and provide meaningful comments, this document extends the comment period established in the **Federal Register** document of January 5, 2026, at 91 FR 271 (FRL–5992–03–OCSPP) for 30 days, from February 19, 2026, to March 23, 2026. More information on the action can be found in the **Federal Register** of January 5, 2026.

To submit comments or access the docket, please follow the instructions provided under **ADDRESSES**. If you have questions, consult the person listed under **FOR FURTHER INFORMATION CONTACT**.

Authority: 7 U.S.C. 136 *et seq.*

Dated: February 6, 2026.

Douglas M. Troutman,

Assistant Administrator, Office of Chemical Safety and Pollution Prevention.

[FR Doc. 2026–02659 Filed 2–10–26; 8:45 am]

BILLING CODE 6560–50–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, Benjamin W. McDonough, Deputy Secretary of the Board, 20th Street and Constitution Avenue NW, Washington, DC 20551–0001, not later than February 26, 2026.

A. Federal Reserve Bank of Atlanta (Erien O. Terry, Assistant Vice President) 1000 Peachtree Street NE, Atlanta, Georgia 30309. Comments can also be sent electronically to Applications.Comments@atl.frb.org:

1. *Harry Phillips Smith 2020 Trust, Raines Smith Bettis and John L. Leach, III, as co-trustees, Robert L. Leach, and Adelaide S. Satterfield, all of Albany, Georgia;* to form the Smith Family Control Group, a group acting in concert, to retain voting shares of Dawson Bancshares, Inc., and thereby indirectly retain voting shares of Bank of Dawson, both of Dawson, Georgia.

Board of Governors of the Federal Reserve System.

Michele Taylor Fennell,

Associate Secretary of the Board.

[FR Doc. 2026–02740 Filed 2–10–26; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–26–1313]

Agency Forms Undergoing Paperwork Reduction Act Review

In accordance with the Paperwork Reduction Act of 1995, the Centers for Disease Control and Prevention (CDC)

has submitted the information collection request (ICR) titled “Distribution of Traceable Opioid Material Kits (TOM Kits) across U.S. and International Laboratories” to the Office of Management and Budget (OMB) for review and approval. CDC previously published a “Proposed Data Collection Submitted for Public Comment and Recommendations” notice on September 4, 2025 to obtain comments from the public and affected agencies. CDC received one comment related to the previous notice. This notice serves to allow an additional 30 days for public and affected agency comments.

CDC will accept all comments for this proposed information collection project. The Office of Management and Budget is particularly interested in comments that:

(a) 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;

(b) Evaluate the accuracy of the agencies 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;

(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; and

(e) Assess information collection costs.

To request additional information on the proposed project or to obtain a copy of the information collection plan and instruments, call (404) 639–7570. 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. Direct written comments and/or suggestions regarding the items contained in this notice to the Attention: CDC Desk Officer, Office of Management and Budget, 725 17th Street NW, Washington, DC 20503 or by fax to (202) 395–5806. Provide written comments within 30 days of notice publication.

Proposed Project

Distribution of Traceable Opioid Material Kits (TOM Kits) across U.S. and International Laboratories (OMB Control No. 0920–1313, Exp. 3/31/2026)—Extension—National Center for Environmental Health (NCEH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

In response to the Health and Human Services (HHS) Acting Secretary's 2017 and ongoing public health emergency declaration on opioids, the Centers for Disease Control and Prevention (CDC) has led the development of Traceable Opioid Material Kits (TOM Kits) to support detection of emerging opioids. CDC maintains the contents of the TOM Kits based on new needs identified, in part, through the U.S. Drug Enforcement Agency (DEA) Emerging Threat Reports. For example, the DEA 2018 data indicated that fentanyl and fentanyl-related compounds accounted for approximately 76% of their opioid identifications. The CDC is requesting a three-year Paperwork Reduction Act (PRA) clearance for an Extension ICR titled "Distribution of Traceable Opioid Material Kits (TOM Kits) across U.S. and International Laboratories" (OMB

Control No. 0920–1313; Expiration 03/31/2026).

CDC will continue to distribute TOM Kits through a single vendor, which will manufacture the test kits. The CDC vendor will distribute these kits to domestic laboratories, as previously approved under CDC contract. The CDC vendor will distribute these test kits to international laboratories in partnership with the United Nations and under a separate contract with the International Narcotics Control Board (INCB) (hereafter, collectively coined the "UN"). The UN, and not the CDC, is paying the vendor to ship the kits to international requesters and kits will only be shipped internationally if excess kits are identified that are not required domestically.

TOM Kits are not intended for diagnostic use and are free to domestic and international laboratories in the public, private, clinical, law enforcement, research, and public health domains. The CDC vendor collects both application and laboratory information on domestic laboratories when they apply for test kits. International laboratories that apply for test kits through the UN will be directed to complete and share their laboratory information with the vendor, but not with the CDC. This information is used

to prioritize which laboratories will receive kits when quantities are limited. The brief web-based surveys will allow the CDC to: (1) determine what service the recipient laboratory performs; and (2) equitably distribute test kits based on the analysis techniques and matrices used by the recipient laboratory.

Since project inception, over 4,000 TOM Kits have been distributed to laboratories to improve their drug testing capabilities. Based on this experience, we anticipate that up to 600 domestic laboratories will request test kits per year. Given that each application will take six minutes, the annual time burden for 600 domestic laboratories will be 60 hours. CDC estimates an additional 20 annual burden hours for the international distribution of test kits. We estimate that 300 international partner laboratories will apply for test kits per year with the UN, which in turn will direct these laboratories to complete the brief four-minute survey on laboratory information on the CDC vendor website.

CDC estimates a total time burden of 80 hours per year and a total number of 900 responses per year which is the same as previously approved. There is no cost to the respondents other than their time to participate.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
US Federal Laboratories	Test Kit Application and Questions for US Laboratories (online).	200	1	6/60
State, Local, and Tribal Government Laboratories.	Test Kit Application and Questions for US Laboratories (online).	200	1	6/60
Private or Not-for-Profit US Institutions	Test Kit Application and Questions for US Laboratories (online).	200	1	6/60
International Laboratories	Test Kit Questions for International Laboratories.	300	1	4/60

Jeffrey M. Zirger,

Lead, Information Collection Review Office,
Office of Public Health Ethics and
Regulations, Office of Science, Centers for
Disease Control and Prevention.

[FR Doc. 2026–02652 Filed 2–10–26; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Disease Control and Prevention**

[60Day–26–1396; Docket No. CDC–2026–0166]

Proposed Data Collection Submitted for Public Comment and Recommendations

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice with comment period.

SUMMARY: The Centers for Disease Control and Prevention (CDC), as part of

its continuing effort to reduce public burden and maximize the utility of government information, invites the general public and other federal agencies the opportunity to comment on a proposed and/or continuing information collection, as required by the Paperwork Reduction Act of 1995. This notice invites comment on a continuing information collection project titled School-Based Active Surveillance (SBAS) of Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) Among Schoolchildren. This project will expand on the work from previous phases for active surveillance of chronic conditions, including ME/CFS and other

infection associated chronic conditions and illnesses (IACCs), using an electronic data collection platform.

DATES: CDC must receive written comments on or before April 13, 2026.

ADDRESSES: You may submit comments, identified by Docket No. CDC–2026–0166 by either of the following methods:

- *Federal eRulemaking Portal:* www.regulations.gov. Follow the instructions for submitting comments.
- *Mail:* Jeffrey M. Zirger, Information Collection Review Office, Centers for Disease Control and Prevention, 1600 Clifton Road NE, MS H21–8, Atlanta, Georgia 30329.

Instructions: All submissions received must include the agency name and Docket Number. CDC will post, without change, all relevant comments to www.regulations.gov.

Please note: Submit all comments through the Federal eRulemaking portal (www.regulations.gov) or by U.S. mail to the address listed above.

FOR FURTHER INFORMATION CONTACT: To request more information on the proposed project or to obtain a copy of the information collection plan and instruments, contact Jeffrey M. Zirger, Information Collection Review Office, Centers for Disease Control and Prevention, 1600 Clifton Road NE, MS H21–8, Atlanta, Georgia 30329; Telephone: 404–639–7570; Email: omb@cdc.gov.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (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. In addition, the PRA also requires federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each new proposed collection, each proposed extension of existing collection of information, and each reinstatement of previously approved information collection before submitting the

collection to the OMB for approval. To comply with this requirement, we are publishing this notice of a proposed data collection as described below.

The OMB is particularly interested in comments that will help:

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;
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; and
5. Assess information collection costs.

Proposed Project

School-Based Active Surveillance (SBAS) of Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) Among Schoolchildren (OMB Control No. 0920–1396, Exp. 4/30/2026)—Revision—National Center for Emerging and Zoonotic and Infectious Disease (NCEZID), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), a complex, chronic, debilitating multi-system disease, affects up to 3.3 million persons in the United States. However, about 90% of people with ME/CFS have not received an official diagnosis from a healthcare professional. ME/CFS affects between 0.10% and 0.75% of children and adolescents, which often goes

undiagnosed by healthcare professionals.

Data on chronic conditions among schoolchildren, such as asthma, has been collected over the years, but there has been little to no emphasis on ME/CFS in the United States. Chronic conditions among school-aged children likely account for a high proportion of chronic school absenteeism and school withdrawal. Conducting active surveillance among students using school nurses could expedite the diagnosis and management of children who present with symptoms commonly seen in ME/CFS. This involves educating school nurses about ME/CFS and its related syndromes, how to best approach parents and guardians when suggesting the diagnosis, and how to support the educational success of students with chronic diseases.

National active surveillance in schools for ME/CFS coupled with education of school nurses about ME/CFS could help improve measuring the burden of ME/CFS in children and provide insights for future plans to improve healthcare in children suffering from ME/CFS and other chronic health conditions. In the next phase of this project, we will expand the active surveillance project beyond the pilot schools to include additional schools in the pilot states as well as in other states. In this national rollout, school nurses will continue to receive education on data collection and ME/CFs as well as technical assistance and training on using the electronic data collection reporting platform.

This project will extend the currently approved data collection to involve more school nurses (respondents). This change will help us to track ME/CFS symptom burden in addition to the ME/CFS prevalence. CDC requests OMB approval for an estimated 631 annualized burden hours. There is no cost to respondents other than their time to participate.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Frontline School Nurses	Electronic Platform Quarterly Chronic Absenteeism Data Reporting Form.	20	4	5	400
Frontline School Nurses	Demographic Data Collection Points	20	1	6	120
Frontline School Nurses	Site Baseline Survey	20	1	20/60	4
Frontline School Nurses	Question Guide for Face-to-Face Evaluation Interviews.	20	3	1.5	90
State Data Coordinators	Webinar 1 Feedback Form	50	1	18/60	15
School District Representative	School District Feedback Form	8	1	18/60	2
Total .....	.....	.....	.....	.....	631

Jeffrey M. Zirger,

Lead, Information Collection Review Office,
Office of Public Health Ethics and
Regulations, Office of Science, Centers for
Disease Control and Prevention.

[FR Doc. 2026-02654 Filed 2-10-26; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-26-1027; Docket No. CDC-2026-
0232]

Proposed Data Collection Submitted for Public Comment and Recommendations

AGENCY: Centers for Disease Control and
Prevention (CDC), Department of Health
and Human Services (HHS).

ACTION: Notice with comment period.

SUMMARY: The Centers for Disease
Control and Prevention (CDC), as part of
its continuing effort to reduce public
burden and maximize the utility of
government information, invites the
general public and other federal
agencies the opportunity to comment on
a continuing information collection, as
required by the Paperwork Reduction
Act of 1995. This notice invites
comment on a proposed information
collection project titled Generic
Clearance for the Collection of
Qualitative Feedback on Agency Service
Delivery. The purpose of the collection
is to enable and facilitate the CDC's
collection and internal processing of
customer and partner feedback in a
timely manner, in alignment with CDC's
commitment to improving service
delivery.

DATES: CDC must receive written
comments on or before April 13, 2026.

ADDRESSES: You may submit comments,
identified by Docket No. CDC-2026-
0232 by either of the following methods:

- **Federal eRulemaking Portal:**
www.regulations.gov. Follow the
instructions for submitting comments.
- **Mail:** Jeffrey M. Zirger, Information
Collection Review Office, Centers for
Disease Control and Prevention, 1600
Clifton Road NE, MS H21-8, Atlanta,
Georgia 30329.

Instructions: All submissions received
must include the agency name and
Docket Number. CDC will post, without
change, all relevant comments to
www.regulations.gov.

Please note: Submit all comments
through the Federal eRulemaking portal
(www.regulations.gov) or by U.S. mail to
the address listed above.

FOR FURTHER INFORMATION CONTACT: To
request more information on the
proposed project or to obtain a copy of
the information collection plan and
instruments, contact Jeffrey M. Zirger,
Information Collection Review Office,
Centers for Disease Control and
Prevention, 1600 Clifton Road NE, MS
H21-8, Atlanta, Georgia 30329;
Telephone: 404-639-7570; Email: omb@cdc.gov.

SUPPLEMENTARY INFORMATION: Under the
Paperwork Reduction Act of 1995 (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. In addition, the PRA also
requires federal agencies to provide a
60-day notice in the **Federal Register**
concerning each proposed collection of
information, including each new
proposed collection, each proposed
extension of existing collection of
information, and each reinstatement of
previously approved information
collection before submitting the
collection to the OMB for approval. To
comply with this requirement, we are
publishing this notice of a proposed
data collection as described below.

The OMB is particularly interested in
comments that will help:

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;
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; and
5. Assess information collection costs.

Proposed Project

Generic Clearance for the Collection
of Qualitative Feedback on Agency
Service Delivery (OMB Control No.
0920-1027, Exp. 6/30/2026)—
Extension—National Center for HIV,
Viral Hepatitis, STD, and TB Prevention
(NCHHSTP), Centers for Disease Control
and Prevention (CDC).

Background and Brief Description

The Centers for Disease Control and
Prevention (CDC), National Center for
HIV, Viral Hepatitis, STD, and TB
Prevention (NCHHSTP) requests an
extension of the currently approved
Generic Clearance for the Collection of
Qualitative Feedback on Agency Service
Delivery for a period of three years. The
previously approved Generic Clearance
will remain unchanged. This Extension
is necessary to align with CDC's
commitment to service delivery
improvement, prioritization of Gold
Standard Science, and maintenance of
public trust.

As a means of ensuring our programs
are effective and meet our customers'
needs, CDC/NCHHSTP (hereafter "the
Agency") utilizes this Generic Clearance
to collect qualitative feedback on our
service delivery. For the purposes of
this Generic Clearance, qualitative
feedback means information that
provides useful insights on perceptions
and opinions but are not statistical
surveys that yield quantitative results
that can be generalized to the
population of study. This collection of
information is necessary for the Agency
to gather customer and partner feedback
in an efficient, timely manner, in
accordance with our commitment to
improving service delivery, enhancing
public trust, and prioritizing Gold
Standard Science. Qualitative data
collected from our customers and
partners helps CDC ensure that they
have effective, efficient, and satisfying
experiences with the Agency's
programs. This feedback provides
valuable insights into customer or
partner perceptions, experiences and
expectations, provides an early warning
of service and/or quality issues, and
focuses attention on areas where
communication, training, or operational
adjustments might improve delivery of
products or services. These collections
are a useful tool in facilitating ongoing,
collaborative, actionable
communication between the Agency
and its customers and partners. Such
feedback contributes directly to
improving CDC's program management
efforts. This information collection
represents CDC/NCHHSTP's attempt to
gather feedback data on CDC services
and programs. There is currently no
information available that can substitute
for the responses to the data collection
instruments and provide essential
program improvement information. No
similar data is gathered and/or
maintained by the Agency or is
available from other sources known to
the Agency.

In the previous three-year approval period, the Agency used 346 burden hours over eight collection activities. However, we anticipate more robust usage of this mechanism over the next three years due to CDC’s renewed emphasis on public trust and accountability, prioritization of Gold Standard Science, and recommitment to high-quality customer and interest holder experiences. As with previous approvals, the Agency will only submit collections for approval under this Generic Clearance that meet the following conditions:

1. Information gathered is used solely on an internal basis for general service improvement and program management purposes and is not intended for release outside of the agency;
2. Information gathered will not be used for the purpose of substantially informing influential policy decisions;
3. Information gathered will yield qualitative information; the collections will not be designed or expected to yield statistically reliable results or used as though the results are generalizable to the population of study;
4. The collections are voluntary;
5. The collections are low burden for respondents (based on considerations of

total burden hours, total number of respondents, or burden hours per respondent) and are low-cost for both the respondents and the federal government;

6. The collections are non-controversial and do not raise issues of concern to other federal agencies;
7. 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;
8. Except for information needed to provide token of appreciation for focus group or key informant participants and cognitive laboratory studies, personally identifiable information (PII) is collected only to the extent necessary and is not retained.

If these conditions are not met, the Agency will submit an information collection request (ICR) to the Office of Management and Budget (OMB) for approval through the normal Paperwork Reduction Act (PRA) process.

Collection types under this Generic Clearance include, but are not limited to:

- Customer comment cards/ complaint forms;
- Small discussion groups;

- Focus Groups of customers, potential customers, delivery partners, or other interest holders;
- Key informant interviews of customers, potential customers, implementing partners, or other interest holders;
- Cognitive laboratory studies, such as those used to refine questions or assess usability of a website;
- Qualitative customer satisfaction surveys (e.g., post-transaction surveys; opt-out web surveys);
- In-person or virtual observation testing (e.g., website or software usability tests);
- Other observational methods (e.g., direct observations, ethnography)

The Agency has established a manager/managing entity to serve for this Generic Clearance and will conduct an independent review of each information collection to ensure compliance with the terms of this clearance prior to submitting each collection to OMB.

There is no change to the previously approved burden estimate. The estimated annualized burden hours for this data collection are 9,690 hours. There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of collection	Number of respondents	Annual frequency per response	Average burden per response (hours)	Total burden (hours)
Online surveys	10,500	1	30/60	5,250
Discussion groups	280	1	2	560
Focus groups	640	1	2	1,280
Website/app usability testing	2,000	1	30/60	1,000
Interviews	800	1	2	1,600
Total	14,220	.....	.....	9,690

Jeffrey M. Zirger,
Lead, Information Collection Review Office, Office of Public Health Ethics and Regulations, Office of Science, Centers for Disease Control and Prevention.
[FR Doc. 2026-02653 Filed 2-10-26; 8:45 am]
BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day-26-0850]

Agency Forms Undergoing Paperwork Reduction Act Review

In accordance with the Paperwork Reduction Act of 1995, the Centers for

Disease Control and Prevention (CDC) has submitted the information collection request titled “Laboratory Response Network (LRN)” to the Office of Management and Budget (OMB) for review and approval. CDC previously published a “Proposed Data Collection Submitted for Public Comment and Recommendations” notice on August 11, 2025, to obtain comments from the public and affected agencies. CDC received one comment related to the previous notice. This notice serves to allow an additional 30 days for public and affected agency comments.

CDC will accept all comments for this proposed information collection project. The Office of Management and Budget is particularly interested in comments that:

- (a) 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;
- (b) Evaluate the accuracy of the agencies 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;
- (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; and

(e) Assess information collection costs.

To request additional information on the proposed project or to obtain a copy of the information collection plan and instruments, call (404) 639-7570.

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. Direct written comments and/or suggestions regarding the items contained in this notice to the Attention: CDC Desk Officer, Office of Management and Budget, 725 17th Street NW, Washington, DC 20503 or by fax to (202) 395-5806. Provide written comments within 30 days of notice publication.

Proposed Project

Laboratory Response Network (OMB Control No. 0920-0850, Exp. 4/30/2026)—Revision—Office of Laboratory Systems and Response (OLSR), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Laboratory Response Network (LRN) was established by the Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC) in accordance with Presidential Decision Directive 39, which outlined national anti-terrorism policies and assigned specific missions to federal departments and agencies. The LRN’s mission is to maintain an integrated national and international network of laboratories that can respond to suspected biological, chemical, or radiological threats and other public health emergencies. To ensure fulfillment of that mission, CDC collects data from the LRN member laboratories related to laboratory capability, capacity, and distribution as well as laboratory test results.

Upon volunteering to join the LRN, laboratories are required to submit qualification information to the LRN Program Office at CDC, to include first and last names, work addresses, work email addresses, work phone numbers, and alternative phone numbers of personnel trained in LRN procedures. This information is needed to contact laboratory personnel in the case of a public health emergency, to ship reagents, test kits, or supplies, and determine laboratory testing capacity.

Laboratories are also required to provide additional qualification information related to testing capability and capacity including available testing equipment, safety equipment, facilities, reagents, test kits, and validated tests. This information is used by CDC to ensure that laboratory testing capability is distributed across the country, and the network has adequate testing capacity to provide adequate public health emergency response. Qualification information is collected in the LRN Secure Information Hub (SIH) accessed through the CDC Secure Access Management System (SAMS). Laboratories are required to update their capability and capacity information whenever changes occur such as personnel changes, the addition of new tests, or the addition of new equipment. For laboratories that hold United States Department of Agriculture (USDA) or Select Agent permits, copies of the permits are also collected. This information is used to inform CDC of additional laboratory capability. These permits are not required for LRN membership.

LRN laboratories are also required to report certain laboratory test results to CDC. The test results include details about the type and source of samples as well as the tests performed, results obtained, and conclusions. CDC collects test results related to validation studies and proficiency testing to verify that laboratories continue to properly perform the tests they have validated. CDC collects test data related to emergency response exercises to verify laboratory performance in a simulated emergency response situation. CDC collects test results related to routine testing of known biological and chemical threat agents. These results are used to monitor emerging threat situations. CDC also collects test results for samples analyzed during a public health threat response to monitor threat levels and determine procurement, allocation, and distribution of response resources.

Laboratory test results are reported to CDC using either a CSV file uploaded into a cloud-based web page (DataLink) or using their laboratory information management system (LIMS) to send an electronic Health Level Seven (HL7) message. DataLink is accessed by the LRN laboratories through SAMS and can be rapidly modified for a new or emerging threat, with the burden of maintenance removed from the member laboratory.

There have been a number of improvements to the LRN SIH: (1) the LRN SIH migrated to SAMS servers to provide a more secure login and user

authentication; and (2) a new CDC template was implemented to support 508 compliance and responsive designs. Additionally, there is a decrease in the estimated burden from 422,716 to 59,024 annual hours. This decrease in burden is due to several factors. Burden has been reduced by the continued expansion of LRN laboratories implementing HL7 reporting and decreasing the need for manual entry to Results Messenger. The number of data elements collected for the LRN Data Exchange has also been reduced. Numerical test results (e.g., Ct values) or a sample conclusion are no longer collected. Burden was further reduced by reevaluating the burden calculation based upon requirements LRN places upon the member laboratories versus the requirements of the Clinical Laboratory Improvement Amendments (CLIA) regulations and other quality management programs placed upon the laboratories. In the instance of proficiency tests and challenge panels, the analysis of these samples is required by CLIA and/or other quality management systems implemented locally. Therefore, the only burden the LRN is placing on the laboratory is the time required to accession the samples and report the results to LRN. In the cases of routine and emergency response testing, these samples are part of the workflow that each LRN laboratory already has in place. The only burden LRN is placing upon the laboratories is the time to report the results to LRN. These changes in how burden hours were determined per activity are reflected in the burden table. Per CDC Notice of Funding Opportunity (NOFO) PHEP Cooperative Agreement CDC-RFA-TU24-0137: Public Health Emergency Preparedness (PHEP) Cooperative Agreement, LRN-C laboratories are required to participate in Surge Capacity Exercises and proficiency testing to ensure laboratory readiness to support CDC laboratory capacity during a national emergency involving chemical threats. There is no cost for respondents other than their time to participate.

This data collection is vital to the continued support of the national public health system in its efforts to respond to chemical and biological threats. The state, local, and federal public health laboratories participating in this program generate the data in this collection as part of their individual emergency response duties. By merging this data into a single collection, a local perspective of an emerging threat becomes a broader national perspective

with greater depth and detail for more efficient and effective decision making.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondent type	Forms	Number of responders	Average number of responses per responder	Average burden per response (hours)
PHLs *	Laboratory Qualification	136	1	2
PHLs	Routine Testing Results	136	25	0.5
PHLs	Challenge Panel/Validation Testing Results	136	2	12
PHLs	Public Health Surge Response Testing Results.	136	625	0.5
PHLs	Proficiency Testing/Characterization Results (LRN-C).	44	35	2
PHLs	Surge Event Testing Results/Exercises (LRN-C: SPaSE, Surge, ERE).	57	6	24

Jeffrey M. Zirger,

Lead, Information Collection Review Office, Office of Public Health Ethics and Regulations, Office of Science, Centers for Disease Control and Prevention.

[FR Doc. 2026-02651 Filed 2-10-26; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30-Day-26-0156]

Agency Forms Undergoing Paperwork Reduction Act Review

In accordance with the Paperwork Reduction Act of 1995, the Centers for Disease Control and Prevention (CDC) has submitted the information collection request titled “Data Management Plan Template for Extramural Research” to the Office of Management and Budget (OMB) for review and approval. CDC previously published a “Proposed Data Collection Submitted for Public Comment and Recommendations” notice on August 26, 2025 to obtain comments from the public and affected agencies. CDC received three comments related to the previous notice, two of which were reviewed and discussed. This notice serves to allow an additional 30 days for public and affected agency comments.

CDC will accept all comments for this proposed information collection project. The Office of Management and Budget is particularly interested in comments that:

(a) 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;

(b) Evaluate the accuracy of the agencies 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;

(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; and

(e) Assess information collection costs.

To request additional information on the proposed project or to obtain a copy of the information collection plan and instruments, call (404) 639-7570. 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. Direct written comments and/or suggestions regarding the items contained in this notice to the Attention: CDC Desk Officer, Office of Management and Budget, 725 17th Street NW, Washington, DC 20503 or by fax to (202) 395-5806. Provide written comments within 30 days of notice publication.

Proposed Project

Notice of Funding Opportunity (NOFO) Data Management Plan (DMP) Template for Extramural Research—New—Office of Science (OS), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Centers for Disease Control and Prevention (CDC), Office of Science (OS) is requesting approval of a New Information Collection Request (ICR) for a period of three years under the project titled, Notice of Funding Opportunity (NOFO) Data Management Plan (DMP) Template for Extramural Research, hereafter referred to as CDC NOFO DMP. OS operates within CDC, and works to collaborate with the agency’s Centers, Institutes, and Offices (CIOs). Multiple CIOs have their own DMPs, and a deep dive into these DMPs showed some common elements. There is a need to have a consistent and unified approach whereby CDC could meet obligations of calls to action.

The White House Office of Science Technology and Policy (OSTP) released a memo in 2013 titled, “Increasing Access to the Results of Federally Funded Scientific Research” [https://obamawhitehouse.archives.gov/sites/default/files/microsites/ostp/ostp_public_access_memo_2013.pdf]. This memo emphasized DMPs and stated the following instructions:

(b) Ensure that all extramural researchers receiving Federal grants and contracts for scientific research and intramural researchers develop data management plans, as appropriate, describing how they will provide for long-term preservation of, and access to, scientific data in digital formats resulting from federally funded research, or explaining why long-term preservation and access cannot be justified;

(c) Allow the inclusion of appropriate costs for data management and access in proposals for Federal funding for scientific research;

(d) Ensure appropriate evaluation of the merits of submitted data management plans;

(e) Include mechanisms to ensure that intramural and extramural researchers comply with data management plans and policies;

In response, CDC developed a data plan, produced a public access policy, and updated its data policy.

In 2022, OSTP released a follow-up memo titled, “Ensuring Free, Immediate, and Equitable Access to Federally Funded Research” [<https://bidenwhitehouse.archives.gov/wp-content/uploads/2022/08/08-2022-OSTP-Public-Access-Memo.pdf>]. This memo emphasized the scientific data underlying peer-reviewed publications. It included the following language.

(b) Scientific Data

i. Scientific data underlying peer-reviewed scholarly publications resulting from federally funded research should be made freely available and publicly accessible by default at the time of publication, unless subject to limitations as described in Section 3(c)(i) and should be subject to federal agency guidelines for researcher responsibilities regarding data management and sharing plans, consistent with Section 3(c) of this memorandum.

(c) Public access plans should outline the policies that federal agencies will use to establish researcher responsibilities on how federally funded scientific data will be managed and shared, including:

(i) Details describing any potential legal, privacy, ethical, technical, intellectual property, or security limitations, and/or any other potential restrictions or limitations on data access, use, and disclosure, including those defined in terms and conditions of funding agreement or award or that convey from a data use agreement or stipulations of an Institutional Review Board;

(ii) Plans to maximize appropriate sharing of the federally funded scientific data identified in Section 3(a) of this memorandum, such as providing risk-mitigated opportunities for limited data access; and,

(iii) The specific online digital repository or repositories where the researcher expects to deposit their

relevant data, consistent with the federal agency’s guidelines.

OSTP released an additional memo in 2025 titled, “Agency Guidance for Implementing Gold Standard Science in the Conduct & Management of Scientific Activities” [<https://www.whitehouse.gov/wp-content/uploads/2025/03/OSTP-Guidance-for-GSS-June-2025.pdf>]. This memo addresses “science conducted in a manner that abides by nine key tenets”: (i) reproducible; (ii) transparent; (iii) communicative of error and uncertainty; (iv) collaborative and interdisciplinary; (v) skeptical of its findings and assumptions; (vi) structured for falsifiability of hypotheses; (vii) subject to unbiased peer review; (viii) accepting of negative results as positive outcomes; and, (ix) without conflicts of interest.

The Executive Order (E.O.), “Establishing the President’s Make America Healthy Again Commission” [<https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/>], emphasizes transparency and open-source data in section 2(a).

“Sec. 2. Policy. It shall be the policy of the Federal Government to aggressively combat the critical health challenges facing our citizens, including the rising rates of mental health disorders, obesity, diabetes, and other chronic diseases. To do so, executive departments and agencies (agencies) that address health or healthcare must focus on reversing chronic disease. Under this policy:

(a) all federally funded health research should empower Americans through transparency and open-source data, and should avoid or eliminate conflicts of interest that skew outcomes and perpetuate distrust;

(b) the National Institutes of Health and other health-related research funded by the Federal Government should prioritize gold-standard research on the root causes of why Americans are getting sick;

(c) agencies shall work with farmers to ensure that United States food is the healthiest, most abundant, and most affordable in the world; and

(d) agencies shall ensure the availability of expanded treatment options and the flexibility for health insurance coverage to provide benefits that support beneficial lifestyle changes and disease prevention.”

This project addresses and responds to these memos and Executive Orders by collecting data using a unified DMP. The CDC NOFO DMP was created to capture information consistent with CDC Grants Notice of Funding Opportunity (NOFO) Additional Requirement 25: Data Management and Access [<https://www.cdc.gov/grants/additional-requirements/ar-25.html>] and is meant to be broadly applicable across CDC. The implementation of a unified DMP is expected to reduce researcher burden when applying for funding and when updating DMPs. This project will also reduce CDC staff burden, reduce cognitive load on DMP reviewers, and make it explicit which DMP elements have no responses. The project will reduce CDC staff time spent on DMP reviews by making each DMP element atomic and specific.

Use of the CDC NOFO DMP will allow CDC to understand the number and types of datasets that are being released and shared alongside publications. The proposed new metadata elements for a unified DMP will also help guide CDC-funded researchers towards greater collaborations through fostering data reuse; improve reproducibility by encouraging greater data documentation; and improve accessibility by making CDC data more open and reusable to researchers and the public.

Respondents are expected to complete the CDC NOFO DMP with as much information as known at the time. The document is a living document and may be updated when additional information is known and during reporting periods. Expected respondents include any researcher responding to Notice of Funding Opportunity (NOFO) announcements. CDC requests OMB approval for an estimated 2,877 total burden hours with an estimated annual burden of 959 hours. There is no cost to respondents other than their time to participate.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Notice of Funding Opportunity (NOFO) Applicants (Initial).	Notice of Funding Opportunity (NOFO) Data Management Plan (DMP) Template for Extramural Research.	548	1	1.5

ESTIMATED ANNUALIZED BURDEN HOURS—Continued

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Notice of Funding Opportunity (NOFO) Applicants (Update).	Notice of Funding Opportunity (NOFO) Data Management Plan (DMP) Template for Extramural Research.	548	1	15/60

Jeffrey M. Zirger,

Lead, Information Collection Review Office, Office of Public Health Ethics and Regulations, Office of Science, Centers for Disease Control and Prevention.

[FR Doc. 2026–02650 Filed 2–10–26; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Solicitation of Nominations for Appointment to the Advisory Council for the Elimination of Tuberculosis

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: In accordance with the Federal Advisory Committee Act, the Centers for Disease Control and Prevention (CDC), within the Department of Health and Human Services (HHS) is seeking nominations for membership on the Advisory Council for the Elimination of Tuberculosis (ACET). ACET consists of 10 experts including the Chair in fields associated with public health, epidemiology, immunology, infectious disease, pulmonary disease, pediatrics, tuberculosis, microbiology, and preventive health care delivery.

DATES: Nominations for membership on the ACET must be received no later than March 31, 2026. Submission received after this time will not be considered for the current membership cycle.

ADDRESSES: All nominations should be emailed to nchhstppolicy@cdc.gov with subject line “ACET 2026 Nomination.”

FOR FURTHER INFORMATION CONTACT: ACET Committee Management, Office of Policy, Planning, and Partnerships, National Center for HIV, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention. Email: nchhstppolicy@cdc.gov.

SUPPLEMENTARY INFORMATION: ACET provides advice and recommendations regarding the elimination of tuberculosis (TB) to the Secretary, HHS;

the Assistant Secretary for Health, HHS; and the Director, CDC. ACET (a) makes recommendations on policies, strategies, objectives, and priorities; (b) addresses development and application of new technologies; (c) provides guidance and review of CDC’s TB prevention research portfolio and program priorities; and (d) reviews the extent to which progress has been made toward eliminating TB.

Nominations are sought for individuals who have the expertise and qualifications necessary to contribute to the accomplishment of the objectives of the ACET. Nominees will be selected on the basis of their expertise in public health, epidemiology, immunology, infectious diseases, pulmonary disease, pediatrics, tuberculosis, microbiology, or preventive health care delivery. Expertise within TB includes having had TB disease or being the parent of a child with TB disease. Federal employees will not be considered for membership. Members may be invited to serve for up to four-year terms. Selection of members is based on candidates’ qualifications to contribute to the accomplishment of ACET objectives.

Department of Health and Human Services (HHS) policy stipulates that committee membership be balanced in terms of points of view represented and the committee’s function. Appointments shall be made free from discrimination on the basis of race, religion, color, national origin, age, disability, or sex. Nominees must be U.S. citizens and cannot be full-time employees of the U.S. Government. Current participation on Federal workgroups or prior experience serving on a Federal advisory committee does not disqualify a candidate; however, HHS policy is to avoid excessive individual service on advisory committees and multiple committee memberships. Committee members are Special Government Employees, requiring the filing of financial disclosure reports at the beginning and annually during their terms. The Centers for Disease Control and Prevention (CDC) reviews potential candidates for ACET membership each year and provides a slate of nominees for consideration to the Secretary of

HHS for final selection. HHS notifies selected candidates of their appointment near the start of the term, or as soon as the HHS selection process is completed. Note that the need for different expertise varies from year to year and a candidate who is not selected in one year may be reconsidered in a subsequent year. Candidates should submit the following items:

- Current curriculum vitae, including complete contact information (telephone numbers, mailing address, and email address).

- At least one letter of recommendation from person(s) not employed by HHS. Candidates may submit letter(s) from current HHS employees if they wish, but at least one letter must be submitted by a person not employed by an HHS agency (*i.e.*, CDC, National Institutes of Health, Food and Drug Administration).

- A biographical sketch of the nominee (500 words or fewer).

Nominations may be submitted by the candidate or by the person/organization recommending the candidate. CDC will collect and retain nominations received for up to two years to create a pool of potential ACET nominees. When a vacancy occurs, CDC will review nominations and may contact nominees at that time.

The Director, Office of Strategic Business Initiatives, Office of the Chief Operating Officer, Centers for Disease Control and Prevention, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Kalwant Smagh,

Director, Office of Strategic Business Initiatives, Office of the Chief Operating Officer, Centers for Disease Control and Prevention.

[FR Doc. 2026–02751 Filed 2–10–26; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Administration for Children and Families**

[Office of Management and Budget #: 0970–0548]

Proposed Information Collection Activity; Tribal Budget and Narrative Justification Template

AGENCY: Office of Child Support Enforcement, Administration for Children and Families, U.S. Department of Health and Human Services.

ACTION: Request for public comments.

SUMMARY: The Office of Child Support Enforcement (OCSE), Administration for Children and Families (ACF), U.S. Department of Health and Human Services (HHS), is proposing to renew the collection of expenditure estimate forms for the tribal child support program through an optional financial reporting form, Tribal Budget and Narrative Justification Template (Office of Management and Budget #: 0970–0548; expiration date May 31, 2026).

Minor changes are proposed. OCSE does not plan to renew either the Word version or the Excel 1115 Waiver version of the Tribal Budget and Narrative Justification Template.

DATES: Comments due April 13, 2026.

ADDRESSES: In compliance with the requirements of the Paperwork Reduction Act of 1995, ACF is soliciting public comment on the specific aspects of the information collection described above. You can obtain copies of the proposed collection of information and submit comments by emailing infocollection@acf.hhs.gov. Identify all requests by the title of the information collection.

SUPPLEMENTARY INFORMATION:

Description: To receive child support funding under 45 CFR part 309, tribes and tribal organizations must submit the financial forms described in 45 CFR 309.130(b) and other forms as the Secretary may designate, due no later than August 1 annually. This optional template is designed for tribes operating an approved tribal child support program to use in preparing their annual budget and narrative justification

estimates in accordance with the tribal child support enforcement regulations. The optional Tribal Budget and Narrative Justification Template helps improve efficiency and establish uniformity and consistency in the annual budget submission and review process. Tribes may use the Excel template or their own format to submit the required financial information.

OCSE has made minor revisions to the Excel template by updating citations and hyperlinks from 45 CFR part 75 to 2 CFR part 200. Other changes include edits to examples in the Excel sample budget to reflect the adoption of 2 CFR part 200 and updated formula errors in the Excel document. OCSE proposes to discontinue the Word template since it is not used.

Respondents: Tribes and Tribal Organizations administering a tribal child support program under title IV–D of the Social Security Act.

Annual Burden Estimates

Burden estimates are for all tribes to provide budget information, as required, using either the ACF provided template or their own format.

Instrument	Total number of respondents	Annual number of responses per respondent	Average burden hours per response	Annual burden hours
Tribal Budget and Narrative Justification	63	1	16	1,008

Comments: The Department specifically requests 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 shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) 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. Consideration will be given to comments and suggestions submitted within 60 days of this publication.

Authority: 45 CFR 309.

Mary C. Jones,
ACF/OPRE Certifying Officer.

[FR Doc. 2026–02663 Filed 2–10–26; 8:45 am]

BILLING CODE 4184–41–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Food and Drug Administration**

[Docket No. FDA–2026–N–0302]

Butylated Hydroxyanisole (BHA); Request for Information

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice; request for information.

SUMMARY: The Food and Drug Administration (FDA or we) is requesting information on the current uses and safety data of butylated hydroxyanisole (BHA) in human food and as a food contact substance. We are requesting this information as part of our systematic process for conducting post-market assessments of chemicals in food. We are conducting a post-market assessment of the safety of BHA in food, considering the latest state of the science. We intend to use the information received and any other available, relevant information to determine if BHA remains safe under its

current conditions of use in food and as a food contact substance.

DATES: Either electronic or written comments and scientific data and information on the notice must be submitted by April 13, 2026.

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 April 13, 2026. 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-2026-N-0302 for "Butylated hydroxyanisole (BHA); Request for Information." 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." We will review this copy, including the claimed confidential information, in our 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 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:

Jason Downey, Office of Food Chemical Safety, Dietary Supplements, and Innovation, Human Foods Program, Food and Drug Administration, 5001 Campus Dr., College Park, MD 20740, 240-402-9241; or Barbara Little, Office of Policy and International Engagement, Human Foods Program, Food and Drug Administration, 5001 Campus Dr., College Park, MD 20740, 240-402-2378.

SUPPLEMENTARY INFORMATION:

I. Background

FDA is requesting information on the current uses and safety data for butylated hydroxyanisole (BHA) in human food and as a food contact substance as part of a post-market assessment. BHA (CAS No. 25013-16-5) is used as an antioxidant in food to prevent the spoilage of fats and oils. BHA used in food is a mixture of predominantly 3-*tert*-butyl-4-hydroxyanisole (3-BHA, CAS No. 121-00-6), with varying amounts of 2-*tert*-butyl-4-hydroxyanisole (2-BHA, CAS No. 88-32-4).

All uses of BHA in food or as a food contact substance must be authorized for that use through a food additive regulation or an effective food contact notification, or be excluded from regulation as a food additive, for example, because such use is generally recognized as safe (GRAS) or is prior sanctioned (see Sections 201(s) and 409 of the Federal Food, Drug, and Cosmetic Act). As described below, BHA is authorized for use in food and as a food

contact substance in the U.S. through multiple regulatory pathways.

FDA lists BHA as GRAS for use as an antioxidant in food generally, with the limitation that the total antioxidant content cannot exceed 0.02% of the total fat or oil content of the food (21 CFR 182.3169) (these uses also appear to be the subject of uncodified prior sanctions (see Ref. 1)). FDA also lists this antioxidant use of BHA as GRAS in food for animals (21 CFR 582.3169); however, the focus of our post-market assessment of BHA is on its safety for use in human food. BHA has prior-sanctioned uses as an antioxidant when migrating from food packaging material with a limit of addition to food of 0.005% (21 CFR 181.24). We are not aware of any other GRAS conclusions or prior sanctions for the use of BHA in food or as a food contact substance.

BHA is authorized as a direct food additive when used as an antioxidant, alone or in combination with butylated hydroxytoluene (BHT), in certain foods with specified limitations (21 CFR 172.110). BHA is also permitted as a direct food additive when used as an antioxidant in flavoring substances such that it does not exceed 0.5% of the essential oil content of the flavoring substance (21 CFR 172.515(d)) and as a direct food additive in chewing gum base when used as an antioxidant, alone or in combination with BHT or propyl gallate, such that the total antioxidant content does not exceed 0.1% of the gum base (21 CFR 172.615(a)).

BHA is authorized as an indirect or secondary direct food additive or a constituent of food additives for use as an antioxidant in food contact materials, including in defoaming agents for processing beet sugar and yeast, such that the total antioxidant content does not exceed 0.1% by weight of defoamer (21 CFR 173.340(a)(3)); adhesives (21 CFR 175.105(c)); pressure sensitive adhesives in labels and/or tapes applied to poultry, dry food, and processed, frozen, dried, partially dehydrated fruits or vegetables, or raw fruit or vegetables (21 CFR 175.125(a)(4), (b)(2)); coatings (21 CFR 175.300(b)(3)(xxx), 175.380(a), 175.390(b)(2)); defoaming agents used in the manufacturer of paper and paperboard, including those in contact with aqueous and fatty foods (21 CFR 176.210(d)(3), 176.170(a)(4)); semirigid and rigid acrylic and modified acrylic plastics (21 CFR 177.1010(a)(5)); closures with sealing gaskets for food containers (177.1210(b)); ethylene-vinyl acetate copolymers (21 CFR 177.1350(a)(1)(iii)); defoaming agents used as optional adjuvants in the production of animal glue (21 CFR 178.3120(d)(3)); machinery lubricants

with incidental food contact (21 CFR 178.3570(a)(3)); and polyethylene film, such that it does not exceed 1% by weight of polyethylene polymer and such that the film is not subjected to a dose of radiation exceeding 60 kilograys by gamma, electron beam, or X-radiation (21 CFR 179.45(d)(2)(i)).

We also note that BHA is listed for use in the United States Department of Agriculture (USDA)'s specifications for butteroil (7 CFR 58.305(b)) and USDA's and FDA's standards of identity for margarine (9 CFR 319.700(b)(6), 21 CFR 166.110(b)(5)). The uses are within the scope of the GRAS regulation at 21 CFR 182.3169.

As part of our systematic review of chemicals in food, FDA is beginning a post-market assessment of the safety of BHA as used in food and as a food contact substance (see <https://www.fda.gov/food/food-chemical-safety/list-select-chemicals-food-supply-under-fda-review>). This assessment supports the Make America Healthy Again Commission's recommendation to implement an evidence-based systematic process for post-market assessment of chemicals in food (see <https://www.whitehouse.gov/wp-content/uploads/2025/09/The-MAHA-Strategy-WH.pdf>). The objective of our assessment is to determine if BHA is safe under its conditions of use in food or as a food contact substance considering the latest state of the science. While FDA previously concluded the authorized uses to be safe, new information may require reconsideration of the regulatory status or the safe uses of a substance in or on food.

II. Request for Information

FDA is requesting information on uses, use levels, dietary exposure, and safety data on BHA currently used in food and as a food contact substance. Information from food manufacturers on uses and levels is crucial for food chemical assessments. We encourage food manufacturers to participate in this data call, with options for aggregated submissions through trade groups or other collaborations. We do not need information about individual products and their recipes, but rather data about the levels of use in general product categories. Voluntary submission of data and information on current uses and use levels will help to refine our dietary exposure assessments. We use maximizing assumptions to estimate dietary exposure (see, e.g., "Guidance for Industry: Estimating Dietary Intake of Substances in Food," available at <https://www.fda.gov/regulatory-information/search-fda-guidance->

[documents/guidance-industry-estimating-dietary-intake-substances-food](https://www.fda.gov/regulatory-information/search-fda-guidance-documents/guidance-industry-estimating-dietary-intake-substances-food)). Without refinements assisted by manufacturer-use information, this may lead to overestimation of dietary exposure that could impact authorizations for the chemical's use in food or as a food contact substance.

Specifically, FDA requests the following:

1. General food categories in which BHA is used (for example, cookies, soft drinks, other categories listed in 21 CFR 170.3(n), USDA's What We Eat in America survey (Ref. 2), or the Codex General Standard for Food Additives (Ref. 3));
2. Typical and maximum use levels of BHA in each applicable general food category;
3. Information on the current food contact uses of BHA, including data on migration of BHA from food contact materials into food;
4. Subpopulations with high BHA dietary exposure or particular safety concerns relevant to food and food contact uses of BHA;
5. Other dietary sources of BHA, such as dietary supplements, natural occurrence in common foods, residues in animal products, or as contaminants in food or drinking water;
6. Market share of foods in each applicable general food category and food contact materials that are formulated with BHA;
7. Biomonitoring data for BHA or its metabolites;
8. Updated market disappearance or poundage data for BHA;
9. Information on potential chemically or pharmacologically related substances used in food or as food contact substances;
10. Safety data relevant to use of BHA in food or as a food contact substance, especially unpublished data;
11. Documentation of GRAS conclusions or prior sanctions for uses of BHA in food or as a food contact substance that are different from those described above;
12. Information that may support the conclusion that BHA is no longer used for one or more of its authorized intended uses in food or as a food contact substance.

III. References

The following references are on display at the Dockets Management Staff (see **ADDRESSES**) and are available for viewing by interested persons between 9 a.m. and 4 p.m., Monday through Friday; they are also available electronically at <https://www.regulations.gov>. Although FDA verified the website addresses in this

document, please note that websites are subject to change over time.

1. Citizen Petition from Roger D. Middlekauff, dated January 23, 1987, available at [regulations.gov](https://www.regulations.gov) in Docket No. FDA-2026-N-0302.
2. What We Eat in America Food Categories, available at <https://www.ars.usda.gov/northeast-area/beltsville-md-bhnrc/beltsville-human-nutrition-research-center/food-surveys-research-group/docs/dmr-food-categories/>.
3. Codex General Standard for Food Additives, available at <https://www.fao.org/gsfaonline/foods/index.html>.

Grace R. Graham,

Deputy Commissioner for Policy, Legislation, and International Affairs.

[FR Doc. 2026-02761 Filed 2-10-26; 8:45 am]

BILLING CODE 4164-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA-2023-N-5706]

Voluntary Quality Management Maturity Prototype Assessment Protocol Evaluation Program

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing an opportunity for a limited number of drug manufacturing establishments to participate in the third year of the voluntary Quality Management Maturity (QMM) Prototype Assessment Protocol Evaluation Program. The Center for Drug Evaluation and Research (CDER) is implementing this voluntary program for manufacturers of CDER-regulated drug products to gain additional experience with the assessment tool and process. The continuation of this voluntary program is needed to assure that these assessments enable consistent and meaningful evaluations of establishments' quality management practices and provide useful feedback for the establishments. This notice outlines the types of establishments FDA is seeking for participation and the process for submitting a request to participate in the program.

DATES: FDA intends to accept requests to participate in the voluntary QMM Prototype Assessment Protocol Evaluation Program through April 13, 2026. See the "Participation" section of this document for instructions on submitting a request to participate and for information about the selection process.

FOR FURTHER INFORMATION CONTACT: For questions about the voluntary QMM Prototype Assessment Protocol Evaluation Program, contact Djamilia Harouaka, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 51, Rm. 4160, Silver Spring, MD 20993-0002, 240-402-0224, CDER-QMM@fda.hhs.gov. To submit a request to participate in the program, contact Conchetta Newton, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Building 51, Rm. 4144, 240-402-6551, CDER-QMM@fda.hhs.gov.

SUPPLEMENTARY INFORMATION:

I. Background

QMM refers to the extent to which drug manufacturing establishments implement quality management practices that prioritize patients, drive continual improvement, and enhance supply chain reliability through the strategic integration of business decisions and manufacturing operations with quality practices and technological advancements. CDER has developed a voluntary QMM program to encourage drug manufacturers to implement quality management practices that go beyond current good manufacturing practice (CGMP) requirements.¹

Following completion of the first year of the program, CDER refined the prototype QMM assessment tool (including both a protocol and rubric), which is used to evaluate how effectively establishments monitor and manage quality and quality systems.² In CY 2026, CDER intends to continue the voluntary QMM Prototype Assessment Protocol Evaluation Program to evaluate a drug manufacturing establishment's quality management practices and provide actionable feedback for the establishment. This notice announces CDER's intent to continue the QMM Prototype Assessment Protocol Evaluation Program, outlines the types of establishments CDER is seeking for participation, and describes the process for submitting a request to participate in the program.

In 2024, CDER evaluated nine establishments during the initial year of the voluntary QMM Prototype Assessment Protocol Evaluation

Program.³ CDER used a standardized prototype assessment protocol and rubric to evaluate each establishment's practices, behaviors, and responses to specific questions. Feedback from participants in the first year of the program indicated that the QMM report, engagement with the assessment team, and the ability to have open discussions provided value to establishments and highlighted strengths and opportunities for improvement. In addition, participating establishments were able to share challenges and successes related to their manufacturing sectors.

The 2024 QMM program provided CDER with experience in the successful application of the standardized prototype assessment protocol and rubric at nine drug manufacturing establishments. The nine establishments represented a range of manufacturing sectors (e.g., generic drug manufacturers, contract testing laboratory, brand drug manufacturers) in the pharmaceutical industry. The prototype assessment protocol and rubric distinguished differences in maturity levels between practice areas at a single establishment. Differences in maturity levels were also clearly discerned between establishments. Using the insights gained from these experiences, CDER streamlined the QMM assessment tool to make the prototype protocol and rubric clearer and more concise.

CDER is now evaluating the refined assessment tool at more establishments in the second year of the QMM Prototype Assessment Protocol Evaluation Program, which is ongoing. Through this announcement, CDER is offering an opportunity for additional establishments to volunteer to participate. This will allow CDER to gain further experience with the assessment tool, expand our knowledge of quality management practices in the industry, and provide additional drug manufacturing establishments with actionable feedback.

II. Participation

A. Establishment Characteristics

CDER will consider the following establishment characteristics when identifying potential participants for the third year of the QMM Prototype Assessment Protocol Evaluation Program:

- The potential participant is an establishment as defined in 21 CFR 207.1 that registers with FDA under section 510 of the Federal Food, Drug, and Cosmetic Act (FD&C Act) and

manufactures, prepares, propagates, compounds, or processes drugs, or APIs used in such drugs, subject to approval or licensure under section 505 of the FD&C Act or section 351 of the Public Health Service Act, or that are marketed pursuant to section 505G of the FD&C Act without an approved application under section 505 of the FD&C Act (often referred to as over-the-counter (OTC) monograph drug products).

- The establishment received at least one human drug surveillance inspection.⁴
- The current inspection classification for the establishment at the time of the request to participate is No Action Indicated (NAI) or Voluntary Action Indicated (VAI).
- The establishment manufactures, prepares, propagates, compounds, or processes at least one CDER-regulated drug (API or finished drug product) that is currently in commercial distribution in the U.S.
- The establishment is willing to participate in an onsite or hybrid assessment.

B. Requests To Participate

Drug product manufacturers that meet the establishment characteristics described in section II.A and are interested in participating in the voluntary QMM Prototype Assessment Protocol Evaluation Program should submit a request directly to Conchetta Newton (see **FOR FURTHER INFORMATION CONTACT**). To be considered for this program, a request should include all the following information:

- (1) A contact person (name and email).
- (2) Manufacturing establishment address.
- (3) Establishment FDA Establishment Identifier (FEI) and Data Universal Numbering System Numbers (DUNS).
- (4) A brief description of the business operations (e.g., manufacturing, testing, re/packaging, re/labeling, sterilizing, storing, distributing, or salvaging) conducted at the establishment. Please indicate whether the establishment produces active pharmaceutical ingredients (APIs), generic drugs, innovator drugs, over-the-counter (OTC) drugs, biological drug products, and if the establishment is a contract manufacturing or contract testing organization.
- (5) Confirmation that the establishment features the characteristics discussed in section II.A of this notice.

⁴ Inspections conducted by FDA or by Mutual Recognition Agreement (MRA) partners and classified by FDA would fulfill this criterion.

¹ FDA has solicited comments to inform the development of this program. See 88 FR 63587, September 15, 2023.

² For additional information, see *CDER's Quality Management Maturity (QMM) Program: Practice Areas and Prototype Assessment Protocol Development* (2023), available at <https://www.fda.gov/media/171705/download?attachment>.

³ See 89 FR 4950, January 25, 2024.

C. Selection Process

CDER intends to select participants that reasonably reflect the diversity of the industry. CDER intends to notify each establishment of a decision on their request to participate within 60 days of receipt. CDER intends to select up to nine volunteer participants for this program.

D. FDA-Participant Interactions

CDER intends to notify participants of their selection and confirm their willingness to participate. Selected participants will receive orientation materials which will contain additional information about program timelines, milestones, and expectations. Participating establishments will also receive a pre-assessment questionnaire, which will provide them with specific topic areas that will be covered during the assessment. The pre-assessment questionnaire is intended to help establishments prepare for the assessment and identify the relevant subject matter experts to support the assessment. CDER will also provide each establishment with options for dates and times to schedule the assessment which may take up to five days.

Each assessment will be conducted by a team of three assessors. The assessment team will be composed of CDER staff and will not include FDA personnel from the Office of Inspections and Investigations charged with the responsibility of ensuring CGMP compliance. In advance of the assessment, the establishment will receive an agenda so that they can assure the appropriate subject matter experts are available at the requested times. The entire leadership team does not need to be present for the full assessment. If necessary, personnel may participate remotely as the establishment deems appropriate.

Following completion of the assessment, each participating establishment will receive a QMM assessment report that provides their score in each practice area and underlying topics covered along with context for how the score was determined. The report will highlight 2–3 areas of strength and 2–3 actionable opportunities for improvement in each practice area. Participating establishments are encouraged to select at least one opportunity for improvement identified in the QMM assessment report and develop a plan to implement improvement(s). Establishments are requested to share their improvement plan with CDER, and a meeting will be scheduled to discuss

the proposed plan 3 months after the assessment. Approximately 6 months after the assessment, CDER will schedule a final check-in meeting to discuss any progress made toward the improvement goals. CDER will solicit feedback from each establishment on the assessment, the QMM assessment report, and invites any suggestions or input to improve the program. This information will help CDER evaluate the QMM assessment tool and process to determine whether it enables a meaningful assessment of the establishment's quality management practices and if feedback for the establishment is actionable.

Lowell M. Zeta,

Acting Deputy Commissioner for Policy, Legislation, and International Affairs.

[FR Doc. 2026–02768 Filed 2–10–26; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of General Medical Sciences; Cancellation of Meeting

Notice is hereby given of a change in the meeting of the National Institute of General Medical Sciences, March 18, 2026, 9:30 a.m. to 4:30 p.m., National Institutes of Health, NIGMS, Natcher Building, 45 Center Drive, Bethesda, MD 20892 which was published in the **Federal Register** on December 29, 2025, FR Doc. 2025–23835, 90 FR 60733.

This meeting notice is to cancel the meeting scheduled for March 18, 2026. This meeting will not be rescheduled.

Dated: February 9, 2026.

David W. Freeman,

Supervisory Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2026–02726 Filed 2–10–26; 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; Fellowships: Risk, Prevention, and Health Behavior.

Date: March 11–12, 2026.

Time: 9:00 a.m. to 5:30 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: Trina Colleen Salm Ward, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (301) 594–5254, salmwardtc@csr.nih.gov.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Career Development K Awards: Clinical Scientists, Bioengineering, Surgery and Imaging.

Date: March 11, 2026.

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: Evon Sami Abisaid, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, Bethesda, MD 20892, (227) 259–7968, evon.abisaid@nih.gov.

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR–23–242: NCI Research Specialist (Laboratory-based Scientist) Award (R50).

Date: March 11, 2026.

Time: 11:00 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: Bruce Daniel Hissong, Ph.D., Scientific Review Officer, Cancer Therapeutics Branch, Division of Translational and Clinical Sciences, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Rm. 806E, Bethesda, MD 20892, (240) 276–7752, bruce.hissong@nih.gov.

Name of Committee: Bioengineering Sciences & Technologies Integrated Review Group; Drug and Biologic Therapeutic Delivery Study Section.

Date: March 16–17, 2026.

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: Janice Duy, Ph.D.,
 Scientific Review Officer, Center for
 Scientific Review, National Institutes of
 Health, 6701 Rockledge Drive, Bethesda, MD
 20892, (301) 594–3139, janice.duy@nih.gov.

Name of Committee: Interdisciplinary
 Molecular Sciences and Training Integrated
 Review Group; Enabling Bioanalytical and
 Imaging Technologies Study Section.

Date: March 16–17, 2026.

Time: 9:30 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant
 applications.

Address: National Institutes of Health,
 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Kenneth Ryan, Ph.D.,
 Scientific Review Officer, Center for
 Scientific Review, National Institutes of
 Health, 6701 Rockledge Drive, Room 3218,
 MSC 7717, Bethesda, MD 20892, 301–435–
 0229, kenneth.ryan@nih.hhs.gov.

Name of Committee: Risk, Prevention and
 Health Behavior Integrated Review Group;
 Biobehavioral Medicine and Health
 Outcomes Study Section.

Date: March 16–17, 2026.

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: Mark A. Vosvick, Ph.D.,
 Scientific Review Officer, Center for
 Scientific Review, National Institutes of
 Health, 6701 Rockledge Drive, Room 3110,
 Bethesda, MD 20892, (301) 402–4128,
mark.vosvick@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: February 6, 2026.

Bruce A. George,

*Program Analyst, Office of Federal Advisory
 Committee Policy.*

[FR Doc. 2026–02669 Filed 2–10–26; 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; Topics in
 Drug Development, Resistance, and
 Therapeutics.

Date: February 23–24, 2026.

Time: 10:00 a.m. to 3:00 p.m.

Agenda: To review and evaluate grant
 applications.

Address: National Institutes of Health,
 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Robert C Unfer, Ph.D.,
 Scientific Review Officer, Scientific Review
 Program, Division of Extramural Activities,
 Room 3F40A, National Institutes of Health,
 NIAID, 5601 Fishers Lane, MSC 9834,
 Bethesda, MD 20892–9834, (240) 669–5035,
robert.unfer@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: February 6, 2026.

Bruce A. George,

*Program Analyst, Office of Federal Advisory
 Committee Policy.*

[FR Doc. 2026–02670 Filed 2–10–26; 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–23–
 077: Collaborative Program Grant for
 Multidisciplinary Teams (RM1—Clinical
 Trial Optional).

Date: February 20, 2026.

Time: 10:00 a.m. to 12:30 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: Bruce Sundstrom, Ph.D.,
 Scientific Review Officer, Center for
 Scientific Review, National Institutes of
 Health, 6701 Rockledge Drive, Bethesda, MD
 20892, (240) 669–5045, sundstromj@niaid.nih.gov.

This notice is being published less than 15
 days from the meeting date due to
 exceptional circumstances. As a result of the
 43-day government shutdown, due to lapsed
 appropriations, the above meeting was
 canceled. This meeting was to assess the
 scientific and technical merit of NIH grant
 applications, required by statute to disburse
 NIH funds. The meeting must take place
 urgently so that evaluations of biomedical
 research applications addressing multiple
 major public health priorities can be
 submitted to the national advisory councils
 for timely funding recommendations.

Name of Committee: Center for Scientific
 Review Special Emphasis Panel; PAR–22–
 180: Maximizing Investigators' Research
 Award (MIRA).

Date: February 23, 2026.

Time: 1:00 p.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: Ezgi Kunttas-Tatli, Ph.D.,
 Scientific Review Officer, Center for
 Scientific Review, National Institutes of
 Health, 6701 Rockledge Drive, Bethesda, MD
 20892, (301) 594–7047, ezgi.kunttas-tatli@nih.gov.

This notice is being published less than 15
 days from the meeting date due to
 exceptional circumstances. As a result of the
 43-day government shutdown, due to lapsed
 appropriations, the above meeting was
 canceled. This meeting was to assess the
 scientific and technical merit of NIH grant
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 Program Nos. 93.306, Comparative Medicine;
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 93.337, 93.393–93.396, 93.837–93.844,
 93.846–93.878, 93.892, 93.893, National
 Institutes of Health, HHS)

Dated: February 6, 2026.

Bruce A. George,

*Program Analyst, Office of Federal Advisory
 Committee Policy.*

[FR Doc. 2026–02668 Filed 2–10–26; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Eunice Kennedy Shriver National Institute of Child Health & Human Development; Notice of Meeting

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of a meeting of the National Advisory Child Health and Human Development Council.

The meeting will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting. The meeting can be accessed from the NIH Videocast at the following link: <https://videocast.nih.gov/>.

The meeting 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: National Advisory Child Health and Human Development Council.

Date: July 8, 2026.

Open: 9:00 a.m. to 2:00 p.m.

Agenda: NICHD Director's Report; NIH Strategic Plan for Disability Health Research; Voice of the trainee; Presentation; Concept Clearance; Council Statement of Understanding.

Address: Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health, 6710 B Rockledge Drive, Bethesda, MD 20817.

Meeting Format: In-person.

Closed: 2:00 p.m. to 5:00 p.m.

Agenda: Review of Applications, Closing remarks; Adjournment.

Address: Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health, 6710 B Rockledge Drive, Bethesda, MD 20817.

Meeting Format: In-person.

Contact Person: Rebekah S. Rasooly, Ph.D., Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health, 6710B Rockledge Drive, Bethesda, MD 20817, Phone: 301-827-2599, Email: Rebekah.rasooly@nih.gov.

Registration is not required to attend the open portion of this meeting.

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

Information is also available on the Institute's/Center's home page: <https://www.nichd.nih.gov/about/advisory/council>, where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program No. 93.242, Mental Health Research Grants, National Institutes of Health, HHS)

Dated: February 6, 2026.

Margaret N. Vardanian,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2026-02671 Filed 2-10-26; 8:45 am]

BILLING CODE 4140-01-P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[Docket No. USCG-2025-0097]

Notification of the Revocation of Facility Exemptions From the Port Security Advisory

AGENCY: Coast Guard, DHS.

ACTION: Notice.

SUMMARY: The Coast Guard announces that it is revoking port facility exemptions from the Port Security Advisory for Cameroon, Iraq, and Madagascar.

DATES: The policy announced in this notice is effective on February 25, 2026.

FOR FURTHER INFORMATION CONTACT: For information about this document call or email Mr. Edward Munoz, Division Chief, International Port Security Assessments, United States Coast Guard, telephone 202-372-2122, HQS-DG-IPSPProgramHQs@uscg.mil.

SUPPLEMENTARY INFORMATION:

Background and Purpose

The authority for this notice is 5 U.S.C. 552(a) ("Administrative Procedure Act"), 46 U.S.C. 70110 ("Maritime Transportation Security Act"), and Department of Homeland Security Delegation No. 0170.1(II)(97)(f). As delegated, section 70110(a) authorizes the Coast Guard to impose conditions of entry on vessels arriving in U.S. waters from ports that the Coast Guard has not found to maintain effective antiterrorism measures.

Effective antiterrorism measures require government oversight and

security functions like risk assessments, drills, enforcement, and intelligence sharing cannot be delegated to individual facilities. Without proper oversight, exempted facilities may lack the necessary approvals, enforcement mechanisms, and broader security coordination, increasing vulnerabilities to the marine transportation system. Accordingly, the Coast Guard is revoking port facility exemptions for Cameroon, Iraq, and Madagascar. With this notice, the current list of countries assessed and not maintaining effective antiterrorism measures is as follows: Cambodia, Cameroon, Comoros, Cuba, Democratic People's Republic of Korea (North Korea), Equatorial Guinea, Gambia (The), Guinea-Bissau, Iran, Iraq, Libya, Madagascar, Micronesia (Federated States of), Nauru, Nigeria, Sao Tome and Principe, Seychelles, Sudan, Suriname, Syria, Timor-Leste, Venezuela, and Yemen. The current Port Security Advisory is available at: <http://www.dco.uscg.mil/Our-Organization/Assistant-Commandant-for-Prevention-Policy-CG-5P/International-Domestic-Port-Assessment/>.

Dated: February 6, 2026.

Douglas M. Schofield,

Rear Admiral, Acting Deputy Commandant for Operations, U.S. Coast Guard.

[FR Doc. 2026-02721 Filed 2-10-26; 8:45 am]

BILLING CODE 9110-04-P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID: FEMA-2025-0311; OMB No. 1660-0070]

Agency Information Collection Activities: Proposed Collection; Comment Request; National Fire Department Registry

AGENCY: Federal Emergency Management Agency, Department of Homeland Security.

ACTION: 60-Day notice of extension 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 an extension of a currently approved information collection. In accordance with the requirements of the Paperwork Reduction Act of 1995, this notice seeks comments concerning the use of a form to collect data for the development and

continuation of the National Fire Department Registry.

DATES: Comments must be submitted on or before April 13, 2026.

ADDRESSES: To avoid duplicate submissions to the docket, please submit comments at www.regulations.gov under Docket ID FEMA-2025-0311. Follow the instructions for submitting comments.

All submissions received must include the agency name and Docket ID. Regardless of the method used to submitting comments or material, all submissions will be posted, without change, to the Federal eRulemaking Portal at 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: Craig Rollins, Supervisory Program Specialist, National Fire Data Center, United States Fire Administration, FEMA, (202) 710-1836, and craig.rollins@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 Federal Fire Prevention and Control Act of 1974 (Pub. L. 93-498), as enacted in 15 U.S.C. chapter 49, provides for the gathering and analyzing of data as deemed useful and applicable for fire departments. The U.S. Fire Administration (USFA) receives many requests from fire service organizations and the general public for information related to fire departments, including the total number of departments, number of stations per department, population protected, and number of firefighters. The USFA also has a need for this information to guide programmatic decisions and produce mailing lists for USFA publications.

Recommendations for the creation of the fire department census database came out of a Blue Ribbon Panel's review of the USFA. The report included a review of the structure, mission, and funding of the USFA, future policies, programmatic needs, course development and delivery, and the role of the USFA to reflect changes in the fire service. As a result of those recommendations, the USFA is working to identify all fire departments in the United States to develop a database that includes information related to demographics, capabilities, and activities of fire departments

nationwide. In the fall of 2016, the USFA renamed the census to the National Fire Department Registry.

Collection of Information

Title: National Fire Department Registry.

Type of Information Collection: Extension of a currently approved information collection.

OMB Number: 1660-0070.

FEMA Forms: FEMA Form FF-USFA-FY-21-100 (formerly 070-0-0-1), Paper Version; FEMA Form FF-USFA-FY-21-110 (formerly 070-0-0-1), Online Version.

Abstract: This collection seeks to identify fire departments in the United States to compile a database related to their demographics, capabilities, and activities. The database is used to guide programmatic decisions and provide information to the public and the fire service.

Affected Public: State, Local or Tribal Government.

Estimated Number of Respondents: 6,375.

Estimated Number of Responses: 6,375.

Estimated Total Annual Burden Hours: 1,219.

Estimated Total Annual Respondent Cost: \$18,216.

Estimated Respondents' Operation and Maintenance Costs: \$0.

Estimated Respondents' Capital and Start-Up Costs: \$0.

Estimated Total Annual Cost to the Federal Government: \$108,310.

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.

Nigel S. Allicock,

Records Management Branch Chief, Office of the Chief Administrative Officer, Mission Support, Federal Emergency Management Agency, Department of Homeland Security.

[FR Doc. 2026-02676 Filed 2-10-26; 8:45 am]

BILLING CODE 9111-76-P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID: FEMA-2025-0047; OMB No. 1660-0152]

Agency Information Collection Activities: Submission for OMB Review, Comment Request; FEMA-Administered Disaster Case Management

AGENCY: Federal Emergency Management Agency, Department of Homeland Security.

ACTION: 30-Day Notice of Reinstatement and Request for Comments.

SUMMARY: The Federal Emergency Management Agency (FEMA) will submit the information collection abstracted below to the Office of Management and Budget for review and clearance in accordance with the requirements of the Paperwork Reduction Act of 1995. FEMA invites the general public to take this opportunity to comment on a reinstatement, without change, of a previously approved information collection for which approval has expired. In accordance with the requirements of the Paperwork Reduction Act of 1995, this notice seeks comments concerning information collected for a FEMA-Administered Disaster Case Management (DCM) program implemented following a major disaster declaration.

DATES: Comments must be submitted on or before March 13, 2026.

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: Requests for additional information or copies of the information collection should be made to Director, Information

Management Division, 500 C Street SW, Washington, DC 20472, email address FEMA-Information-Collections-Management@fema.dhs.gov or Heather Spadaro, Section Chief, Community Services Section, Individual Assistance Division, 202-646-3642, and fema-hq.css@fema.dhs.gov.

SUPPLEMENTARY INFORMATION: Pursuant to Executive Order (E.O.) 12148, as amended by E.O. 12673 and E.O. 13286, the President of the United States has delegated to the Department of Homeland Security (DHS), including FEMA, the authority to provide case management services pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), 42 U.S.C. 5189d. Under the Stafford Act, FEMA may provide DCM services directly to survivors through financial assistance to State, Tribal, or local government agencies or qualified private organizations. DCM services include identifying and addressing disaster-caused unmet needs of survivors through identification of, and referrals to, available resources. A disaster-caused unmet need is an un-resourced item, support, or assistance that has been assessed and verified as necessary for a survivor to recover from a disaster. This may include food, clothing, shelter, first aid, emotional and spiritual care, household items, home repair, or rebuilding. When a case manager speaks to a survivor, they will ask the survivor to provide information through a series of questions (data elements), as outlined within the intake form. This will allow the case manager to better understand the survivor's disaster-caused unmet needs, to identify what types of referrals the case manager may provide, and to decide whether there is a need to meet again to address continuing disaster-caused unmet needs. Case managers then type the responses to the data elements into their proprietary electronic secured case management database.

This proposed information collection previously published in the **Federal Register** on August 1, 2025, at 90 FR 36167 with a 60-day public comment period. One public comment was received (FEMA-2025-0047-0002) that suggests changes to the overall Disaster Case Management Program, but not germane to these collection forms. The purpose of this notice is to notify the public that FEMA will submit the information collection abstracted below to the Office of Management and Budget for review and clearance.

Collection of Information

Title: FEMA-Administered Disaster Case Management.

Type of Information Collection: Reinstatement, without change, of a previously approved information collection.

OMB Number: 1660-0152.

FEMA Forms: FEMA Form FF-104-FY-21-146, Administered DCM Intake Form; and FEMA Form FF-104-FY-21-147, Consent Form.

Abstract: This collection tool will primarily be used as a guide to support FEMA-administered DCM case managers by outlining the allowable data elements they can collect from survivors on behalf of FEMA. While there will be a paper collection tool, the case managers will primarily be using the tool as a reference for data elements they can collect and using their own case management database systems to guide the order in which the elements are collected. The elements within the tool are used to assess, screen, and refer disaster survivors to available resources that address their specific disaster-related unmet needs. Case managers then take the information from the intake form and manually upload the data into their secured case management database. Prior to any data collection, survivors will complete and sign a FEMA administered DCM Consent Form, authorizing FEMA, or its agent, to collect data from the survivor in order to effectively provide case management services.

Affected Public: Individuals and Households.

Estimated Number of Respondents: 30,750.

Estimated Number of Responses: 30,750.

Estimated Total Annual Burden Hours: 19,680.

Estimated Total Annual Respondent Cost: \$932,045.

Estimated Respondents' Operation and Maintenance Costs: \$0.

Estimated Respondents' Capital and Start-Up Costs: \$0.

Estimated Total Annual Cost to the Federal Government: \$51,693,869.

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.

Nigel S. Allicock,

Records Management Branch Chief, Office of the Chief Administrative Officer, Mission Support, Federal Emergency Management Agency, Department of Homeland Security.

[FR Doc. 2026-02683 Filed 2-10-26; 8:45 am]

BILLING CODE 9111-24-P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID: FEMA-2025-0212; OMB No. 1660-0080]

Agency Information Collection Activities: Proposed Collection, Comment Request; Application for Surplus Federal Real Property Public Benefit Conveyance and BRAC Program for Emergency Management Use

AGENCY: Federal Emergency Management Agency, Department of Homeland Security.

ACTION: 60-Day notice of extension 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 an extension of a currently approved information collection. In accordance with the requirements of the Paperwork Reduction Act of 1995, this notice seeks comments concerning the application process for the conveyance of Federal real property for public benefit. The purpose of this application is to implement the processes and procedures for the successful, lawful, and expeditious conveyance of real property from the Federal Government to public entities such as State, local, city, town, or other like government bodies as it relates to emergency management response purposes, including fire and rescue services. Compliance will ensure that properties will be fully positioned to use at their highest and best potentials as required

by General Services Administration (GSA) and Department of Defense (DOD) regulations, Federal law, Executive Orders, and the Code of Federal Regulations (CFR).

DATES: Comments must be submitted on or before April 13, 2026.

ADDRESSES: To avoid duplicate submissions to the docket, please submit comments at <http://www.regulations.gov> under Docket ID FEMA-2025-0212. Follow the instructions for submitting comments.

All submissions received must include the Agency name and Docket ID. Regardless of the method used to 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 <http://www.regulations.gov>.

FOR FURTHER INFORMATION CONTACT: Justin Dowdy, Realty Specialist, Federal Emergency Management Agency, 202-735-6328, justin.dowdy@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: Excess Federal real property is defined as property that is no longer mission critical to the needs of the Federal Government. The conveyance and disposal of excess real property is governed by the Federal Property and Administrative Services Act of 1949 (Property Act) as amended, 40 U.S.C. 541, *et seq.*, 40 U.S.C. 553, and applicable regulations (41 CFR parts 102-75.750 through 102.75.815). Under the sponsorship of FEMA the Property Act gives the GSA Administrator authority to convey Federal real and related surplus property (without monetary consideration) to units of State and local government for emergency management response purposes, including fire rescue services. The scope and philosophy of GSA's real property policies are contained in 41 CFR part 102-71.

Collection of Information

Title: Application for Surplus Federal Real Property Public Benefit Conveyance and BRAC Program for Emergency Management Use.

Type of Information Collection: Extension of a currently approved information collection.

OMB Number: 1660-0080.

FEMA Forms: FEMA Form FF-119-FY-22-133, Application for Surplus Federal Real Property Public Benefit Conveyance.

Abstract: Use of the Application for Surplus Federal Real Property Public Benefit Conveyance and Base Realignment and Closure (BRAC) Program for Emergency Management Use is necessary to implement the processes and procedures for the successful, lawful, and expeditious conveyance of real property from the Federal Government to public entities such as State, local, county, city, town, or other like government bodies, as it relates to emergency management response purposes, including fire and rescue services. Utilization of this application will ensure that properties will be fully positioned for use at their highest and best potentials as required by GSA and DOD regulations, public law, Executive Orders, and the CFR.

Affected Public: State, Local or Tribal Government.

Estimated Number of Respondents: 15.

Estimated Number of Responses: 15.

Estimated Total Annual Burden Hours: 68.

Estimated Total Annual Respondent Cost: \$3,744.

Estimated Respondents' Operation and Maintenance Costs: \$0.

Estimated Respondents' Capital and Start-Up Costs: \$0.

Estimated Total Annual Cost to the Federal Government: \$3,730.

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.

Nigel S. Allicock,

Records Management Branch Chief, Office of the Chief Administrative Officer, Mission Support, Federal Emergency Management Agency, Department of Homeland Security.

[FR Doc. 2026-02678 Filed 2-10-26; 8:45 am]

BILLING CODE 9111-19-P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID: FEMA-2025-0015; OMB No. 1660-NW179]

Agency Information Collection Activities: Submission for OMB Review, Comment Request; FEMA Reasonable Accommodation Medical Request Form

AGENCY: Federal Emergency Management Agency, Department of Homeland Security.

ACTION: 30-Day Notice of New Collection and Request for Comments.

SUMMARY: The Federal Emergency Management Agency (FEMA) will submit the information collection abstracted below to the Office of Management and Budget (OMB) for review and clearance in accordance with the requirements of the Paperwork Reduction Act of 1995. FEMA invites the general public to take this opportunity to comment on an existing information collection in use without an OMB control number. In accordance with the requirements of the Paperwork Reduction Act of 1995, this notice seeks comments concerning FEMA's new instrument to collect information to make informed reasonable accommodation decisions.

DATES: Comments must be submitted on or before March 12, 2026.

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: Requests for additional information or copies of the information collection should be made to Director, Information Management Division, 500 C Street SW, Washington, DC 20472, email address FEMA-Information-Collections-

Management@fema.dhs.gov or Mr. Michael Butkovich, Senior Director, Office of the Chief Administrative Officer, Integration and Coordination Division, (202) 919-1589 or Michael.Butkovich@fema.dhs.gov.

SUPPLEMENTARY INFORMATION: FEMA is making a submission to OMB for this collection of information requesting medical documentation from a licensed health care provider about the functional limitations, duration, and need for a reasonable accommodation that support an employee or applicant's request for reasonable accommodation in accordance with the Rehabilitation Act of 1973, 29 CFR part 1614, and Executive Order 13163 on Increasing the Opportunity for Individuals With Disabilities To Be Employed in the Federal Government.

Consistent with the law, FEMA managers have a right to request medical documentation when a disability or need for accommodation is not known or obvious. The intended respondents include primarily employees and their respective licensed health care providers but may also include applicants for FEMA employment. Generally, two individuals will complete each form, the requestor and the licensed medical professional. An estimated 2,000 individuals will be requested to fill out this form annually, and an estimated 232 will respond to the collection of information.

FEMA managers will use the information gathered to inform decisions about whether to grant an accommodation and determine together with the employee in an interactive process what accommodations would most appropriately address the requestor's functional limitations. The medical data on this form will be considered confidential and will only be distributed to those in the organization with a need to know. The data will be saved in an approved system of records (authorized by the Department of Homeland Security), which will require an additional recordkeeping burden of approximately two (2) hours per form (including analyzing the form and saving the form in the approved recordkeeping system).

This proposed information collection previously published in the **Federal Register** on August 15, 2025, at 90 FR 39411 with a 60-day public comment period. No comments were received. The purpose of this notice is to notify the public that FEMA will submit the information collection abstracted below to OMB for review and clearance.

Collection of Information

Title: FEMA Reasonable Accommodation Medical Request Form

Type of Information Collection: Existing information collection in use without an OMB control number.

OMB Number: 1660-NW179.

FEMA Forms: FEMA Form FF-256-FY-25-100, FEMA Reasonable Accommodation Medical Request Form.

Abstract: FEMA's new form supports a fair, efficient, and consistent process for evaluating employee requests for reasonable accommodations. It ensures that medical information is collected by license health care providers, helping the agency make informed decisions. FEMA is streamlining the process by ensuring that all necessary and relevant information is consistently captured. By providing a clear and uniform structure, it enhances efficiency for employees and licensed health care providers, while reducing the potential for delays caused by incomplete or insufficient submissions of medical documentation.

Affected Public: Business or other for-profit, and not-for-profit institutions.

Estimated Number of Respondents: 232.

Estimated Number of Responses: 232.

Estimated Total Annual Burden Hours: 116.

Estimated Total Annual Respondent Cost: \$7,901.

Estimated Respondents' Operation and Maintenance Costs: \$0.

Estimated Respondents' Capital and Start-Up Costs: \$0.

Estimated Total Annual Cost to the Federal Government: \$469,728.

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.

Nigel S. Allicock,

Records Management Branch Chief, Office of the Chief Administrative Officer, Mission Support, Federal Emergency Management Agency, Department of Homeland Security.

[FR Doc. 2026-02685 Filed 2-10-26; 8:45 am]

BILLING CODE 9111-19-P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID: FEMA-2024-0032; OMB No. 1660-NW178]

Agency Information Collection Activities: Proposed Collection, Comment Request; CBRNResponder Network

AGENCY: Federal Emergency Management Agency, Department of Homeland Security.

ACTION: 60-Day Notice of New Collection 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 an existing information collection in use without an OMB control number. In accordance with the requirements of the Paperwork Reduction Act of 1995, this notice seeks comments concerning allowing first responders and other response organizations to create accounts and share hazard specific data in the event of a chemical, biological, radiological, or nuclear (CBRN) disaster.

DATES: Comments must be submitted on or before April 13, 2026.

ADDRESSES: To avoid duplicate submissions to the docket, please submit comments at <http://www.regulations.gov> under Docket ID FEMA-2024-0032. Follow the instructions for submitting comments.

All submissions received must include the Agency name and Docket ID. Regardless of the method used to 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 <http://www.regulations.gov>.

FOR FURTHER INFORMATION CONTACT:

Joselito Ignacio, Acting Director and Public Health Advisor, Office of Emerging Threats, 202–212–5710, and joselito.ignacio@fema.dhs.gov or Diane Cooper, Senior Risk Analyst, Office of Emerging Threats, 202–701–4521, and diane.cooper@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: FEMA's CBRNResponder new user request, new organization request and hazard specific data input forms bring together both Federal and State partners in the unified response to a chemical, biological, radiological, or nuclear disaster. These collections meet the requirements set forth in the Homeland Security Act of 2002, Public Health Security and Bioterrorism Preparedness and Response Act of 2002, the Homeland Security and Presidential Directive HSPD–5, Presidential Policy Directive 44, Memorandum of Agreement between DHS and FEMA operations and coordination, the National Oil and Hazardous Substances Pollution Contingency Plan, the National Response Framework and the Nuclear/Radiological Annex. Responders across the country can opt into this service and utilize its tools to create a common operating picture and streamline a unified response. This occurs when a first responder signs up for an account, joins their local organization and responds to a disaster utilizing the tool.

Collection of Information

Title: CBRNResponder Network.

Type of Information Collection:

Existing information collection in use without an OMB control number.

OMB Number: 1660–NW178.

FEMA Forms: FEMA Form FF–104–FY–24–125, New Users Request for an Account; FEMA Form FF–104–FY–24–124, New User Request for an Organization; and FEMA Form FF–104–FY–24–126, Users Submitting Hazard Specific Data.

Abstract: The collection of this information is primarily for State and local response organizations and the first responders that support incidents. This information will inform State and locals, as well as their partner agencies, of the actual hazard and amounts of that hazard on the ground, in the water, and in the air. The data will also be viewable in the CBRNResponder Network to Federal agencies that have a supporting role to a CBRN incident. In addition, the data may be distributed to Federal Partners if a Federal Partner requests the

information to support incident response and recovery activities.

Affected Public: State, local or Tribal Governments.

Estimated Number of Respondents: 2,550.

Estimated Number of Responses: 2,550.

Estimated Total Annual Burden Hours: 81.

Estimated Total Annual Respondent Cost: \$4,031.

Estimated Respondents' Operation and Maintenance Costs: \$0.

Estimated Respondents' Capital and Start-Up Costs: \$0.

Estimated Total Annual Cost to the Federal Government: \$19,815.

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.

Nigel S. Allicock,

Records Management Branch Chief, Office of the Chief Administrative Officer, Mission Support, Federal Emergency Management Agency, Department of Homeland Security.

[FR Doc. 2026–02684 Filed 2–10–26; 8:45 am]

BILLING CODE 9111–24–P

DEPARTMENT OF HOMELAND SECURITY**Federal Emergency Management Agency**

[Docket ID: FEMA–2026–0003; OMB No. 1660–0072]

Agency Information Collection Activities: Proposed Collection, Comment Request; Hazard Mitigation Grant Programs

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 the information collection instruments for FEMA's Hazard Mitigation Assistance (HMA) Grant programs.

DATES: Comments must be submitted on or before April 13, 2026.

ADDRESSES: Submit comments at www.regulations.gov under Docket ID FEMA–2026–0003. Follow the instructions for submitting comments.

All submissions received must include the agency name and Docket ID, and 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: H-Camille Crain, Deputy Director, Documents, Design, Program Effectiveness Branch, FEMA, at 202–212–4871 or via email at H-Camille.Crain@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: This collection of information is necessary for eligibility determinations, grants management, and compliance with other Federal laws and regulations for HMA's financial and technical assistance programs. HMA programs included in this information collection are the Flood Mitigation Assistance (FMA) program, the FMA Swift Current (Swift Current) program, the Building Resilient Infrastructure and Communities (BRIC) program, BRIC Direct Technical Assistance (DTA), the Pre-Disaster Mitigation (PDM) program, the Safeguarding Tomorrow Revolving Loan Fund (RLF) Program, the Rehabilitation of High Hazard Potential Dams (HHPD), and the National Dam Safety Program (NDSP).

The FMA program is authorized by Section 1366 of the National Flood Insurance Act of 1968, as amended (Pub. L. 90–448, 42 U.S.C. 4104c); the

Flood Disaster Protection Act of 1973 (Pub. L. 93–234, 42 U.S.C. 4001 *et seq.*); and the National Flood Insurance Reform Act of 1994 (Pub. L. 103–325, 42 U.S.C. 4001). FMA under 44 CFR part 77 (October 1, 2021) (previously located at 44 CFR part 79) provides funding for measures taken to reduce or eliminate the long-term risk of flood damage to buildings, manufactured homes, and other structures insured under the National Flood Insurance Program (NFIP).

The BRIC program is authorized by Section 203 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), as amended (Pub. L. 93–288, 42 U.S.C. 5133). The BRIC program seeks to fund effective and innovative activities that will reduce risk, increase resilience, and serve as a catalyst to encourage the whole community to invest in and adopt hazard mitigation policies. BRIC is designed to promote a national culture of preparedness and public safety by encouraging investments to protect our communities and infrastructure and strengthen our national hazard mitigation capabilities to foster resilience.

BRIC DTA provides non-financial direct technical assistance as authorized by Section 203 of the Stafford Act to eligible communities, helping them reduce risks from natural disasters and build resilience. The program offers hands-on guidance for developing and implementing mitigation projects, navigating funding opportunities, and strengthening local capability and capacity to address natural hazards. BRIC DTA focuses on ensuring communities can access resources and expertise to enhance disaster preparedness and resilience.

The PDM grant program is authorized under Section 203 of the Stafford Act. PDM makes Federal funds available to State, local, Tribal, and territorial governments to plan for and implement sustainable cost-effective measures designed to reduce the risk to individuals and property from future natural hazards, while also reducing reliance on federal funding from future disasters.

The NDSP is authorized under Section 215 of the Water Resources Development Act of 1996 (Public Law 104–303, 33 U.S.C. 467f). The NDSP was reauthorized in the Water Resources Reform and Development Act of 2014 (Pub. L. 113–121, 33 U.S.C. 2201). The NDSP enhances dam safety across the United States by reducing risks to life and property associated with dam failures through coordinated efforts among federal and state agencies

to improve dam safety practices, promote public awareness, and support the development and implementation of safety programs.

The HHPD program, established under Section 5006 of the Water Infrastructure Improvements for the Nation Act signed on December 16, 2016, is a grant program under the NDSP. The HHPD program provides technical, planning, design, and construction assistance through grants to support the rehabilitation of eligible high hazard potential dams. 33 U.S.C. 467f–2(f) mandates the development of a risk-based priority system to identify eligible high hazard potential dams for grant funding. Applicants must coordinate with the State Dam Safety Officer and State Hazard Mitigation Officer to meet grant requirements, including NFIP participation, hazard mitigation plans, floodplain management plans, risk prioritization, and state dam safety agency approval.

The Safeguarding Tomorrow RLF program, authorized under Section 205 of the Stafford Act, is a competitive grant program providing capitalization grants to States, eligible Federally recognized Tribes, territories, and the District of Columbia to establish revolving loan funds that provide hazard mitigation assistance for local governments to reduce risks from natural hazards and disasters.

In accordance with 2 CFR 200.204, FEMA requires that all parties interested in receiving FEMA mitigation grants submit an application package for grant assistance. Applications and subapplications for BRIC and FMA are submitted via FEMA Grants Outcomes (FEMA GO). FEMA GO was developed to meet the intent of the e-Government initiative, authorized by Federal Financial Assistance Management Improvement Act of 1999 (Pub. L. 106–107, 31 U.S.C. 6101). This initiative requires that all Government agencies both streamline grant application processes and provide for the means to electronically create, review, and submit a grant application via the internet.

FEMA is revising this information collection by adding three new instruments for the Safeguarding Tomorrow RLF Grant (the Grants Capitalization Form, Project Proposal List, and Intended Use Plan) and one new instrument for the HHPD program. The new instruments for the Safeguarding Tomorrow RLF Grant will facilitate program administration, track proposed projects, and outline intended use of funds. The HHPD Prioritization Tool will assist with the prioritization of dam safety projects.

Collection of Information

Title: FEMA Mitigation Grant Programs.

Type of Information Collection: Revision of a currently approved information collection.

OMB Number: 1660–0072.

FEMA Forms: FEMA Form FF–206–FY–22–151, Quarterly Progress Report (QPR); FEMA Form FF–206–FY–22–155, Building Resilient Infrastructure and Communities (BRIC) Direct Technical Assistance (DTA) Request Form; FEMA Form FF–206–FY–22–156, Model Statement of Assurances for Property Acquisition Projects; FEMA Form FF–206–FY–22–157, FEMA Model Deed Restriction; FEMA Form FF–206–FY–22–158; Acknowledgement of Conditions For Properties Using FEMA Hazard Mitigation Assistance Grant Funds; FEMA Form FF–206–FY–26–100, Benefit Cost Analysis (BCA) Toolkit; FEMA Form FF–206–FY–26–101, Safeguarding Tomorrow Revolving Loan Fund (RLF) Grant Capitalization Application; FEMA Form FF–206–FY–26–102 Safeguarding Tomorrow Revolving Loan Fund (RLF) Project Proposal List (PPL); FEMA Form FF–206–FY–26–103, Safeguarding Tomorrow Revolving Loan Fund (RLF) Intended Use Plan (IUP); FEMA Form FF–206–FY–26–104, FEMA Go Project Narrative Subgrant Application; FEMA Form FF–206–FY–26–105, Building Resilient Infrastructure and Communities (BRIC) National Review Panel Solicitation; FEMA Form FF–206–FY–26–106, High Hazard Potential Dams (HHPD) Prioritization Tool; and FEMA Form FF–207–FY–21–100 (formerly 024–0–1), Environmental and Historic Preservation (EHP) Review.

Abstract: HMA's financial and technical assistance programs use an automated grant application and management system called FEMA GO to collect information for eligibility determinations, grants management, and compliance with other Federal laws and regulations. The FEMA GO system includes application information needed to apply for funding under these grant programs. These programs seek to reduce or eliminate risk to insured structures, increase resilience, invest in community hazard mitigation policies, and strengthen local capability and capacity to address natural hazards.

Affected Public: State, local or Tribal Governments.

Estimated Number of Respondents: 841.

Estimated Number of Responses: 28,449.

Estimated Total Annual Burden Hours: 144,525.

Estimated Total Annual Respondent Cost: \$10,100,277.

Estimated Respondents' Operation and Maintenance Costs: \$0.

Estimated Respondents' Capital and Start-Up Costs: \$0.

Estimated Total Annual Cost to the Federal Government: \$8,350,161.

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.

Nigel S. Allicock,

Records Management Branch Chief, Office of the Chief Administrative Officer, Mission Support, Federal Emergency Management Agency, Department of Homeland Security.

[FR Doc. 2026-02677 Filed 2-10-26; 8:45 am]

BILLING CODE 9111-BW-P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID: FEMA-2025-0278; OMB No. 1660-0131]

Agency Information Collection Activities: Proposed Collection, Comment Request; Threat and Hazard Identification and Risk Assessment (THIRA)/Stakeholder Preparedness Review (SPR) Unified Reporting Tool

AGENCY: Federal Emergency Management Agency, Department of Homeland Security.

ACTION: 60-Day notice of extension 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 an

extension of a currently approved information collection. In accordance with the requirements of the Paperwork Reduction Act of 1995, this notice seeks comments concerning this annual requirement for the U.S. Department of Homeland Security (DHS), FEMA to identify current capability levels for all States, territories, urban areas, and Tribes receiving non-disaster preparedness grant funds administered by DHS.

DATES: Comments must be submitted on or before April 13, 2026.

ADDRESSES: To avoid duplicate submissions to the docket, please submit comments at <http://www.regulations.gov> under Docket ID FEMA-2025-0278. Follow the instructions for submitting comments.

All submissions received must include the Agency name and Docket ID. Regardless of the method used to 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 <http://www.regulations.gov>.

FOR FURTHER INFORMATION CONTACT: Benjamin Berger, Branch Chief, Risk Identification and Capability Assessments Branch, National Integration Center, FEMA, 202-372-5446, and Benjamin.berger@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: This package is an extension to the collection titled the Threat and Hazard Identification and Risk Assessment (THIRA)/Stakeholder Preparedness Review (SPR) Unified Reporting Tool under OMB Control Number 1660-0131. The Post-Katrina Emergency Management Reform Act of 2006 (PKEMRA) (Pub. L. 109-295), as amended by the Implementing Recommendations of the 9/11 Commission Act of 2007 (Pub. L. 110-53), established an annual requirement for the 56 States and territories to submit a State Preparedness Report. States, territories, urban areas, and Tribes receiving non-disaster preparedness grant funds administered by DHS submit the SPR annually, and this encompasses the requirements of the previous State Preparedness Report,

while reflecting the updated methodology reporting needs. The legislation requires a report on current capability levels and a description of targeted capability levels from all States, territories, urban areas, and Tribes receiving non-disaster preparedness grant funds administered by DHS. Each report must also include a discussion of the extent to which target capabilities identified in the applicable state homeland security plan and other applicable plans are unmet, and an assessment of resources needed to meet the preparedness priorities established under PKEMRA Section 646(e), including: (i) an estimate of the amount of expenditures required to attain the preparedness priorities; and (ii) the extent to which the use of Federal assistance during the preceding fiscal year achieved the preparedness priorities. To meet this requirement, States, territories, urban areas, and Tribes first identify capability targets through THIRA and then assess against these targets in the SPR. Through the SPR, these jurisdictions estimate their current capabilities, identify and describe gaps between current capabilities and targets, indicate their intended approach for addressing gaps in the future, and report on the impact of Federal grant dollars in building and sustaining capabilities. It is also important to note that completing the THIRA and SPR are allowable expenses under the grant awards.

Collection of Information

Title: Threat and Hazard Identification and Risk Assessment (THIRA)/Stakeholder Preparedness Review (SPR) Unified Reporting Tool.

Type of Information Collection: Extension, without change, of a currently approved information collection.

OMB Number: 1660-0131.

FEMA Forms: FEMA Form FF-008-FY-21-106 (formerly FEMA Forms 008-0-19 and 008-0-20), Threat and Hazard Identification and Risk Assessment (THIRA)/Stakeholder Preparedness Review (SPR) Unified Reporting Tool; FEMA Form FF-008-FY-21-107 (formerly FEMA Form 0080-0-23), THIRA/SPR After Action Conference Calls.

Abstract: The information collected enables States, territories, urban areas, and Tribes, along with the Federal Government, to understand the risks these jurisdictions face from threats and hazards, to estimate the capabilities and resources they need to manage those risks, to assess their current capability levels against their targeted capability levels, and to identify gaps between

their current capabilities and the capabilities they need. FEMA and state, territory, urban area, and tribal jurisdictions use THIRA and SPR information to inform and prioritize their preparedness programs and activities.

Affected Public: State, Local or Tribal Government.

Estimated Number of Respondents: 256.

Estimated Number of Responses: 256.

Estimated Total Annual Burden Hours: 88,779.

Estimated Total Annual Respondent Cost: \$5,553,127.

Estimated Respondents' Operation and Maintenance Costs: \$18,564,156.

Estimated Respondents' Capital and Start-Up Costs: \$0.

Estimated Total Annual Cost to the Federal Government: \$2,427,319.

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.

Nigel S. Allicock,

Records Management Branch Chief, Office of the Chief Administrative Officer, Mission Support, Federal Emergency Management Agency, Department of Homeland Security.
[FR Doc. 2026-02682 Filed 2-10-26; 8:45 am]

BILLING CODE 9111-27-P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID: FEMA-2025-0377; OMB No. 1660-0085]

Agency Information Collection Activities: Proposed Collection; Comment Request; Crisis Counseling Assistance and Training Program

AGENCY: Federal Emergency Management Agency, Department of Homeland Security.

ACTION: 60-Day notice of extension 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 an extension, without change, of a currently approved information collection. In accordance with the Paperwork Reduction Act of 1995, this notice seeks comments concerning the Crisis Counseling Assistance and Training Program, which provides federal funding in response to a State or Federally recognized Tribe's request for Crisis Counseling services for a presidentially declared major disaster.

DATES: Comments must be submitted on or before April 13, 2026.

ADDRESSES: To avoid duplicate submissions to the docket, please submit comments at www.regulations.gov under Docket ID FEMA-2025-0377. 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: Heather Spadaro, State-Led Disaster Services Section, Individual Assistance Division, FEMA, 202-646-3642, and FEMA-HQ-IA-SDB-SLDS@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: Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, (Pub. L. 93-288, as amended and codified at 42 U.S.C. 5183) ("Act"), authorizes the President to provide professional counseling services, including financial assistance to States (which includes the fifty states, the District of Columbia, and the U.S. territories), Federally recognized Indian Tribal governments, local agencies or private mental health organizations for professional counseling services, to survivors of major disasters to relieve mental health problems caused or aggravated by a major disaster or its aftermath. The implementing regulations for Section 416 of the Stafford Act are at 44 CFR 206.171. Under 44 CFR 206.171 and by agreement, the U.S. Department of Health and Human Services-Center for Mental Health Services (HHS-CMHS), which has expertise in crisis counseling, coordinates with FEMA in administering the Crisis Counseling Assistance and Training Program (CCP). FEMA and HHS-CMHS provide program oversight, technical assistance, and training to States and Federally recognized Tribes applying for CCP funding for major disasters. The information submitted in the application is disaster-specific. The information submitted is used in the consideration of the following: funding for community outreach services, public education on behavioral health matters, group and individual crisis counseling, and resource and referral information (including coping techniques).

Collection of Information

Title: Crisis Counseling Assistance and Training Program.

Type of Information Collection: Extension, without change, of a currently approved information collection.

OMB Number: 1660-0085.

FEMA Forms: FEMA Form FF-104-FY-21-148 (formerly 003-0-1), Crisis Counseling Assistance and Training (ISP) Application; FEMA Form FF-104-FY-21-149 (formerly 003-0-2), Crisis Counseling Assistance and Training Program, Regular Services Program (RSP) Application; ISP Final Report Narrative; RSP Quarterly Final RSP Report Narrative. Final RSP Report Narrative.

Abstract: The CCP consists of two grant programs, the ISP and RSP. The ISP and RSP provide supplemental funding to States and Federally recognized Tribes following a Presidentially declared major disaster under the Stafford Act. These grant

programs provide funding for training and services, including community outreach, public education, and counseling techniques. States and Federally recognized Tribes are required to submit an application that provides information on Needs Assessment, Plan of Service, Program Management, and an accompanying Budget. The information being collected from both forms will be used to determine if existing resources are adequate to meet the behavioral health needs of disaster survivors and to determine if supplemental funds for crisis counseling services are necessary. Additionally, the information gathered from these forms will help to ensure the program's objectives are met and grants are properly administered in accordance with all applicable laws and regulations.

Affected Public: State, Local or Tribal Government.

Estimated Number of Respondents: 90.

Estimated Number of Responses: 108.

Estimated Total Annual Burden Hours: 1,728.

Estimated Total Annual Respondent Cost: \$185,379.

Estimated Respondents' Operation and Maintenance Costs: \$0.

Estimated Respondents' Capital and Start-Up Costs: \$0.

Estimated Total Annual Cost to the Federal Government: \$200,501.

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.

Nigel S. Allicock,

Records Management Branch Chief, Office of the Chief Administrative Officer, Mission Support, Federal Emergency Management Agency, Department of Homeland Security.

[FR Doc. 2026-02679 Filed 2-10-26; 8:45 am]

BILLING CODE 9111-24-P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID: FEMA-2025-0344; OMB No. 1660-0115]

Agency Information Collection Activities: Proposed Collection; Comment Request; Environmental and Historic Preservation Screening Form

AGENCY: Federal Emergency Management Agency, Department of Homeland Security.

ACTION: 60-Day notice of renewal 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 an extension, without change, of a currently approved information collection. In accordance with the Paperwork Reduction Act of 1995, this notice seeks comments concerning the information collection activities required to administer the Environmental and Historic Preservation Environmental Screening Form.

DATES: Comments must be submitted on or before April 13, 2026.

ADDRESSES: To avoid duplicate submissions to the docket, please submit comments at www.regulations.gov under Docket ID FEMA-2025-0344. 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 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: Beth McWaters-Bjorkman, Environmental Protection Specialist, Grant Programs Directorate, FEMA, 202-431-8594, elizabeth.mcwaters-bjorkman@fema.dhs.gov. You may contact the Records Management Division for copies of the proposed collection of information at email address: FEMA-Information-Collections-Management@fema.dhs.gov.

SUPPLEMENTARY INFORMATION: FEMA's Grant Programs Directorate (GPD) awards thousands of grants each year through various grant programs. These programs award funds for projects used to improve homeland security and emergency preparedness. The National Environmental Policy Act of 1969 (NEPA), Public Law 91-190, 42 U.S.C. 4321 *et seq.*, the National Historic Preservation Act of 1966 (NHPA), Public Law 89-665, 54 U.S.C. 300101 *et seq.*, the Endangered Species Act of 1973, Public Law 93-205, 16 U.S.C. 1531 *et seq.*, and a variety of other environmental and historic preservation laws and Executive Orders (E.O.) require the Federal Government to examine the potential environmental impacts of its proposed actions on communities, public health and safety, and cultural, historic, and natural resources, including endangered and threatened species, prior to implementing those actions. The GPD process of considering these potential impacts is called an environmental and historic preservation (EHP) review which is employed to achieve compliance with multiple EHP authorities through one consolidated process.

Collection of Information

Title: Environmental and Historic Preservation Screening Form.

Type of Information Collection: Extension, without change, of a currently approved information collection.

OMB Number: 1660-0115.

FEMA Forms: FEMA Form FF-119-FY-21-105 (formerly 024-0-1), Environmental and Historic Preservation Screening Form.

Abstract: NEPA requires that each Federal agency examine the impact of a major Federal action (including the actions of recipients using grant funds) significantly affecting the quality of the human environment. This involves considering the environmental impact of the proposed action, alternatives to the proposed action, informing both decision-makers and the public of the impacts through a transparent process, and identifying mitigation measures for any potential adverse impacts. Among other environmental laws, the review also involves considering the effects of the undertaking on historic properties under Section 106 of the National Historic Preservation Act and the effects of the action on any threatened or endangered species and their habitat under Section 7 of the Endangered Species Act of 1973. This Screening Form will facilitate FEMA's review of recipient Federally-funded actions in

FEMA's effort to comply with the environmental requirements.

Affected Public: State, local or Tribal government; Not-for-Profit Institutions.

Estimated Number of Respondents: 2,300.

Estimated Number of Responses: 2,300.

Estimated Total Annual Burden Hours: 16,752.

Estimated Total Annual Respondent Cost: \$1,140,739.

Estimated Respondents' Operation and Maintenance Costs: \$0.

Estimated Respondents' Capital and Start-Up Costs: \$0.

Estimated Total Annual Cost to the Federal Government: \$1,974,808.

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.

Nigel S. Allicock,

Records Management Branch Chief, Office of the Chief Administrative Officer, Mission Support, Federal Emergency Management Agency, Department of Homeland Security.

[FR Doc. 2026-02680 Filed 2-10-26; 8:45 am]

BILLING CODE 9111-78-P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID: FEMA-2025-0245; OMB No. 1660-0117]

Agency Information Collection Activities: Proposed Collection, Comment Request; FEMA's Grants Reporting Tool (GRT)

AGENCY: Federal Emergency Management Agency, Department of Homeland Security.

ACTION: 60-Day notice of extension 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 an extension of a currently approved information collection. In accordance with the requirements of the Paperwork Reduction Act of 1995, this notice seeks comments concerning the extension of this Information Collection Activities for the Grants Reporting Tool (GRT). The GRT is a web-based reporting system designed to help State, local, Tribal, and territorial (SLTT) grant recipients meet all reporting requirements as identified in the grant guidance of FEMA's portfolio of preparedness grants managed by the FEMA's Grant Programs Directorate (GPD), to include the Homeland Security Grant Program (HSGP), the Nonprofit Security Grant Program (NSGP), the Tribal Homeland Security Grant Program (THSGP), and the Emergency Management Performance Grant Program (EMPG).

DATES: Comments must be submitted on or before April 13, 2026.

ADDRESSES: To avoid duplicate submissions to the docket, please submit comments at <http://www.regulations.gov> under Docket ID FEMA-2025-0245. Follow the instructions for submitting comments.

All submissions received must include the Agency name and Docket ID. Regardless of the method used to 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 <http://www.regulations.gov>.

FOR FURTHER INFORMATION CONTACT:

Richard Moore, GRT System Owner, FEMA Resilience Grants Technology Directorate, 202-531-0572, and richard.moore.2@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 GRT is a web-based reporting system designed to help SLTT grant recipients meet all reporting requirements as identified in the grant guidance of

FEMA's portfolio of preparedness grants sponsored by FEMA's GPD. The purpose of the GRT collection is to satisfy FEMA's statutory requirement to monitor the use of FEMA grant funds by its SLTT grant recipients.

Title 2 CFR part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, establishes uniform administrative requirements, cost principles, and audit requirements for FEMA. Title XX of the Homeland Security Act of 2002 authorizes the Secretary of Homeland Security, acting through the FEMA Administrator, to provide grants to assist SLTT governments in preventing, preparing for, protecting against, and responding to acts of terrorism. Recipients use the GRT to submit annual investment justifications and biannual progress reports. Further, section 2022 of the Homeland Security Act of 2002 (6 U.S.C. 612) mandates that FEMA review grants awarded to States and high-risk urban areas at least every two years and requires that recipients submit annual reports on the use of funds awarded under sections 2003 or 2004 of the Homeland Security Act of 2002 (6 U.S.C. 604, 605, respectively). Section 2022 also provides the Department of Homeland Security (DHS) the authority to have full access to information regarding activities carried out under any grant DHS administers.

Additionally, Section 662 of the Post-Katrina Emergency Management Reform Act of 2006 (PKEMRA), as amended, (Pub. L. 109-295) (6 U.S.C. 762); the Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended (Pub. L. 93-288) (42 U.S.C. 5121 *et seq.*); the Earthquake Hazards Reduction Act of 1977, as amended (Pub. L. 95-124) (42 U.S.C. 7701 *et seq.*); and the National Flood Insurance Act of 1968, as amended (Pub. L. 90-448) (42 U.S.C. 4001 *et seq.*) authorize FEMA to administer the EMPG Program. Recipients use the GRT to submit biannual progress reports.

Collection of Information

Title: FEMA's Grants Reporting Tool (GRT).

Type of Information Collection: Extension, without change, of a currently approved information collection.

OMB Number: 1660-0117.

FEMA Forms: FEMA Form FF-207-FY-22-121, Biannual Strategy Implementation Report (BSIR).

Abstract: The GRT is a web-based reporting system designed to help State Administrative Agencies (SAAs) and directly eligible SLTT Governments

meet all reporting requirements as identified in the grant guidance of FEMA's portfolio of preparedness grants sponsored by FEMA's Grant Programs Directorate (GPD). The information enables FEMA to evaluate applications and make award decisions, monitor ongoing performance, and manage the flow of Federal funds, and to appropriately close out grants. GRT supports the information collection needs of each grant program processed in the system.

Affected Public: State, Local or Tribal Government.

Estimated Number of Respondents: 81.

Estimated Number of Responses: 162.

Estimated Total Annual Burden Hours: 2,471.

Estimated Total Annual Respondent Cost: \$130,741.

Estimated Respondents' Operation and Maintenance Costs: \$0.

Estimated Respondents' Capital and Start-Up Costs: \$0.

Estimated Total Annual Cost to the Federal Government: \$1,281,820.

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.

Nigel S. Allicock,

Records Management Branch Chief, Office of the Chief Administrative Officer, Mission Support, Federal Emergency Management Agency, Department of Homeland Security.

[FR Doc. 2026-02681 Filed 2-10-26; 8:45 am]

BILLING CODE 9111-78-P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA-2025-0080]

State of Michigan Radiological Emergency Preparedness Plan

AGENCY: Federal Emergency Management Agency, Department of Homeland Security.

ACTION: Notice of State plan approval.

SUMMARY: The Federal Emergency Management Agency (FEMA) is announcing the approval of radiological emergency response plans submitted by the State of Michigan. The approved plans support Holtec International's Palisades Nuclear Generating Station located in Van Buren County, Michigan.

DATES: The radiological emergency response plans were approved on September 25, 2025.

FOR FURTHER INFORMATION CONTACT: Michael Chesney, Acting Regional Administrator, FEMA Region 5, 536 S. Clark Street, 6th Floor, Chicago, IL 60605. Phone: 312-408-5501; email: FEMA-publiccomment-Palisades@fema.dhs.gov.

SUPPLEMENTARY INFORMATION: In support of the Federal requirement for radiological emergency response plans, FEMA's regulations at 44 CFR part 350 describe the agency's procedures for review and approval of State and local governments' radiological emergency response plans. The FEMA Region 5 office received an application from the State of Michigan on May 30, 2025. The application included a state plan and plans for local governments which are wholly or partially within the plume exposure pathway emergency planning zones of the nuclear plant. For the Palisades Nuclear Generating Station, plans are included for Allegan, Berrien, and Van Buren counties.

The requirements of 44 CFR part 350 have been met for the State's application. A joint exercise was conducted on July 29, 2025. A public meeting was held on August 5, 2025. Following evaluation of the State plans by the Regional Administrator for FEMA Region 5, the Acting Deputy Assistant Administrator for the National Preparedness Directorate has determined that the State plans and preparedness are adequate to protect the health and safety of the public living in the vicinity of the nuclear power facility by providing reasonable assurance that appropriate protective measures can be taken offsite in the event of a

radiological emergency; and are capable of being implemented. Accordingly, the Acting Deputy Assistant Administrator for the National Preparedness Directorate has approved the State plans.

Authority: The Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended, 42 U.S.C. 5121 *et seq.*; 6 U.S.C. 101 *et seq.*; and 44 CFR part 350.

Joel A. Doolin

Acting Assistant Administrator, National Preparedness Directorate, Federal Emergency Management Agency.

[FR Doc. 2026-02667 Filed 2-10-26; 8:45 am]

BILLING CODE 9110-LH-P

DEPARTMENT OF HOMELAND SECURITY

Transportation Security Administration

Revision of Agency Information Collection Activity Under OMB Review: Law Enforcement Officers (LEOs) Flying Armed

AGENCY: Transportation Security Administration, DHS.

ACTION: 30-Day notice.

SUMMARY: This notice announces that the Transportation Security Administration (TSA) has forwarded the Information Collection Request (ICR), Office of Management and Budget (OMB) control number 1652-0072, abstracted below, to OMB for review and approval of a revision of the currently approved collection under the Paperwork Reduction Act (PRA). The ICR describes the nature of the information collection and its expected burden. The collection involves gathering information from federal, state, local, tribal, or territorial armed law enforcement officers (LEOs) who require specialized screening at the TSA checkpoint.

DATES: Send your comments by March 13, 2026. A comment to OMB is most effective if OMB receives it within 30 days of publication.

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" and by using the find function.

FOR FURTHER INFORMATION CONTACT: Christina A. Walsh, TSA PRA Officer, Information Technology, TSA-11, Transportation Security Administration,

6595 Springfield Center Drive, Springfield, VA 20598–6011; telephone (571) 227–2062; email TSAPRA@tsa.dhs.gov.

SUPPLEMENTARY INFORMATION: TSA published a **Federal Register** notice, with a 60-day comment period soliciting comments, of the following collection of information on August 1, 2025, 90 FR 36172. TSA did not receive any comments on the notice.

Comments Invited

In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The ICR documentation will be available at <https://www.reginfo.gov> upon its submission to OMB. Therefore, in preparation for OMB review and approval of the following information collection, TSA is soliciting comments to—

(1) Evaluate whether the proposed information requirement 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;

(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 using appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Information Collection Requirement

Title: Law Enforcement Officers (LEOs) Flying Armed.

Type of Request: Revision of a currently approved collection.

OMB Control Number: 1652–0072.

Form(s): TSA Form 413A, Checkpoint Sign-In Log.

Affected Public: Federal, state, local, tribal, or territorial armed LEOs.

Abstract: Under 49 CFR 1540.111(b), LEOs may carry a firearm or other weapons while in the performance of law enforcement duties at the airport and may also fly armed if they meet the specific requirements in 49 CFR 1544.219. When flying armed, federal, state, local, tribal, or territorial LEOs must also comply with specialized screening processes. To document completion of TSA's specialized screening process, LEOs who pass through a TSA checkpoint must complete TSA Form 413A, Checkpoint Sign-In Log.

TSA is revising the information collection by changing the identification of weapons section of the form, “Carrying:” to “Are you carrying?” and adding the option “Unarmed LEO Escort.” In addition, TSA is changing the question, “Completed Required LEO Flying Armed Training?” to “Completed Required TSA LEO Flying Armed Training?” TSA is making the changes for programmatic needs to capture information of unarmed escorts¹ and to differentiate the TSA administered course from local, state, and other LEO Flying Armed Training courses.

Estimated Annual Number of Respondents: 83,749.

Estimated Annual Number of Burden Hours: 5,583.27.

Dated: February 9, 2026.

Christina A. Walsh,

*Paperwork Reduction Act Officer,
Information Technology, Transportation
Security Administration.*

[FR Doc. 2026–02722 Filed 2–10–26; 8:45 am]

BILLING CODE 9110–05–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

**[Docket No. FWS–R5–FAC–2025–1529;
FXFR13350500000–267–FF05F24400; OMB
Control Number 1018–0195]**

Agency Information Collection Activities; Horseshoe Crab and Cooperative Fish Tagging Programs

AGENCY: Fish and Wildlife Service,
Interior.

ACTION: Notice of information collection;
request for comment.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, we, the U.S. Fish and Wildlife Service (Service), are proposing to renew a currently approved information collection without change.

DATES: Interested persons are invited to submit comments on or before April 13, 2026.

ADDRESSES: Send your comments on the information collection request (ICR) by one of the following methods (please reference OMB Control No. 1018–0127 in the subject line of your comment):

- *Internet (preferred):* <https://www.regulations.gov>. Follow the instructions for submitting comments on Docket No. FWS–R5–FAC–2025–1529.

- *U.S. Mail:* Service Information Collection Clearance Officer, U.S. Fish

¹ Unarmed LEOs may escort individuals, including dignitaries, prisoners, deserters, detainees, or deportees to foreign destinations.

and Wildlife Service, 5275 Leesburg Pike, MS: PRB (JAO/3W); Falls Church, VA 22041–3803.

FOR FURTHER INFORMATION CONTACT:

Madonna L. Baucum, Service Information Collection Clearance Officer, by email at Info_Coll@fws.gov, or by telephone at (703) 358–2503. 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. You may also view the ICR at <https://www.reginfo.gov/public/do/PRAMain>.

SUPPLEMENTARY INFORMATION: In accordance with the Paperwork Reduction Act (PRA; 44 U.S.C. 3501 *et seq.*) and its implementing regulations at 5 CFR part 1320, all information collections require approval under the PRA. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number.

As part of our continuing effort to reduce paperwork and respondent burdens, we are again inviting 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 might the agency 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 personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Abstract: The Fish and Wildlife Act of 1956 (16 U.S.C. 742f) requires the Department of the Interior to take steps “required for the development, advancement, management, conservation, and protection of fish and wildlife resources.” In addition, the Endangered Species Act of 1973 (16 U.S.C. 1531–1544), the Fish and Wildlife Coordination Act (16 U.S.C. 661–666c–1), and the Anadromous Fish Conservation Act (16 U.S.C. 757a–757f) each authorize the Department of the Interior to enter into cooperative agreements with stakeholders to protect and conserve fishery resources. The Service’s Maryland Fish and Wildlife Conservation Office (MDFWCO) will collect information on horseshoe crabs and fishes captured by the public. Tag information provided by the public will be used to estimate recreational and commercial harvest rates, estimate natural mortality rates, and evaluate migratory patterns, length and age frequencies, and effectiveness of current regulations.

Horseshoe crabs play a vital role commercially, biomedically, and ecologically along the Atlantic coast. Horseshoe crabs are commercially harvested and used as bait in eel and conch fisheries. Biomedical companies along the coast also collect and bleed horseshoe crabs at their facilities. *Limulus amebocyte lysate*, derived from horseshoe crab blood, is used by pharmaceutical companies to test sterility of products. Finally, migratory shorebirds also depend on the eggs of horseshoe crabs to refuel on their migrations from South America to the Arctic. One bird in particular, the rufa red knot (*Calidris canutus rufa*), feeds primarily on horseshoe crab eggs during its stopover. Effective January 12, 2015, the rufa red knot was listed as threatened under the Endangered Species Act (79 FR 73706; December 11, 2014).

In 1998, the ASMFC, a management organization with representatives from each State on the Atlantic coast, developed a horseshoe crab

management plan. The ASMFC plan and its subsequent addenda established mandatory State-by-State harvest quotas and created the 1,500-square-mile Carl N. Shuster, Jr., Horseshoe Crab Sanctuary off the mouth of Delaware Bay.

Restrictive measures have been taken in recent years; however, populations are increasing slowly. Because horseshoe crabs do not breed until they are 9 years or older, it may take some time before the population measurably increases. Federal and State agencies, universities, and biomedical companies participate in a Horseshoe Crab Cooperative Tagging Program. The Service’s MDFWCO maintains the information collected under this program and uses it to evaluate migratory patterns, survival, and abundance of horseshoe crabs.

Members of the public who recover tagged crabs provide the following information using Form 3–2310 (Horseshoe Crab Recapture Report):

- Tag number;
- Whether or not tag was removed;
- Condition of crab;
- Date captured/found;
- Crab fate;
- Finder type;
- Capture method;
- Capture location;
- Reporter information; and
- Comments.

Agencies that tag and release the crabs complete Form 3–2311 (Horseshoe Crab Tagging) and provide the Service with:

- Organization name;
- Contact person name;
- Tag number;
- Sex of crab;
- Prosomal width; and
- Capture site, latitude, longitude, waterbody, State, and date.

At the request of the public participant reporting the tagged crab, we send data pertaining to the tagging program and tag and release information on the horseshoe crab tag that was found.

Fish will be tagged with an external tag containing a toll-free number for MDFWCO. Tagged species of fish include striped bass (*Morone saxatilis*), Atlantic sturgeon (*Acipenser oxyrinchus*) and shortnose sturgeon (*Acipenser brevirostrum*), northern snakehead (*Channa argus*), and American shad (*Alosa sapidissima*). Members of the public reporting a tag will be asked a series of questions pertaining to the fish that they are referencing. The Service uses the following four forms to collect information used by fisheries managers throughout the Atlantic Coast, depending on species:

- Form 3–2493, “American Shad Recapture Report”;
- Form 3–2494, “Snakehead Recapture Report”;
- Form 3–2495, “Striped Bass Recapture Report”; and
- Form 3–2496, “Sturgeon Recapture Report.”

American shad are tagged by the New York State Department of Environmental Conservation (NYS DEC), which retains all fish tagging information. The public reports tags to MDFWCO, who provides information on tag returns to NYS DEC. Tag return data are used to monitor migration and abundance of shad along the Atlantic coast.

Northern snakehead is an invasive species found in many watersheds throughout the mid-Atlantic region. It has been firmly established in the Potomac River since at least 2004 and is now in nearly every major Chesapeake Bay tributary. Federal and State biologists within the Chesapeake Bay watershed have been tasked with managing the impacts of northern snakehead. Tagging of northern snakehead is used to learn more about the species so that control efforts can be better informed. Tagging is also used to estimate population sizes to monitor trends in abundance. Recreational and commercial fishers reporting tags provide information on harvest rates and migration patterns as well.

Striped bass are cooperatively managed by Federal and State agencies through the Atlantic States Marine Fisheries Commission (ASMFC). The ASMFC uses fish tag return data to conduct stock assessments for striped bass. The database and collection are housed within MDFWCO, while the tagging is conducted by State agencies participating in striped bass management. Without this data collection, striped bass management would likely suffer from a lack of quality data. As required by Congress under the Atlantic Striped Bass Conservation Act (16 U.S.C. 5151–5158), striped bass tagging data is used to manage the coast-wide stock.

Sturgeon are tagged by Federal, State, and university biologists and nongovernmental organizations along the U.S. east coast and into Canada, and throughout the United States and Canada. Local populations of Atlantic sturgeon have been listed as either threatened or endangered since 2012, and shortnose populations have been listed since 1973. The information collected provides data on tag retention and sturgeon movement along the east coast. The data are also used to address some of the management and research

needs identified by amendment 1 to the ASMFC's Atlantic Sturgeon Fishery Management Plan.

Data collected across these tagging programs are similar in nature, including:

- Tag number;
- Date of capture;
- Waterbody of capture;
- Capture method;
- Fish length, weight, and fate (whether released or killed); and
- Fisher type (*i.e.*, commercial, recreational, etc.).

In addition, if the tag reporter desires more information on their tagged fish or wants the modest reward that comes with reporting a tag, we ask their address so that we can mail them the information.

The public may request a copy of any form contained in this information collection by sending a request to the Service Information Collection Clearance Officer (see **ADDRESSES**).

Title of Collection: Horseshoe Crab and Cooperative Fish Tagging Programs.

OMB Control Number: 1018–0127.

Form Number: Forms 3–2310, 3–2311, and 3–2493 through 3–2496.

Type of Review: Extension without change of a currently approved collection.

Respondents/Affected Public: Respondents include Federal and State agencies, universities, and biomedical companies who conduct tagging, and members of the general public who provide recapture information.

Total Estimated Number of Annual Respondents: 2,026.

Total Estimated Number of Annual Responses: 3,648.

Estimated Completion Time per Response: Varies from 5 minutes to 95 hours, depending on activity.

Total Estimated Number of Annual Burden Hours: 2,241.

Respondent's Obligation: Voluntary.

Frequency of Collection: Respondents will provide information on occasion, upon tagging or upon encounter with a tagged crab or fish.

Total Estimated Annual Nonhour Burden Cost: None.

The authority for this action is the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Madonna Baucum,
Information Collection Clearance Officer, U.S. Fish and Wildlife Service.

[FR Doc. 2026–02735 Filed 2–10–26; 8:45 am]

BILLING CODE 4333–15–P

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

**[OMB Control Number 1076–0136;
267A2100DD/AAKP300000/
A0A501010.000000]**

Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Indian Self-Determination and Education Assistance Act Programs

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice of Information Collection; request for comment.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, the Bureau of Indian Affairs (BIA) is proposing to renew an information collection without change.

DATES: Interested persons are invited to submit comments. To be considered, your comments must be received on or before March 13, 2026.

ADDRESSES: Send your written comments and recommendations for the proposed information collection request (ICR) to the Office of Information and Regulatory Affairs (OIRA) through https://www.reginfo.gov/public/do/PRA/ICRPublicCommentRequest?ref_nbr=202505-1076-006 or by visiting <https://www.reginfo.gov/public/do/PRAMain> and selecting “Currently under Review—Open for Public Comments” and then scrolling down to the “Department of the Interior.”

FOR FURTHER INFORMATION CONTACT: Steven Mullen, Information Collection Clearance Officer, Office of Regulatory Affairs and Collaborative Action—Indian Affairs, U.S. Department of the Interior, 1001 Indian School Road NW, Suite 229, Albuquerque, New Mexico 87104; comments@bia.gov; (202) 924–2650. 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. You may also view the ICR at <https://www.reginfo.gov/public/Forward?SearchTarget=PRA&textfield=1076-0136>.

SUPPLEMENTARY INFORMATION: In accordance with the Paperwork Reduction Act of 1995 (PRA, 44 U.S.C. 3501 *et seq.*) and 5 CFR 1320.8(d)(1), we provide the general public and other Federal agencies with an opportunity 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.

A **Federal Register** notice with a 60-day public comment period soliciting comments on this collection of information was published on July 11, 2025 (90 FR 30949). No comments were received.

As part of our continuing effort to reduce paperwork and respondent burdens, we are again soliciting comments from the public and other Federal agencies on the proposed ICR that is described below. 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 might the agency 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 personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Abstract: Regulations at 25 CFR part 900 codify the Indian Self-Determination and Education Assistance Act, which authorizes and directs BIA to contract or compact with and fund Indian Tribes and Tribal organizations that choose to take over the operation of programs, services, functions, and activities (PSFAs) that would otherwise be operated by the BIA. These PSFAs include programs such as law enforcement, social services, and Tribal priority allocation programs. The data is maintained by

BIA's Office of Indian Services, Division of Self-Determination.

Title of Collection: Indian Self-Determination and Education Assistance Act Programs.

OMB Control Number: 1076-0136.

Form Number: None.

Type of Review: Extension of a currently approved collection.

Respondents/Affected Public: Federally recognized Indian Tribes, Tribal organizations and contractors. *Total Estimated Number of Annual Respondents:* 567.

Total Estimated Number of Annual Responses: 7,063.

Estimated Completion Time per Response: Varies from 4 hours to 122 hours.

Total Estimated Number of Annual Burden Hours: 127,127 hours.

Respondent's Obligation: Required to obtain a benefit.

Frequency of Collection: Annually.

Total Estimated Annual Nonhour Burden Cost: \$0.

Authority

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 authority for this action is the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Steven Mullen,

*Information Collection Clearance Officer,
Office of Regulatory Affairs and Collaborative
Action—Indian Affairs.*

[FR Doc. 2026-02767 Filed 2-10-26; 8:45 am]

BILLING CODE 4337-15-P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[A2407-014-004-065516, #O2509-014-004-125222]

Notice of 2026 National Petroleum Reserve—Alaska Oil and Gas Lease Sale Lease Sale

Editorial Note: This BLM document FR Doc. 2026-02719 was originally scheduled to publish in the **Federal Register** issue of February 6, 2026, as FR Doc. 2026-02421.

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice.

SUMMARY: The Bureau of Land Management's (BLM) Alaska State Office will hold an oil and gas lease sale bid opening for over 600 tracts in the National Petroleum Reserve—Alaska (NPR-A).

DATES: The oil and gas lease sale bid opening will be at 10 a.m. (AKST) on

March 18, 2026. The BLM must receive all sealed bids by 4 p.m. (AKST) on March 16, 2026. The Detailed Statement of Sale for the National Petroleum Reserve—Alaska Oil and Gas Lease Sale 2026 will be available to the public on February 11, 2026.

ADDRESSES: Sealed bids must be received at the BLM-Alaska State Office, ATTN: Wayne Svejnoha (AK932); 222 West 7th Avenue, #13; Anchorage, AK 99513-7504. The Detailed Statement of Sale is available from the BLM Alaska website at <https://www.blm.gov/programs/energy-and-minerals/oil-and-gas/leasing/regional-lease-sales/alaska>.

FOR FURTHER INFORMATION CONTACT:

Wayne Svejnoha, Acting Deputy State Director Resources, phone 907-271-4407 or email, wsvejnoh@blm.gov. 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 for contacting Mr. Svejnoha. Individuals outside the United States should use the relay services within their country to make international calls to the point-of-contact in the United States.

SUPPLEMENTARY INFORMATION: The 2026 NPR-A Oil and Gas Lease Sale will include over 600 tracts totaling approximately 5.5 million acres that are available for leasing under the 2025 Record of Decision (ROD) for the NPR-A Integrated Activity Plan (IAP). This action advances priorities in Executive Order 14153 and Secretary's Order 3422—Unleashing Alaska's Extraordinary Resource Potential—and implements direction in Public Law (Pub. L.) 119-21, the One Big Beautiful Bill Act. Section 50105 of Public Law 119-21 directed BLM to expeditiously restore and resume oil and gas lease sales under the competitive oil and gas leasing, exploration, development, and production program established by the Naval Petroleum Reserves Production Act of 1976, as amended (42 U.S.C. 6506a), requiring at least five lease sales of at least 4,000,000 acres each beginning with an initial lease sale no later than July 4, 2026.

The opening and reading of the bids for the 2026 lease sale will be available for online public viewing via video livestreaming at <http://www.blm.gov/live>.

The Detailed Statement of Sale includes a description of the areas the BLM is offering for lease, as well as the lease terms, conditions, special stipulations, required operating procedures, and directions for how to submit bids. If you plan to submit a bid(s), please note that all bids must be

sealed in accordance with the provisions identified in the Detailed Statement of Sale.

The United States reserves the right to withdraw any tract from this sale prior to issuance of a written acceptance of a bid.

Authority: The Naval Petroleum Reserves Production Act (NPRPA) of 1976 (42 U.S.C. 6501 *et seq.*), as amended; Pub. L. 119-21, the One Big Beautiful Bill Act; 43 CFR 3131.4-1.

Kevin J. Pendergast,

State Director, Alaska.

[FR Doc. 2026-02719 Filed 2-10-26; 8:45 am]

BILLING CODE 4310-JA-P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6920; NPS-WASO-NAGPRA-PPWOCRADN0-PCU00RP14.R50000]

Notice of Intended Repatriation: Buffalo Society of Natural Sciences, Buffalo Museum of Science, Buffalo, NY

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the Buffalo Society of Natural Sciences intends to repatriate certain cultural items that meet the definition of sacred objects and that have a cultural affiliation with the Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the cultural items in this notice may occur on or after March 13, 2026.

ADDRESSES: Send additional, written requests for repatriation of the cultural items in this notice to Kathryn H. Leacock, Buffalo Society of Natural Sciences, Buffalo Museum of Science, 1020 Humboldt Parkway, Buffalo, NY 14211, email kleacock@sciencebuff.org.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the Buffalo Society of Natural Sciences and additional information on the determinations in this notice, including the results of consultation, can be found in the summary or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

A total of 37 sacred objects have been requested for repatriation. The 37 sacred

objects are Medicine Face Masks and include 30 wooden faces and seven cornhusk. The 37 faces were acquired by the Buffalo Society of Natural Sciences from six different sources and represent nine separate accessions. Fifteen masks were collected by Dr. Ernest Wende at the end of the 19th century and were accessioned by the Buffalo Museum of Science in 1904–1905. Six masks known as catalog numbers C20028 through C20036 were purchased from John R. Taft of Dayton, New York on 10/31/1958. The belongings known as catalog numbers C22543 and C22544 were purchased from William Guy Spittal of Ontario, Canada on 12/10/1962. The masks known as catalog numbers C22604 through C22607 (four) were purchased from Fred T. Hall of Buffalo, New York on 9/15/1963. The masks known as catalog numbers C22771, C22764, & C22765 (three) were received as a donation to the Museum from the Estate of Ellsworth Jaeger in 1964. The mask known as catalog number C23205 was received as a gift from Dr. Thalia Feldman of Buffalo, New York on 7/31/1973. The remaining masks (six) have no known donor or accession information.

Determinations

The Buffalo Society of Natural Sciences has determined that:

- The 37 sacred objects described in this notice are specific ceremonial objects needed by a traditional Native American religious leader for present-day adherents to practice traditional Native American religion, according to the Native American traditional
- There is a connection between the cultural items described in this notice and the Seneca Nation of Indians.

Requests for Repatriation

Additional, written requests for repatriation of the cultural items in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or a culturally affiliated Indian Tribe or Native Hawaiian organization.

Repatriation of the cultural items in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the Buffalo Society of Natural Sciences must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the cultural

items are considered a single request and not competing requests. The Buffalo Society of Natural Sciences is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and to any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3004 and the implementing regulations, 43 CFR 10.9.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026–02697 Filed 2–10–26; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6912; NPS–WASO–NAGPRA–NPS0041984; PPWOCRADNO–PCU00RP14.R50000]

Notice of Inventory Completion: Office of the State Archaeologist, University of Iowa, Iowa City, IA

AGENCY: National Park Service, Interior.
ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the Office of the State Archaeologist Burials Program (OSA BP) has completed an inventory of human remains and has determined that there is a cultural affiliation between the human remains and Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the human remains in this notice may occur on or after March 13, 2026.

ADDRESSES: Send written requests for repatriation of the human remains in this notice to Dr. Lara Noldner, Office of the State Archaeologist Bioarchaeology Program, University of Iowa, 700 S Clinton Street, Iowa City, IA 52242, email lara-noldner@uiowa.edu.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the OSA BP, and additional information on the determinations in this notice, including the results of consultation, can be found in its inventory or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

Human remains representing, at least, one individual have been identified. No

associated funerary objects are present. A single human tooth was recovered from a site in Plymouth County, IA during excavations by the National Park Service and University of Nebraska–Lincoln in 1974 along with several other faunal bone fragments. Subsequent to excavation, the materials were reposed by the US Army Corps of Engineers (USACE), Omaha District. The human remains were discovered among faunal remains in 2018, when the USACE collection was moved to the repository of the OSA. The partial left mandibular first molar likely represents one juvenile or very young adult based on dental wear (BP 3331). No potentially hazardous substances were used to treat the human remains.

Cultural Affiliation

Based on the information available and the results of consultation, cultural affiliation is clearly identified by the information available about the human remains described in this notice.

Determinations

- The OSA BP has determined that:
- The human remains described in this notice represent the physical remains of one individual of Native American ancestry.
 - There is a connection between the human remains described in this notice and the Pawnee Nation of Oklahoma and the Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota.

Requests for Repatriation

Written requests for repatriation of the human remains in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by:

1. Any one or more of the Indian Tribes or Native Hawaiian organizations identified in this notice.
2. Any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or an Indian Tribe or Native Hawaiian organization with cultural affiliation.

Repatriation of the human remains described in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the OSA BP must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the human remains are considered a single request and not competing requests. The OSA BP is responsible for sending a copy of this notice to the Indian Tribes and

Native Hawaiian organizations identified in this notice and any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3003, and the implementing regulations, 43 CFR 10.10.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026-02704 Filed 2-10-26; 8:45 am]

BILLING CODE 4312-52-P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6917; NPS-WASO-NAGPRA-NPS0041990; PPWOCRADN0-PCU00RP14.R50000]

Notice of Intended Repatriation: Los Angeles County Museum of Natural History, Los Angeles, CA

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the Los Angeles County Museum of Natural History (LACMNH) intends to repatriate certain cultural items that meet the definition of objects of cultural patrimony and that have a cultural affiliation with the Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the cultural items in this notice may occur on or after March 13, 2026.

ADDRESSES: Send additional, written requests for repatriation of the cultural items in this notice to Amy E. Gusick, NAGPRA Officer, Los Angeles County Museum of Natural History, 900 Exposition Boulevard, Los Angeles, CA 90007, email agusick@nhm.org.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the LACMNH, and additional information on the determinations in this notice, including the results of consultation, can be found in the summary or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

A total of 16 cultural items have been requested for repatriation. The 16 objects of cultural patrimony are 14 baskets, one mano, and one metate. The objects of cultural patrimony were

primarily collected from various locations within San Bernardino County, California, with one object collected in Riverside County, California. One basket was made by Dolores Crispin, a known maker from the Serrano community. The basket was collected from Coachella by Edward Strasburg at an unknown date and donated to LACMNH in 1928. Nine baskets were collected from the San Manuel Reservation and one basket was collected from Arrowhead Springs by L.B. Manson at an unknown date and donated to LACMNH by Byrne C. Manson in 1946. One basket was collected from Del Rosa Rancheria by Henrietta Waters Cole in the early 1900s and donated to LACMNH by Caroline S. Waters and Leila B. Waters in 1947. Two baskets were purchased in Highland by Helen A. Vahey in the early 1900s and donated to LACMNH in 1961. The mano and metate were collected near Baldwin Lake, Bear Valley by an unspecified collector and date. They were donated to LACMNH by Glenn Edgerton in 1932.

Determinations

The LACMNH has determined that:

- The 16 objects of cultural patrimony described in this notice have ongoing historical, traditional, or cultural importance central to the Native American group, including any constituent sub-group (such as a band, clan, lineage, ceremonial society, or other subdivision), according to the Native American traditional knowledge of an Indian Tribe or Native Hawaiian organization.

- There is a connection between the cultural items described in this notice and the Yuhaaviatam of San Manuel Nation (previously listed as San Manuel Band of Mission Indians, California).

Requests for Repatriation

Additional, written requests for repatriation of the cultural items in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or a culturally affiliated Indian Tribe or Native Hawaiian organization.

Repatriation of the cultural items in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the LACMNH must determine the most appropriate requestor prior to repatriation. Requests for joint

repatriation of the cultural items are considered a single request and not competing requests. The LACMNH is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and to any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3004 and the implementing regulations, 43 CFR 10.9.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026-02710 Filed 2-10-26; 8:45 am]

BILLING CODE 4312-52-P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6914; NPS-WASO-NAGPRA-NPS0041987; PPWOCRADN0-PCU00RP14.R50000]

Notice of Intended Repatriation: Mount Holyoke College Art Museum, South Hadley, MA

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the Mount Holyoke College Art Museum intends to repatriate certain cultural items that meet the definition of unassociated funerary objects and that have a cultural affiliation with the Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the cultural items in this notice may occur on or after March 13, 2026.

ADDRESSES: Send additional, written requests for repatriation of the cultural items in this notice to Abigail Hoover, Associate Director of Registration and Collections, Mount Holyoke College Art Museum, Lower Lake Road, South Hadley, MA 01075, email ahoover@mholyoke.edu.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the Mount Holyoke College Art Museum, and additional information on the determinations in this notice, including the results of consultation, can be found in the summary or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

A total of six cultural items have been claimed for repatriation. The six unassociated funerary objects are one adze, one pipe, one lot of beads, one lot of iron ore, one pipe, and one pipe bowl. The basalt adze was “found on an Indian grave on bank of the Connecticut River at Chicopee” and was donated to the Art Museum by Mrs. T. Chapin. The slate tobacco pipe is recorded as “found in a grave at Holyoke” and was given to the Museum by Mr. Joseph E. Chase. The one lot of beads are two strings of beads are recorded as “found on a grave at Depot Hill, Holyoke, MA” and were given to the Museum by Mr. Joseph E. Chase. They were later documented on a 1970 packing list, therefore they were acquired prior to 1970. The one lot of iron ore are two pieces of iron ore “from a grave on Depot Hill, Holyoke, MA” were given to the Museum by Mr. Joseph E. Chase. One piece of ore has a paper tag that reads “Jos. E. Chase.” The steatite (soapstone) pipe and pipe bowl are part of the Joseph Allen Skinner Museum collection, which is owned by the Trustees of Mount Holyoke College and overseen by the Mount Holyoke College Art Museum. This collection of 7,300 objects was amassed by the Museum’s namesake (1862–1946) over a lifetime and displayed in his Museum in South Hadley, MA from its founding in 1932. Records indicate that the pipe and the pipe bowl were removed from their original locations in Springfield, Massachusetts. The pipe has a paper tag that reads “19 Long Hill.”

Determinations

The Mount Holyoke College Art Museum has determined that:

- The six unassociated funerary objects described in this notice are reasonably believed to have been placed intentionally with or near human remains, and are connected, either at the time of death or later as part of the death rite or ceremony of a Native American culture according to the Native American traditional knowledge of a lineal descendant, Indian Tribe, or Native Hawaiian organization. The unassociated funerary objects have been identified by a preponderance of the evidence as related to human remains, specific individuals, or families, or removed from a specific burial site or burial area of an individual or individuals with cultural affiliation to an Indian Tribe or Native Hawaiian organization.
- There is a connection between the cultural items described in this notice and the Stockbridge Munsee Community, Wisconsin.

Requests for Repatriation

Additional, written requests for repatriation of the cultural items in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or a culturally affiliated Indian Tribe or Native Hawaiian organization.

Repatriation of the cultural items in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the Mount Holyoke College Art Museum must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the cultural items are considered a single request and not competing requests. The Mount Holyoke College Art Museum is responsible for sending a copy of this notice to the Indian Tribes and/or Native Hawaiian organizations identified in this notice and to any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3004 and the implementing regulations, 43 CFR 10.9.

Dated: February 4, 2026.

Melanie O’Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026–02707 Filed 2–10–26; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6922; NPS–WASO–NAGPRA–NPS0041995; PPWOCRADNO–PCU00RP14.R50000]

Notice of Intended Repatriation: University of Denver Museum of Anthropology, Denver, CO

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the University of Denver Museum of Anthropology (DUMA) intends to repatriate certain cultural items that meet the definition of unassociated funerary objects, sacred objects, and/or objects of cultural patrimony and that have a cultural affiliation with the Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the cultural items in this notice may occur on or after March 13, 2026.

ADDRESSES: Send additional, written requests for repatriation of the cultural items in this notice to Dena Sedar, University of Denver Museum of Anthropology, 2000 E Asbury Avenue, Sturm Hall 146, Denver, CO 80210, email dena.sedar@du.edu.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service’s administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the DUMA, and additional information on the determinations in this notice, including the results of consultation, can be found in the summary or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

A total of 12 cultural items have been requested for repatriation.

The eight sacred objects were acquired in southern Arizona by Father James O’Brien and Colleen Anderson in the second half of the 20th century. Their collection was bequeathed to Lon D. Anderson, who donated the cultural items to DUMA in 2019. The eight sacred objects are four basketry trays (DU ID #2019.6.13, 2019.6.15, 2019.6.16, 2019.6.17), three basketry bowls (DU ID #2019.6.18, 2019.6.20, 2019.6.21), and one bolo tie (DU ID #2019.6.56).

The four objects of cultural patrimony are one ceramic bowl, two ceramic jars, and one shell gaming piece. The ceramic bowl (DU ID#2017.1.21) was collected by Allene and Charles Mueldener in the 20th century and bequeathed to William Mueldener, who donated the cultural item to DUMA in 2017. The two ceramic jars (DU ID #2019.6.44 and 2019.6.46) were acquired in southern Arizona by Father James O’Brien and Colleen Anderson in the second half of the 20th century. Their collection was bequeathed to Lon D. Anderson, who donated the cultural items to DUMA in 2019. The one shell gaming piece (DU ID#3917B) came into the possession of Fallis F. Rees at an unknown date from an unknown location. In 1967, Mr. Rees donated this cultural item to DUMA.

Determinations

The DUMA has determined that:

- The eight sacred objects described in this notice are specific ceremonial objects needed by a traditional Native American religious leader for present-day adherents to practice traditional

Native American religion, according to the Native American traditional knowledge of a lineal descendant, Indian Tribe, or Native Hawaiian organization.

- The four objects of cultural patrimony described in this notice have ongoing historical, traditional, or cultural importance central to the Native American group, including any constituent sub-group (such as a band, clan, lineage, ceremonial society, or other subdivision), according to the Native American traditional knowledge of an Indian Tribe or Native Hawaiian organization.

- There is a connection between the cultural items described in this notice and the Gila River Indian Community of the Gila River Indian Reservation, Arizona.

Requests for Repatriation

Additional, written requests for repatriation of the cultural items in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or a culturally affiliated Indian Tribe or Native Hawaiian organization.

Repatriation of the cultural items in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the DUMA must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the cultural items are considered a single request and not competing requests. The DUMA is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and to any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3004 and the implementing regulations, 43 CFR 10.9.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026-02699 Filed 2-10-26; 8:45 am]

BILLING CODE 4312-52-P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6911; NPS-WASO-NAGPRA-NPS0041982; PPWOCRADNO-PCU00RP14.R50000]

Notice of Inventory Completion: University at Buffalo, State University of New York, Department of Anthropology, Buffalo, NY

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the University at Buffalo, State University of New York, Department of Anthropology has completed an inventory of human remains and associated funerary objects and has determined that there is a cultural affiliation between the human remains and associated funerary objects and Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the human remains and associated funerary objects in this notice may occur on or after March 13, 2026.

ADDRESSES: Send written requests for repatriation of the human remains and associated funerary objects in this notice to Madeline Smith, University at Buffalo, SUNY, Department of Anthropology, 380 Academic Center, Ellicott Complex, Buffalo, NY 14261-0026, email mgsmith3@buffalo.edu.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the University at Buffalo, SUNY, Department of Anthropology, and additional information on the determinations in this notice, including the results of consultation, can be found in its inventory or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

Human remains representing, at least, four individuals have been identified. The two associated funerary objects are pottery sherds and soil.

At minimum four individuals were believed to have been removed from a site known as Davenport Farm in Ulster County, New York sometime in the mid-20th century. The human remains and associated funerary objects were excavated from land owned by Bruce Davenport at an unknown time by archaeologist Mary Ann Niemczycki. Geographical affiliation of the

Davenport Farm site is consistent with the archaeologically documented territory of the Delaware Nation, Delaware Tribe of Indians, Saint Regis Mohawk Tribe, and Stockbridge Munsee Community.

Cultural Affiliation

Based on the information available and the results of consultation, cultural affiliation is reasonably identified by the geographical location or acquisition history of the human remains and associated funerary objects described in this notice.

Determinations

The University at Buffalo, SUNY, Department of Anthropology has determined that:

- The human remains described in this notice represent the physical remains of four individuals of Native American ancestry.
- The two objects described in this notice are reasonably believed to have been placed intentionally with or near individual human remains at the time of death or later as part of the death rite or ceremony.
- There is a connection between the human remains and associated funerary objects described in this notice and the Delaware Nation, Oklahoma; Delaware Tribe of Indians; Saint Regis Mohawk Tribe; and the Stockbridge Munsee Community, Wisconsin.

Requests for Repatriation

Written requests for repatriation of the human remains and associated funerary objects in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by:

1. Any one or more of the Indian Tribes or Native Hawaiian organizations identified in this notice.
2. Any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or an Indian Tribe or Native Hawaiian organization with cultural affiliation.

Repatriation of the human remains and associated funerary objects described in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the University at Buffalo, SUNY, Department of Anthropology must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the human remains and associated funerary objects are considered a single request and not competing requests. The University at Buffalo, SUNY, Department of

Anthropology is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3003, and the implementing regulations, 43 CFR 10.10.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026-02703 Filed 2-10-26; 8:45 am]

BILLING CODE 4312-52-P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6919; NPS-WASO-NAGPRA-NPS0041992; PPWOCRADN0-PCU00RP14.R50000]

Notice of Intended Repatriation: Mississippi Department of Archives and History, Jackson, MS

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the Mississippi Department of Archives and History (MDAH) intends to repatriate certain cultural items that meet the definition of unassociated funerary objects and that have a cultural affiliation with the Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the cultural items in this notice may occur on or after March 13, 2026.

ADDRESSES: Send additional, written requests for repatriation of the cultural items in this notice to Jaquelin Padilla, NAGPRA Coordinator, Mississippi Department of Archives and History, Historic Preservation Division, 100 South State Street, P.O. Box 571, Jackson, MS 3205, email jpadilla@mdah.ms.gov.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the Mississippi Department of Archives and History, and additional information on the determinations in this notice, including the results of consultation, can be found in the summary or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

A total of four lots of cultural items have been requested for repatriation from 22CS502 (Owl Creek/Shiloh Church Mounds). The four lots of cultural objects consist of one lot lithics, one lot Native American ceramics, one lot faunal remains, and one lot organic materials.

The site 22CS502 was excavated by MDAH archaeologist Moreau B. Chambers in 1935. The collection from this excavation was curated at Louisiana State University and transferred to MDAH in 2005.

Through Tribal consultation, these four lots of unassociated funerary objects were identified as culturally affiliated with The Chickasaw Nation. To our knowledge, no potentially hazardous substances were used to treat any of the unassociated funerary objects.

Determinations

The Mississippi Department of Archives and History has determined that:

- The four lots of unassociated funerary objects described in this notice are reasonably believed to have been placed intentionally with or near human remains, and are connected, either at the time of death or later as part of the death rite or ceremony of a Native American culture according to the Native American traditional knowledge of a lineal descendant, Indian Tribe, or Native Hawaiian organization. The unassociated funerary objects have been identified by a preponderance of the evidence as related to human remains, specific individuals, or families, or removed from a specific burial site or burial area of an individual or individuals with cultural affiliation to an Indian Tribe or Native Hawaiian organization.

- There is a connection between the cultural items described in this notice and The Chickasaw Nation.

Requests for Repatriation

Additional, written requests for repatriation of the cultural items in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or a culturally affiliated Indian Tribe or Native Hawaiian organization.

Repatriation of the cultural items in this notice to a requestor may occur on or after March 13, 2026. If competing

requests for repatriation are received, the Mississippi Department of Archives and History must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the cultural items are considered a single request and not competing requests. The Mississippi Department of Archives and History is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and to any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3004 and the implementing regulations, 43 CFR 10.9.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026-02696 Filed 2-10-26; 8:45 am]

BILLING CODE 4312-52-P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6927; NPS-WASO-NAGPRA-NPS0041986; PPWOCRADN0-PCU00RP14.R50000]

Notice of Inventory Completion: Office of the State Archaeologist, University of Iowa, Iowa City, IA

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the Office of the State Archaeologist Bioarchaeology Program (OSA BP) has completed an inventory of human remains and associated funerary objects and has determined that there is a cultural affiliation between the human remains and associated funerary objects and Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the human remains and associated funerary objects in this notice may occur on or after March 13, 2026.

ADDRESSES: Send written requests for repatriation of the human remains and associated funerary objects in this notice to Dr. Lara Noldner, Office of the State Archaeologist Bioarchaeology Program, University of Iowa, 700 S Clinton Street, Iowa City, IA 52242, email lara-noldner@uiowa.edu.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the

sole responsibility of the OSA BP, and additional information on the determinations in this notice, including the results of consultation, can be found in its inventory or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

Human remains representing at least 13 individuals have been identified. The 20 associated funerary objects are one drill fragment, 13 flakes, and six faunal elements. The individuals and their burial property were excavated in the spring and summer of 1954 by Jim Pilgrim and Lowell S. Miller. The exact location of the excavation is unknown but is believed to be in Clinton County, Iowa. The individuals and artifacts were stored in the basement of Jim Pilgrim until his death in 2020; his daughter has been going through his belongings since and transferring human remains and artifacts as she finds them. Pilgrim was a prolific collector throughout Iowa, and his family has made multiple transfers of his collection following his death. The individuals from the 1954 excavation were transferred to the OSA in March of 2023. Of the 13 individuals there is one adult male, six adults of unknown sex and age, and six juveniles. The juveniles include one 0–5 month-old, one 3–5 year-old, three 7–11 year-olds and one 10–15 year-old (BP3769). No known hazardous substances were used to treat any of the human remains or associated funerary objects.

Cultural Affiliation

Based on the information available and the results of consultation cultural affiliation is reasonably identified by the geographical location and acquisition history of the human remains and associated funerary objects described in this notice.

Determinations

The OSA BP has determined that:

- The human remains described in this notice represent the physical remains of 13 individuals of Native American ancestry.
- The 20 objects described in this notice are reasonably believed to have been placed intentionally with or near individual human remains at the time of death or later as part of the death rite or ceremony.
- There is a connection between the human remains and associated funerary objects described in this notice and the Cheyenne River Sioux Tribe of the Cheyenne River Reservation, South Dakota; Citizen Potawatomi Nation, Oklahoma; Flandreau Santee Sioux Tribe of South Dakota; Ho-Chunk

Nation of Wisconsin; Iowa Tribe of Kansas and Nebraska; Iowa Tribe of Oklahoma; Lower Sioux Indian Community in the State of Minnesota; Miami Tribe of Oklahoma; Omaha Tribe of Nebraska; Otoe-Missouria Tribe of Indians, Oklahoma; Pawnee Nation of Oklahoma; Peoria Tribe of Indians of Oklahoma; Ponca Tribe of Indians of Oklahoma; Ponca Tribe of Nebraska; Prairie Band Potawatomi Nation; Prairie Island Indian Community in the State of Minnesota; Sac & Fox Nation of Missouri in Kansas and Nebraska; Sac & Fox Nation, Oklahoma; Sac & Fox Tribe of the Mississippi in Iowa; Santee Sioux Nation, Nebraska; Sisseton-Wahpeton Oyate of the Lake Traverse Reservation, South Dakota; Spirit Lake Tribe, North Dakota; The Osage Nation; Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota; Upper Sioux Community, Minnesota; Winnebago Tribe of Nebraska; and the Yankton Sioux Tribe of South Dakota.

Requests for Repatriation

Written requests for repatriation of the human remains and associated funerary objects in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by:

1. Any one or more of the Indian Tribes or Native Hawaiian organizations identified in this notice.
2. Any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or an Indian Tribe or Native Hawaiian organization with cultural affiliation.

Repatriation of the human remains and associated funerary objects described in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the OSA BP must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the human remains and associated funerary objects are considered a single request and not competing requests. The OSA BP is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3003, and the implementing regulations, 43 CFR 10.10.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026–02706 Filed 2–10–26; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6918; NPS–WASO–NAGPRA–NPS0041991; PPWOCRADNO–PCU00RP14.R50000]

Notice of Intended Repatriation: Mississippi Department of Archives and History, Jackson, MS

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the Mississippi Department of Archives and History (MDAH) intends to repatriate certain cultural items that meet the definition of unassociated funerary objects, sacred objects, and/or objects of cultural patrimony and that have a cultural affiliation with the Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the cultural items in this notice may occur on or after March 13, 2026.

ADDRESSES: Send additional, written requests for repatriation of the cultural items in this notice to Jaquelin Padilla, NAGPRA Coordinator, Mississippi Department of Archives and History, Historic Preservation Division, 100 South State Street, P.O. Box 571, Jackson, MS 39205, email jpadilla@mdah.ms.gov.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the Mississippi Department of Archives and History, and additional information on the determinations in this notice, including the results of consultation, can be found in the summary or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

A total of 112 cultural items have been requested for repatriation. The 112 unassociated funerary objects include an axe; lithics; Native American ceramics; clay; shell; faunal remains; organic materials; soil samples; effigy beads; gorget; beads; pendants; and a lithic pipe fragment.

Unassociated funerary objects were removed from several sites in Alcorn County, MS, including, 22AL00B (Mound North of Corinth), 22AL504 (Wiggington #1), 22AL505 (Wiggington #2), and 22AL536 (Massengill I). The unassociated funerary objects from this county were acquired through donations by private collectors and others were removed during archaeological surveys conducted by MDAH in the 1970s. Additionally, some objects from this county have no provenience information.

Unassociated funerary objects were removed from several sites in Benton County, MS, including, 22BE00A (Ashland City), 22BE00B, 22BE507 (Talmar), and 2BE512 (Wilkinson). The unassociated funerary objects from this county were acquired through donations by private collectors or transferred from the C.H. Nash Museum and the DeSoto Museum to MDAH between 2012–2019. Additionally, some objects from this county have no provenience information.

Unassociated funerary objects were removed from several sites in DeSoto County, MS, including, 22DS00A (Tipplah Farms), 22DS00B (MAG's Lot #23), 22DS00C (Between Shannon and Shannon #2), 22DS00E, 22DS000/2019.17000.02 (Old Culture Site on HWY 51, below airport; MAGS Lot #32), 22DS000/2019.17000.03 (Taylor Plantation/MAGS Lot #20), 22DS000/2019.17000.05 (A1990.10.01), 22DS000/2019.17000.06 (Midway), 22DS000/2019.17000.04 (East of Walls), 22DS000/2019.17000.10 (Delta Material), 22DS505 (Sullivan), 22DS515 (Withers), 22DS520 (Twinkletown), 22DS521 (Lakeside), 22DS522, 22DS523, 22DS524, 22DS525, 22DS530, 22DS531, 22DS580, 22DS592 (Cub L.) and 22DS654 (Twinkletown East). The unassociated funerary objects from this county were acquired through donations by private collectors or transferred from the DeSoto Museum to MDAH in 2019 and from the Mississippi Department of Transportation (MDOT) in 2025. Additionally, some objects from this county have no provenience information.

Unassociated funerary objects were removed from several sites in Prentiss County, MS, including, 22PS501 (St. Smith Mound), 22PS504 (Le Croy Site), 22PS505 (Sale Martin), 22PS506 (Wells Mound), 22PS507 (Doss Site), 22PS508 (Church Site), 22PS510 (Lost Site), 22PS516 (Ridge Site), and 22PS528 (King Creek Area/King's Creek). The unassociated funerary objects from this county were acquired through donations by private collectors and others were removed during archaeological surveys

conducted by MDAH in the 1970s. Additionally, some objects from this county have no provenience information.

Unassociated funerary objects were removed from several sites in Quitman County, MS, including 22QU522 (Denton) and 22QU567 (Tackett). A large quantity of unassociated funerary objects from this county were acquired through donations by private collectors. Other objects were removed during various archaeological surveys conducted by MDAH, the Mississippi State University, and an unknown institution in the 1960s-1970s. Also, a transfer was received from the Mississippi Department of Transportation (MDOT) in 2025. Additionally, some objects from this county have no provenience information.

Through Tribal consultation, these 112 lots of unassociated funerary objects were identified as culturally affiliated with The Chickasaw Nation. To our knowledge, no potentially hazardous substances were used to treat any of the unassociated funerary objects.

Determinations

The Mississippi Department of Archives and History has determined that:

- The 112 lots of unassociated funerary objects described in this notice are reasonably believed to have been placed intentionally with or near human remains, and are connected, either at the time of death or later as part of the death rite or ceremony of a Native American culture according to the Native American traditional knowledge of a lineal descendant, Indian Tribe, or Native Hawaiian organization. The unassociated funerary objects have been identified by a preponderance of the evidence as related to human remains, specific individuals, or families, or removed from a specific burial site or burial area of an individual or individuals with cultural affiliation to an Indian Tribe or Native Hawaiian organization.
- There is a connection between the cultural items described in this notice and The Chickasaw Nation.

Requests for Repatriation

Additional, written requests for repatriation of the cultural items in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that

the requestor is a lineal descendant or a culturally affiliated Indian Tribe or Native Hawaiian organization.

Repatriation of the cultural items in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the Mississippi Department of Archives and History must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the cultural items are considered a single request and not competing requests. The Mississippi Department of Archives and History is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and to any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3004 and the implementing regulations, 43 CFR 10.9.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026–02695 Filed 2–10–26; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6913; NPS–WASO–NAGPRA–NPS0041985; PPWOCRADN0–PCU00RP14.R50000]

Notice of Inventory Completion: Office of the State Archaeologist, University of Iowa, Iowa City, IA

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the Office of the State Archaeologist Bioarchaeology Program (OSA BP) has completed an inventory of human remains and has determined that there is a cultural affiliation between the human remains and Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the human remains in this notice may occur on or after March 13, 2026.

ADDRESSES: Send written requests for repatriation of the human remains in this notice to Dr. Lara Noldner, Office of the State Archaeologist Bioarchaeology Program, University of Iowa, 700 S Clinton Street, Iowa City, IA 52242, email lara-noldner@uiowa.edu.

SUPPLEMENTARY INFORMATION: This notice is published as part of the

National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the OSA BP, and additional information on the determinations in this notice, including the results of consultation, can be found in the inventory or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

Human remains representing, at least, one individual have been reasonably identified. No associated funerary objects are present. The human remains were collected from Aztec Ruins National Monument at an unknown date prior to 1964 and donated the University of Northern Iowa (UNI), before being transferred to the OSA-BP in March of 2023. Handwritten labels accompany the two elements. A partial cranium (UNI catalogue #: 280-2) is labeled: "Skull Brought from Aztec Ruins, New Mexico. Donated by E.A. Snyder, Cedar Falls, Iowa. 700-3,000 years old". A right femur (UNI accession/catalogue #: 00.5.28) is labeled: "Human femur from Aztec Ruins New Mexico. 700-3,000 years old.". There is no documentation regarding the excavation or burial context of the human remains nor indication of how the date ranges for the elements were determined. The human remains are from a burial context, exhibit preservation typical of the desert Southwest, and are most likely of Puebloan ancestry. A middle-aged adult male individual is represented (BP3774). No treatments with hazardous chemicals are evident.

Cultural Affiliation

Based on the information available and the results of consultation, cultural affiliation is reasonably identified by the geographical location and acquisition history of the human remains in this notice.

Determinations

The OSA BP has determined that:

- The human remains described in this notice represent the physical remains of one individual of Native American ancestry.
- There is a reasonable connection between the human remains described in this notice and the Hopi Tribe of Arizona; Jicarilla Apache Nation, New Mexico; Mescalero Apache Tribe of the Mescalero Reservation, New Mexico; Navajo Nation, Arizona, New Mexico, & Utah; Ohkay Owingeh, New Mexico; Pueblo of Acoma, New Mexico; Pueblo of Cochiti, New Mexico; Pueblo of Isleta, New Mexico; Pueblo of Jemez,

New Mexico; Pueblo of Laguna, New Mexico; Pueblo of Nambe, New Mexico; Pueblo of Picuris, New Mexico; Pueblo of Pojoaque, New Mexico; Pueblo of San Felipe, New Mexico; Pueblo of San Ildefonso, New Mexico; Pueblo of Sandia, New Mexico; Pueblo of Santa Ana, New Mexico; Pueblo of Santa Clara, New Mexico; Pueblo of Taos, New Mexico; Pueblo of Tesuque, New Mexico; Pueblo of Zia, New Mexico; Santo Domingo Pueblo; Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado; Ute Mountain Ute Tribe; Ysleta del Sur Pueblo; and the Zuni Tribe of the Zuni Reservation, New Mexico.

Requests for Repatriation

Written requests for repatriation of the human remains in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by:

1. Any one or more of the Indian Tribes or Native Hawaiian organizations identified in this notice.
2. Any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or a culturally affiliated Indian Tribe or Native Hawaiian organization.

Repatriation of the human remains in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the OSA BP must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the human remains are considered a single request and not competing requests. The OSA BP is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3003, and the implementing regulations, 43 CFR 10.10.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026-02705 Filed 2-10-26; 8:45 am]

BILLING CODE 4312-52-P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6925; NPS-WASO-NAGPRA-NPS0041998; PPWOCRADNO-PCU00RP14.R50000]

Notice of Intended Repatriation: Sonoma State University, Rohnert Park, CA

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), Sonoma State University intends to repatriate certain cultural items that meet the definition of unassociated funerary objects, sacred objects, and/or objects of cultural patrimony and that have a cultural affiliation with the Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the cultural items in this notice may occur on or after March 13, 2026.

ADDRESSES: Send additional, written requests for repatriation of the cultural items in this notice to Kirsten Twork, Sonoma State University, 1801 E Cotati Avenue, Rohnert Park, CA 94928, email tworkk@sonoma.edu.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of Sonoma State University, and additional information on the determinations in this notice, including the results of consultation, can be found in the summary or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

A total of 2,568 lots of cultural items have been requested for repatriation. Of the cultural items being requested 2,485 lots are unassociated funerary objects and 83 lots are sacred objects.

A total of 1,821 lots of unassociated funerary objects were removed from CA-SON-518 in Cotati, California in Sonoma County. Items were removed from the site during two different time periods. The first removal occurred in 1973 during the Gossage Creek site excavation. The second occurred in 1989 during the Stony Point Road reconstruction test. The items include flaked stone debitage, flaked stone tools, charcoal, ash, botanical materials, ground stone tools, ocher, fire cracked rock, baked clay, modified faunal bone, unmodified faunal bone, historic

material, modified shell, and unmodified shell. The cultural items have been at Sonoma State University since their removal from the site.

A total of 172 lots of unassociated funerary objects were removed from CA–SON–447 in Rohnert Park, California in Sonoma County. Items were removed from the site during two different time periods. The first removal occurred in 1973 during the Russian River Water Supply Project. This project was proposed by the Marin Municipal Water District to construct an aqueduct from the Russian River and Mark West Creek in Sonoma county to Terra Linda in Marin County. The second occurred in 1990, additional information as to why the cultural material was removed from the site was not found. The items include groundstone tools, charmstone, flaked stone debitage, flaked stone tools, unmodified faunal bone and unmodified shell. The cultural items have been at Sonoma State University since their removal from the site.

A total of 24 lots of unassociated funerary objects were removed from CA–SON–1442 in Rohnert Park, California in Sonoma County. Items were removed from the site during two different time periods. The first removal occurred in 1984 and the second occurred in 1987. Further detail as to why the items were removed was not located. The items include flaked stone debitage and ground stone tools. The cultural items have been at Sonoma State University since their removal from the site.

A total of 277 lots of unassociated funerary objects were removed from CA–SON–1794 and CA–SON–1975 in Cotati, California in Sonoma County. Items were removed from the sites during the Stony Point Road Road Reconstruction Project. The items include groundstone tools, flaked stone debitage, flaked stone tools, historic material, organic material, unmodified faunal bone and unmodified shell. The cultural items have been at Sonoma State University since 1989.

A total of two lots of unassociated funerary objects were removed from the surface on Sonoma State University's campus in Rohnert Park, California. The items include flaked obsidian and a possible groundstone tool. The cultural items have been at Sonoma State University since 2021.

A total of 174 lots of unassociated funerary objects were removed from the ground on Sonoma State University's campus in Rohnert Park, California. The material was removed during the construction of the Green Music Center. The items include groundstone tools, historic material, flaked stone debitage,

and modified stone tools. The cultural items have been at Sonoma State University since 2006.

A total of 15 lots of unassociated funerary objects were removed from the Fairfield Osborn Preserve in Penngrove, California. The cultural material was removed from display and brought to the Anthropology Studies Center in August 2020. The items include groundstone tools, historic material, flaked stone debitage, and modified stone tools. The cultural items have been at Sonoma State University since.

A total of 17 lots of sacred objects were removed from CA–SON–1567 in Rohnert Park, California in Sonoma County. Further detail as to why the items were removed was not located. The items include flaked stone debitage. The cultural items have been at Sonoma State University since 1987.

A total of 21 lots of sacred objects were removed from CA–SON–686 in Cotati, California in Sonoma County. Items were removed from the site during two different time periods. The first removal occurred in 1978 the second occurred in 1988. Further detail as to why the items were removed was not located. The items include flaked stone debitage and modified stone tools. The cultural items have been at Sonoma State University since their removal from the site.

A total of two lots of sacred objects were removed from CA–SON–927 in Rohnert Park, California in Sonoma County. Further detail as to why the items were removed was not located. The items include modified stone tools. The cultural items have been at Sonoma State University since 1977.

A total of eight lots of sacred objects were removed from their origin in Cotati, California in Sonoma county and donated to the university by Nancy Moore. The items include modified stone tools, flaked stone debitage, and historic period material. The cultural items have been at Sonoma State University since 1976.

A total of five lots of sacred objects were removed during the Crane Creek Regional Park survey in Rohnert Park, California in Sonoma county. The items include modified stone tools and flaked stone debitage. The cultural items have been at Sonoma State University since 1973.

A total of 13 lots of sacred objects were removed from CA–SON–1506 in Rohnert Park, California in Sonoma County. Further detail as to why the items were removed was not located. The items include modified obsidian and flaked debitage. The cultural items have been at Sonoma State University since 1986.

A total of five lots of sacred objects were removed from CA–SON–1923 in Rohnert Park, California in Sonoma County. The cultural items were collected on Sonoma State University's campus. The items include flaked obsidian. The cultural items have been at Sonoma State University since 1991.

A total of 10 lots of sacred objects were removed during the construction of new dorms on Sonoma State University's campus in Rohnert Park, California. The items include flaked obsidian and modified obsidian. The cultural items have been at Sonoma State University since 1998.

A total of two lots of sacred objects were removed from CA–SON–1016 in Cotati, California in Sonoma County. The cultural items were removed during an archaeological evaluation of a portion of the site that overlapped with the Cotati Creek Bypass Project for the City of Cotati. The work was conducted by the Anthropological Studies Center at Sonoma State University. The items include flaked chert. The cultural items have been at Sonoma State University since 2005.

In the case of missing cultural items, any additional items when located will also be repatriated from the collections discussed above. Based on records concerning the cultural items and the institution in which they are housed, there is no evidence of the items being treated with hazardous substances.

Determinations

Sonoma State University has determined that:

- The 2,485 lots of unassociated funerary objects described in this notice are reasonably believed to have been placed intentionally with or near human remains, and are connected, either at the time of death or later as part of the death rite or ceremony of a Native American culture according to the Native American traditional knowledge of a lineal descendant, Indian Tribe, or Native Hawaiian organization. The unassociated funerary objects have been identified by a preponderance of the evidence as related to human remains, specific individuals, or families, or removed from a specific burial site or burial area of an individual or individuals with cultural affiliation to an Indian Tribe or Native Hawaiian organization.

- The 83 lots sacred objects described in this notice are specific ceremonial objects needed by a traditional Native American religious leader for present-day adherents to practice traditional Native American religion, according to the Native American traditional knowledge of a lineal descendant,

Indian Tribe, or Native Hawaiian organization.

- There is a connection between the cultural items described in this notice and the Federated Indians of Graton Rancheria, California.

Requests for Repatriation

Additional, written requests for repatriation of the cultural items in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or a culturally affiliated Indian Tribe or Native Hawaiian organization.

Repatriation of the cultural items in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, Sonoma State University must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the cultural items are considered a single request and not competing requests. The Sonoma State University is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and to any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3004 and the implementing regulations, 43 CFR 10.9.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026-02702 Filed 2-10-26; 8:45 am]

BILLING CODE 4312-52-P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6923; NPS-WASO-NAGPRA-NPS0041996; PPWOCRADN0-PCU00RP14.R50000]

Notice of Inventory Completion: California Polytechnic State University, San Luis Obispo, CA

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), California Polytechnic State University (Cal Poly), has completed an inventory of human remains and has determined that there is a cultural affiliation between the human remains and Indian Tribes or

Native Hawaiian organizations in this notice.

DATES: Repatriation of the human remains in this notice may occur on or after March 13, 2026.

ADDRESSES: Send written requests for repatriation of the human remains in this notice to Kent Spiers, Cal Poly, 1 Grand Avenue, San Luis Obispo, CA 93407, email spiers@calpoly.edu.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of Cal Poly, and additional information on the determinations in this notice, including the results of consultation, can be found in its inventory or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

Human remains representing, at least, two individuals have been identified. No associated funerary objects are present. The human remains are presumed to have been unearthed in downtown San Luis Obispo, CA, as noted in a newspaper clipping from 1958 that was provided with the human remains and given to Cal Poly. There are no records of indication that hazardous substances were used on these human remains.

Cultural Affiliation

Based on the information available and the results of consultation, cultural affiliation is reasonably identified by the geographical location or acquisition history of the human remains described in this notice.

Determinations

Cal Poly has determined that:

- The human remains described in this notice represent the physical remains of two individuals of Native American ancestry.
- There is a connection between the human remains described in this notice and the Santa Ynez Band of Chumash Mission Indians of the Santa Ynez Reservation, California.

Requests for Repatriation

Written requests for repatriation of the human remains in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by:

1. Any one or more of the Indian Tribes or Native Hawaiian organizations identified in this notice.
2. Any lineal descendant, Indian Tribe, or Native Hawaiian organization

not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or an Indian Tribe or Native Hawaiian organization with cultural affiliation.

Repatriation of the human remains described in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the Cal Poly must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the human remains are considered a single request and not competing requests. Cal Poly is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3003, and the implementing regulations, 43 CFR 10.10.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026-02700 Filed 2-10-26; 8:45 am]

BILLING CODE 4312-52-P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6921; NPS-WASO-NAGPRA-NPS0041994; PPWOCRADN0-PCU00RP14.R50000]

Notice of Intended Repatriation: Santa Barbara Museum of Natural History, Santa Barbara, CA

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the Santa Barbara Museum of Natural History intends to repatriate a certain cultural item that meets the definition of a sacred object and that has a cultural affiliation with the Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the cultural item in this notice may occur on or after March 13, 2026.

ADDRESSES: Send additional, written requests for repatriation of the cultural item in this notice to Luke Swetland, President and CEO, Santa Barbara Museum of Natural History, 2559 Puesta del Sol, Santa Barbara, CA 93105, email lswetland@sbnature2.org.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative

responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the Santa Barbara Museum of Natural History, and additional information on the determinations in this notice, including the results of consultation, can be found in the summary or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

A total of one cultural item has been requested for repatriation. The one sacred object is a Yurok/Hupa (Hoopa)/Karuk Jump Dance Medicine Basket. This item was purchased by the Santa Barbara Museum of Natural History, from Bonhams auction house, in San Francisco, CA, on Dec. 7, 2015. Limited provenience information indicates, “the original collector was an anthropologist from Southern California who bought lots of things in the 1950s, ’60s (mostly), and ’70s. They are being sold by his heirs.”

Determinations

The Santa Barbara Museum of Natural History has determined that:

- The one sacred object described in this notice is a specific ceremonial object needed by a traditional Native American religious leader for present-day adherents to practice traditional Native American religion, according to the Native American traditional knowledge of a lineal descendant, Indian Tribe, or Native Hawaiian organization.
- There is a reasonable connection between the cultural item described in this notice and the Big Lagoon Rancheria, California; Cher-Ae Heights Indian Community of the Trinidad Rancheria, California; Hoopa Valley Tribe, California; Karuk Tribe; Pulikla Tribe of Yurok People (previously listed as Resighini Rancheria, California); and the Yurok Tribe of the Yurok Reservation, California.

Requests for Repatriation

Additional, written requests for repatriation of the cultural item in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or a culturally affiliated Indian Tribe or Native Hawaiian organization.

Repatriation of the cultural item in this notice to a requestor may occur on or after March 13, 2026. If competing

requests for repatriation are received, the Santa Barbara Museum of Natural History must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the cultural item are considered a single request and not competing requests. The Santa Barbara Museum of Natural History is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and to any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3004 and the implementing regulations, 43 CFR 10.9.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026–02698 Filed 2–10–26; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6915; NPS–WASO–NAGPRA–NPS0041988; PPWOCRADNO–PCU00RP14.R50000]

Notice of Intended Repatriation: Mount Holyoke College Art Museum, South Hadley, MA

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the Mount Holyoke College Art Museum intends to repatriate certain cultural items that meet the definition of sacred objects and that have a cultural affiliation with the Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the cultural items in this notice may occur on or after March 13, 2026.

ADDRESSES: Send additional, written requests for repatriation of the cultural items in this notice to Abigail Hoover, Associate Director of Registration and Collections, Mount Holyoke College Art Museum, Lower Lake Road, South Hadley, MA 01075, email ahoover@mt_holyoke.edu.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service’s administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the Mount Holyoke College Art Museum, and additional information on the determinations in this notice, including

the results of consultation, can be found in the summary or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

A total of 14 cultural items have been requested for repatriation. The 14 sacred objects are one pōhaku ku’i ai (poi pounder), one lei niho palaoa (whale tooth pendant necklace), one lot of three pieces of kapa (bark cloth), eight kapa (bark cloth), one hoe (carved paddle), one lot of makaloa (reeds), and one kapa (bark cloth) book.

There is no available information for the acquisition history of the pōhaku ku’i ai (poi pounder), three pieces of kapa (bark cloth), and the makaloa (reeds). One piece of kapa was donated by Olive Beeman of South Hadley, MA. One piece of kapa was donated by Mrs. Arthur E. Richardson of Springfield, MA. According to available documentation, various cultural items were donated by individuals, including Mary Ella Spooner Brown, Julia Brooks Spaulding, Persis Thurston, and Dwight Baldwin, working as missionaries in the Hawaiian Islands in the nineteenth century. The group of three kapa and one piece of kapa are recorded as having belonged to Bernice Pauahi Pākī Bishop, and one piece of kapa donated in 1857 is recorded as having belonged to an unnamed “Queen of the Sandwich Islands.” Most of the above cultural items were formally transferred from the Mount Holyoke College Archives and Special Collections to the Mount Holyoke College Art Museum in 2003. The book made of kapa is in the collection of the Joseph Allen Skinner Museum at Mount Holyoke College, but the source and date of acquisition of the book are unknown. There are no available records indicating whether or not any potentially hazardous substances were used to treat any of these cultural items.

Determinations

The Mount Holyoke College Art Museum has determined that:

- The 14 sacred objects described in this notice are specific ceremonial objects needed by a traditional Native American religious leader for present-day adherents to practice traditional Native American religion, according to the Native American traditional knowledge of a Native Hawaiian organization.

- There is a connection between the cultural items described in this notice and Hui Iwi Kuamo’o.

Requests for Repatriation

Additional, written requests for repatriation of the cultural items in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by any lineal descendant or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or a culturally affiliated Native Hawaiian organization.

Repatriation of the cultural items in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the Mount Holyoke College Art Museum must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the cultural items are considered a single request and not competing requests. The Mount Holyoke College Art Museum is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and to any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3004 and the implementing regulations, 43 CFR 10.9.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026–02708 Filed 2–10–26; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6910; NPS–WASO–NAGPRA–
NPS0041981; PPWOCRADN0–
PCU00RP14.R50000]

Notice of Inventory Completion: University of Alabama at Birmingham, Birmingham, AL

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the University of Alabama at Birmingham has completed an inventory of human remains and associated funerary objects and has determined that there is a cultural affiliation between the human remains and associated funerary objects and Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the human remains and associated funerary objects

in this notice may occur on or after March 13, 2026.

ADDRESSES: Send written requests for repatriation of the human remains and associated funerary objects in this notice to Dr. Lauren Downs, University of Alabama at Birmingham, Department of Anthropology, UH 3165, 1720 2nd Avenue South, Birmingham, AL 35294, email nagprastaff@uab.edu.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the University of Alabama at Birmingham, and additional information on the determinations in this notice, including the results of consultation, can be found in its inventory or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

Human remains representing, at least, five individuals have been identified. The 101 associated funerary objects are 46 lithic flakes; 19 undecorated pottery sherds; 11 miscellaneous stone; five chert lithic fragments; four unmodified sandstone fragments; three soil samples; two faunal bone fragments, species unknown; two fragments of white clay; two lots of charcoal; two wood fragments; one quartz projectile point; one soil and charred organics sample; one lot of charred organics; one charred seed fragment; and one chert projectile point. Site 1Sc245 is a large multi-component camp/village site spanning 40–50 acres adjacent to Little Cahaba River in St. Clair County, AL, near the modern town of Moody. The site was excavated several times by different UAB-affiliated personnel. Dr. Roger Nance and graduate student Chris McLaughlin visited the site in 1978 and 1987. This work included survey and excavations associated with graduate student research and a UAB-sponsored field school. Additionally, the site was visited by Dr. Jack Bergstresser and staff in 1998 to conduct test excavations as part of a contract archaeology project. Site use dates from the Early Archaic to the Late Woodland/Early Mississippian periods, and the ancestors and belongings date to the Late Woodland/Early Mississippian period—likely to the West Jefferson phase (roughly A.D. 900–1100). There is no record of potentially hazardous substances being used to treat the ancestors or associated funerary objects.

Cultural Affiliation

Based on the information available and the results of consultation, cultural affiliation is reasonably identified by the geographical location or acquisition history of the human remains and associated funerary objects described in this notice.

Determinations

The University of Alabama at Birmingham has determined that:

- The human remains described in this notice represent the physical remains of five individuals of Native American ancestry.
- The 101 objects described in this notice are reasonably believed to have been placed intentionally with or near individual human remains at the time of death or later as part of the death rite or ceremony.
- There is a connection between the human remains and associated funerary objects described in this notice and the Alabama-Coushatta Tribe of Texas; Poarch Band of Creek Indians; Seminole Tribe of Florida; The Muscogee (Creek) Nation; and the Thlopthlocco Tribal Town.

Requests for Repatriation

Written requests for repatriation of the human remains and associated funerary objects in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by:

1. Any one or more of the Indian Tribes or Native Hawaiian organizations identified in this notice.
2. Any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or an Indian Tribe or Native Hawaiian organization with cultural affiliation.

Repatriation of the human remains and associated funerary objects described in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the University of Alabama at Birmingham must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the human remains and associated funerary objects are considered a single request and not competing requests. The University of Alabama at Birmingham is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25

U.S.C. 3003, and the implementing regulations, 43 CFR 10.10.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026-02694 Filed 2-10-26; 8:45 am]

BILLING CODE 4312-52-P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6928; NPS-WASO-NAGPRA-
NPS0041999; PPWOCRADNO-
PCU00RP14.R50000]

Notice of Inventory Completion: Sam Noble Oklahoma Museum of Natural History, University of Oklahoma, Norman, OK

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the Sam Noble Oklahoma Museum of Natural History (SNOMNH) has completed an inventory of human remains and associated funerary objects and has determined that there is a cultural affiliation between the human remains and associated funerary objects and Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the human remains and associated funerary objects in this notice may occur on or after March 13, 2026.

ADDRESSES: Send written requests for repatriation of the human remains and associated funerary objects in this notice to Chelsea Rose, Interim NAGPRA Program Coordinator, Sam Noble Oklahoma Museum of Natural History, 2401 Chautauqua Avenue, Norman, OK 73072, email chelsea.rose@ou.edu.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the SNOMNH, and additional information on the determinations in this notice, including the results of consultation, can be found in its inventory or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

Human remains representing, at least, one individual have been identified from site 34LF22 in LeFlore County, Oklahoma; the lots of associated funerary objects listed below are not

associated with this individual. One lot of lithics and one lot of faunal remains from 34LF22 have also been identified. These lots of objects are in addition to the group of associated funerary objects previously identified in a Notice of Inventory Completion published in the **Federal Register** on July 1, 2024 (89 FR 54499-54501) for 34LF22.

One lot of associated funerary objects (beads) from site 34LF38 in LeFlore Co., Oklahoma has been identified. This object is in addition to the group of associated funerary objects previously identified in a Notice of Inventory Completion published in the **Federal Register** on June 27, 2025 (90 FR 27673) for 34LF38.

One lot of associated funerary objects (pots-various temper) from site 34LF75 in LeFlore Co., Oklahoma has been identified. This lot of objects is in addition to the group of association funerary objects previously identified in a Notice of Inventory Completion published in the **Federal Register** on December 9, 2022 (87 FR 75655) for 34LF75.

One lot of associated funerary objects (pots-various temper) from site 34LF77 in LeFlore Co., Oklahoma has been identified. This lot of objects is in addition to the group of association funerary objects previously identified in a Notice of Inventory Completion published in the **Federal Register** on December 9, 2022 (87 FR 75655) for 34LF77.

One lot of associated funerary objects (pots) from site 34MC6 in McCurtain Co., Oklahoma has been identified. This object is in addition to the group of associated funerary objects previously identified in a Notice of Inventory Completion published in the **Federal Register** on December 19, 2023 (88 FR 87810) for 34MC6.

To our knowledge, no potentially hazardous substances were used to treat the human remains or associated funerary objects. Through tribal consultation, the individual and additional associated funerary objects were identified as culturally affiliated with the Caddo Nation of Oklahoma and the Wichita and Affiliated Tribes (Wichita, Keechi, Waco, & Tawakonie), Oklahoma.

Cultural Affiliation

Based on the information available and the results of consultation, cultural affiliation is clearly identified by the information available about the human remains and associated funerary objects described in this notice.

Determinations

The SNOMNH has determined that:

- The human remains described in this notice represent the physical remains of one individual of Native American ancestry.
- The six lots of objects described in this notice are reasonably believed to have been placed intentionally with or near individual human remains at the time of death or later as part of the death rite or ceremony.
- There is a connection between the human remains and associated funerary objects described in this notice and the Caddo Nation of Oklahoma and the Wichita and Affiliated Tribes (Wichita, Keechi, Waco, & Tawakonie), Oklahoma.

Requests for Repatriation

Written requests for repatriation of the human remains and associated funerary objects in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by:

1. Any one or more of the Indian Tribes or Native Hawaiian organizations identified in this notice.
2. Any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or an Indian Tribe or Native Hawaiian organization with cultural affiliation.

Repatriation of the human remains and associated funerary objects described in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the SNOMNH must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the human remains and associated funerary objects are considered a single request and not competing requests. The SNOMNH is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3003, and the implementing regulations, 43 CFR 10.10.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026-02711 Filed 2-10-26; 8:45 am]

BILLING CODE 4312-52-P

DEPARTMENT OF THE INTERIOR**National Park Service**

[N6924; NPS-WASO-NAGPRA-NPS0041997; PPWOCRADNO-PCU00RP14.R50000]

**Notice of Intended Repatriation:
Western Washington University
Archaeological Repository,
Department of Anthropology,
Bellingham, WA**

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the Western Washington University Archaeological Repository (WWUAR), intends to repatriate certain cultural items that meet the definition of sacred objects/objects of cultural patrimony and that have a cultural affiliation with the Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the cultural items in this notice may occur on or after March 13, 2026.

ADDRESSES: Send additional, written requests for repatriation of the cultural items in this notice to Dr. Judith Pine, Western Washington University, Department of Anthropology, Arntzen Hall 340, 516 High Street, Bellingham, WA 98225, email pinej@wwu.edu.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the WWUAR, and additional information on the determinations in this notice, including the results of consultation, can be found in the summary or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

A total of 12,556 cultural items have been requested for repatriation. The 12,556 sacred objects/objects of cultural patrimony are lithic bifaces, scrapers, choppers, hammerstones, adzes, cores, flakes, and debitage. This collection, known as the Woodhaven Olcott Collection, was derived from an archaeological compliance project conducted by Drayton Archaeology (DA) for a private landowner. In accordance with the State Environmental Policy Act (SEPA), DA conducted an initial archaeological assessment of the project area, resulting in the identification and recording of 45SN417, the Woodhaven Olcott Site. 45SN417 is a precontact village site that consists of extensive

Paleoindian-period lithic materials and fire modified rock (FMR) located along a broad flat terrace of a former channel of the Pilchuck River in Snohomish County, WA. The collection was purchased by Mr. Baldwin of DA from the private landowner and was subsequently donated to the WWUAR. Thermal luminescence dated two items in the collection to 8700 BP and 7400 BP, respectively. The WWUAR has no information about the collection being treated with potentially hazardous substances.

Determinations

The WWUAR has determined that:

- The 12,556 sacred objects/objects of cultural patrimony described in this notice have ongoing historical, traditional, or cultural importance central to the Native American group, including any constituent sub-group (such as a band, clan, lineage, ceremonial society, or other subdivision), according to the Native American traditional knowledge of an Indian Tribe or Native Hawaiian organization.
- There is a connection between the cultural items described in this notice and the Stillaguamish Tribe of Indians of Washington; Swinomish Indian Tribal Community; and the Tulalip Tribes of Washington.

Requests for Repatriation

Additional, written requests for repatriation of the cultural items in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or a culturally affiliated Indian Tribe or Native Hawaiian organization.

Repatriation of the cultural items in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the WWUAR must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the cultural items are considered a single request and not competing requests. The WWUAR is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and to any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3004 and the implementing regulations, 43 CFR 10.9.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026-02701 Filed 2-10-26; 8:45 am]

BILLING CODE 4312-52-P

DEPARTMENT OF THE INTERIOR**National Park Service**

[N6909; NPS-WASO-NAGPRA-NPS0041980; PPWOCRADNO-PCU00RP14.R50000]

**Notice of Inventory Completion:
University of Alabama at Birmingham,
Birmingham, AL**

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the University of Alabama at Birmingham has completed an inventory of human remains and associated funerary objects and has determined that there is a cultural affiliation between the human remains and associated funerary objects and Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the human remains and associated funerary objects in this notice may occur on or after March 13, 2026.

ADDRESSES: Send written requests for repatriation of the human remains and associated funerary objects in this notice to Dr. Lauren Downs, University of Alabama at Birmingham, Department of Anthropology, UH 3165, 17202nd Avenue South, Birmingham, AL 35294, email nagprastaff@uab.edu.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the University of Alabama at Birmingham, and additional information on the determinations in this notice, including the results of consultation, can be found in its inventory or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

Ancestor remains representing, at least, one individual have been identified. The 818 associated funerary objects are 253 pottery sherds, decorated and undecorated; 507 chert lithic flakes; three lots of faunal remains, species unidentified; three lots of charcoal and soil; two lots of comingled charcoal, soil, and faunal remains; two clay pipe fragments; 24 chert lithic tool fragments;

six greenstone flakes; two pigment fragments, including limonite and hematite; two charcoal fragments; 10 miscellaneous stones; one burned shell fragment; one daub fragment; one calcined shell fragment; and one broken clay bead. Site 1Cu24 is a multi-component village site, located on a high terrace of Mulberry Fork of the Black Warrior River in Cullman County, AL. The collection was removed from the site by University of Alabama at Birmingham, Department of Anthropology faculty member Dr. Roger Nance as part of a university-sponsored field school in 1989–1990. Based on diagnostic artifacts from the site, site use dates to the Late Archaic (3800 BC–1200 BC), Woodland (1200 BC–A.D. 1000), and Early Mississippian (A.D. 1000–1350) periods. The ancestor and belongings likely date to the Late Woodland to Early Mississippian periods. There is no record of any potentially hazardous substances being used to treat either the ancestor or the associated belongings.

Cultural Affiliation

Based on the information available and the results of consultation, cultural affiliation is reasonably identified by the geographical location or acquisition history of the human remains and associated funerary objects described in this notice.

Determinations

The University of Alabama at Birmingham has determined that:

- The human remains described in this notice represent the physical remains of one individual of Native American ancestry.
- The 818 objects described in this notice are reasonably believed to have been placed intentionally with or near individual human remains at the time of death or later as part of the death rite or ceremony.
- There is a connection between the human remains and associated funerary objects described in this notice and the Alabama-Coushatta Tribe of Texas; Poarch Band of Creek Indians; The Muscogee (Creek) Nation; and the Thlopthlocco Tribal Town.

Requests for Repatriation

Written requests for repatriation of the human remains and associated funerary objects in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by:

1. Any one or more of the Indian Tribes or Native Hawaiian organizations identified in this notice.

2. Any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or an Indian Tribe or Native Hawaiian organization with cultural affiliation.

Repatriation of the human remains and associated funerary objects described in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the University of Alabama at Birmingham must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the human remains and associated funerary objects are considered a single request and not competing requests. The University of Alabama at Birmingham is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3003, and the implementing regulations, 43 CFR 10.10.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026–02693 Filed 2–10–26; 8:45 am]

BILLING CODE 4312–52–P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6916; NPS–WASO–NAGPRA–NPS0041989; PPWOCRADNO–PCU00RP14.R50000]

Notice of Intended Repatriation: Cincinnati Museum Center, Cincinnati, OH

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the Cincinnati Museum Center intends to repatriate certain cultural items that meet the definition of objects of cultural patrimony and that have a cultural affiliation with the Indian Tribes or Native Hawaiian organizations in this notice.

DATES: Repatriation of the cultural items in this notice may occur on or after March 13, 2026.

ADDRESSES: Send additional, written requests for repatriation of the cultural items in this notice to Tyler Swinney, Cincinnati Museum Center, 1301

Western Avenue, Cincinnati, OH 45203, email tswinney@cincymuseum.org.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the Cincinnati Museum Center, and additional information on the determinations in this notice, including the results of consultation, can be found in the summary or related records. The National Park Service is not responsible for the determinations in this notice.

Abstract of Information Available

A total of six cultural items have been requested for repatriation. The six objects of cultural patrimony are five pair of beaded moccasins and one beaded jacket. The moccasins were donated to the museum by Mary L. Melvin and E.V. Clarke and were accessioned in 1993. The jacket was donated to the museum by Mrs. Frederick Shaffer and was accessioned in 1961. The Cincinnati Museum Center has no records indicating that these cultural items were exposed to any hazardous substances while in the stewardship of the Museum.

Through consultation, it has been determined that floral beadwork designs are characteristic of the 'Santee Floral' style and date to between ca. 1860 and 1900. Santee Floral is a common clothing decoration for the Mdewakanton and is central to the ongoing cultural identity of the Flandreau Santee Sioux Tribe.

Determinations

The Cincinnati Museum Center has determined that:

- The six objects of cultural patrimony described in this notice have ongoing historical, traditional, or cultural importance central to the Native American group, including any constituent sub-group (such as a band, clan, lineage, ceremonial society, or other subdivision), according to the Native American traditional knowledge of an Indian Tribe or Native Hawaiian organization.

- There is a connection between the cultural items described in this notice and the Flandreau Santee Sioux Tribe of South Dakota.

Requests for Repatriation

Additional, written requests for repatriation of the cultural items in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by any lineal descendant, Indian Tribe, or

Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or a culturally affiliated Indian Tribe or Native Hawaiian organization.

Repatriation of the cultural items in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the Cincinnati Museum Center must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the cultural items are considered a single request and not competing requests. The Cincinnati Museum Center is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and to any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3004 and the implementing regulations, 43 CFR 10.9.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026-02709 Filed 2-10-26; 8:45 am]

BILLING CODE 4312-52-P

DEPARTMENT OF THE INTERIOR

National Park Service

[N6929; NPS-WASO-NAGPRA-NPS0042000; PPWOCRADNO-PCU00RP14.R50000]

Notice of Intended Repatriation Amendment: Indianapolis Museum of Art at Newfields, Indianapolis, IN

AGENCY: National Park Service, Interior.

ACTION: Notice; amendment.

SUMMARY: In accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), the Indianapolis Museum of Art at Newfields has amended a notice of intended repatriation published in the **Federal Register** on December 16, 2025. This notice amends the Indian Tribes or Native Hawaiian organizations with cultural affiliation.

DATES: Repatriation of the cultural items in this notice may occur on or after March 13, 2026.

ADDRESSES: Send additional, written requests for repatriation of the cultural items in this notice to Jennifer Gallatin Rigsby, Indianapolis Museum of Art at Newfields, 4000 Michigan Road, Indianapolis, IN 46208, email jrigsby@discovernewfields.org.

SUPPLEMENTARY INFORMATION: This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA. The determinations in this notice are the sole responsibility of the Indianapolis Museum of Art at Newfields, and additional information on the determinations in this notice, including the results of consultation, can be found in the summary or related records. The National Park Service is not responsible for the determinations in this notice.

Amendment

This notice amends the determination of cultural affiliation published in a notice of intended repatriation in the **Federal Register** (FR 2025-22903, December 16, 2025). Repatriation of the cultural items in the original notice of intended repatriation has not occurred.

Determinations

The Indianapolis Museum of Art at Newfields has determined that:

- There is a reasonable connection between the cultural items described in the original notice and the Tule River Indian Tribe of the Tule River Reservation, California.

Requests for Repatriation

Additional, written requests for repatriation of the cultural items in this notice must be sent to the authorized representative identified in this notice under **ADDRESSES**. Requests for repatriation may be submitted by any lineal descendant, Indian Tribe, or Native Hawaiian organization not identified in this notice who shows, by a preponderance of the evidence, that the requestor is a lineal descendant or a culturally affiliated Indian Tribe or Native Hawaiian organization.

Repatriation of the cultural items in this notice to a requestor may occur on or after March 13, 2026. If competing requests for repatriation are received, the Indianapolis Museum of Art at Newfields must determine the most appropriate requestor prior to repatriation. Requests for joint repatriation of the cultural items are considered a single request and not competing requests. The Indianapolis Museum of Art at Newfields is responsible for sending a copy of this notice to the Indian Tribes and Native Hawaiian organizations identified in this notice and to any other consulting parties.

Authority: Native American Graves Protection and Repatriation Act, 25 U.S.C. 3004 and the implementing regulations, 43 CFR 10.9.

Dated: February 4, 2026.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2026-02712 Filed 2-10-26; 8:45 am]

BILLING CODE 4312-52-P

DEPARTMENT OF THE INTERIOR

Bureau of Reclamation

[RR040U2000, XXXR4081G3, RX.05940913.FY19400]

Public Meeting of the Glen Canyon Dam Adaptive Management Work Group

AGENCY: Bureau of Reclamation, Interior.

ACTION: Notice of public meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act of 1972, the Bureau of Reclamation (Reclamation) is publishing this notice to announce that a Federal Advisory Committee meeting of the Glen Canyon Dam Adaptive Management Work Group (AMWG) will take place. The meeting is open to the public.

DATES: The meeting will be held in-person and virtually on Wednesday, February 25, 2026, beginning at 9:30 a.m. to approximately 5:00 p.m. (MST); and Thursday, February 26, 2026, from 8:30 a.m. to approximately 3:30 p.m. (MST).

ADDRESSES: The in-person meeting will be held in the Ballroom at the Hilton Garden Inn, Phoenix Tempe University Research Park, 7290 S Price Road, Tempe, AZ 85283.

Please follow the link provided to register for the virtual meeting held on Wednesday, February 25, 2026. <https://events.gcc.teams.microsoft.com/event/68fa8b47-cb91-4f5d-9a27-c7e56e67ec53@0693b5ba-4b18-4d7b-9341-f32f400a5494>.

Please follow the link provided to register for the virtual meeting held on Thursday, February 26, 2026. <https://events.gcc.teams.microsoft.com/event/391fc2d6-d1a5-44e6-8748-4df4138934d6@0693b5ba-4b18-4d7b-9341-f32f400a5494>.

FOR FURTHER INFORMATION CONTACT: Mr. William Stewart, Bureau of Reclamation, telephone (385) 622-2179, email at wstewart@usbr.gov. 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: The Glen Canyon Dam Adaptive Management Program (GCDAMP) was implemented as a result of the Record of Decision on the Operation of Glen Canyon Dam Final Environmental Impact Statement to comply with consultation requirements of the Grand Canyon Protection Act (Pub. L. 102–575) of 1992. The AMWG makes recommendations to the Secretary of the Interior concerning Glen Canyon Dam operations and other management actions to protect resources downstream of Glen Canyon Dam, consistent with the Grand Canyon Protection Act. The AMWG meets two to three times a year.

Agenda: The AMWG will meet to receive updates on: (1) current basin hydrology and water year 2026 operations; (2) experiments considered for implementation in 2026; (3) the status of threatened and endangered species; (4) long-term funding considerations. The AMWG will also discuss other administrative and resource issues pertaining to the GCDAMP. To view a copy of the agenda and documents related to the above meeting, please visit Reclamation's website at <https://www.usbr.gov/uc/progact/amp/amwg.html>.

Meeting Accessibility/Special Accommodations: The meeting is open to the public. Please make requests in advance for sign language interpreter services, assistive listening devices, or other reasonable accommodations. We ask that you contact Mr. William Stewart (see **FOR FURTHER INFORMATION CONTACT** section of this notice) at least seven (7) business days prior to the meeting to give the Department of the Interior sufficient time to process your request. All reasonable accommodation requests are managed on a case-by-case basis.

Public Disclosure of Comments: Time will be allowed on both days for any individual or organization wishing to make extemporaneous and/or formal oral comments. Depending on the number of persons wishing to speak, and the time available, the time for individual comments may be limited. Interested parties should contact Mr. William Stewart (see **FOR FURTHER INFORMATION CONTACT**) for placement on the public speaker list for this meeting. Members of the public may also choose to submit written comments by emailing them to wstewart@usbr.gov. Due to time constraints during the meeting, the AMWG is not able to read written public comments. All written comments will be made part of the public record

and will be provided to the AMWG members.

Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

(Authority: 5 U.S.C. Ch. 10)

Wayne Pullan,

Regional Director, Upper Colorado Basin—Interior Region 7, Bureau of Reclamation.

[FR Doc. 2026–02687 Filed 2–10–26; 8:45 am]

BILLING CODE 4332–90–P

INTERNATIONAL TRADE COMMISSION

[Investigation No. 731–TA–1742 (Final)]

Lattice-Boom Crawler Cranes (LBCCs) From Japan; Scheduling of the Final Phase of Antidumping Duty Investigation

AGENCY: United States International Trade Commission.

ACTION: Notice.

SUMMARY: The Commission hereby gives notice of the scheduling of the final phase of antidumping duty investigation No. 731–TA–1742 (Final) pursuant to the Tariff Act of 1930 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 Lattice-Boom Crawler Cranes (LBCCs) from Japan, provided for in subheading 8426.49.00, or may be classified under statistical reporting numbers 8425.19.0000, 8431.49.1060, or 8431.49.1090 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: February 9, 2026.

FOR FURTHER INFORMATION CONTACT: Laurel Schwartz (205–2398), 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 this investigation may be viewed on the Commission's electronic docket (EDIS) at <https://edis.usitc.gov>.

SUPPLEMENTARY INFORMATION:

Scope—For purposes of this investigation, Commerce has defined the subject merchandise as lattice boom crawler cranes, and lattice boom crawler crane assemblies. Lattice boom crawler cranes combine the assemblies defined below, among other components, including a lower carriage assembly fitted with tank-link crawler tracks, an upper carriage housing the operator cab, engine, and hydraulics, and a boom made of steel pipe welded together in a distinctive lattice pattern. The scope of this investigation covers lattice boom crawler cranes and lattice boom crawler crane assemblies, whether assembled or unassembled, and whether or not the lattice boom crawler crane contains any additional features that provide for functions beyond the primary lifting function. All lattice boom crawler cranes are included in the scope regardless of maximum lift capacity, lattice boom length, jib configuration, or other added features.

Subject merchandise includes, but is not limited to, the following lattice boom crawler crane assemblies which can be imported in isolation or combined in different configurations at the time of import:

Lattice boom assemblies and pieces thereof. Lattice boom assemblies are formed of interlocking sections of welded high-strength steel pipe, that form the lifting attachment of the crane. A lattice boom is formed by welding main chords together with lacing pipes typically arranged in a “W” or “V” pattern. Lattice boom assemblies consist of a boom butt (also known as a boom bottom or boom base), which attaches to the upper carriage assembly, and a boom head (also known as a boom tip or boom hat), which forms the other end of the boom structure. In between the boom butt and boom head, boom inserts of various lengths can be inserted to reach the desired boom height and load bearing capability. Lattice boom assemblies may be imported with boom butt, boom tip, and boom inserts together, but boom butt, boom tip, and boom inserts imported alone are also covered by the scope.

Lower carriage assembly. The lower carriage assembly (also may be referred

to as a carbody or lower works) is constructed with high-strength steel components and forms the base of the crawler crane. The lower carriage assembly typically includes various motors, drive mechanisms, and hydraulics. The lower carriage assembly may also include a set of counterweights to provide backward stability for the assembled crane. The lower carriage typically has a circular center that is connected to the upper carriage assembly with a bearing. The lower and upper carriage assemblies may or may not be connected by a bearing at the time of importation. Steel arms extend from the center of the lower carriage and connect to the front and rear of the crawler assemblies that are positioned on both sides of the lower carriage assembly. The lower carriage assembly may also contain a hydraulic system that allows for the extension and retraction of the crawler assemblies to create a wider base. A lower carriage assembly may be imported with or without crawler assemblies.

Crawler assembly. Each lattice boom crawler crane contains at least two crawler assemblies, which are continuous tracks that provide mobility and distribute the crane's weight evenly across the ground. The tracks of a lattice boom crawler crane consist of steel track shoes, which are interlocking steel plates that form the tread of the tracks and make direct contact with the ground, a track chain, which is a continuous loop of interconnected steel links, and a crawler body and track rollers, which support the track shoes and track chain. Typically, drive motors mounted on the lower carriage assembly connect to crawler-mounted drive sprockets, which engage the track chain and allow the LBCC to move forward and backward.

Upper carriage assembly. The upper carriage assembly, also known as the upper works, typically includes the operator's cab, hydraulic systems, engine, boom hoist, mast, and a turntable base with swing drive mechanism that connects to the lower carriage assembly and allows the upper carriage to pivot on the lower carriage assembly. The upper and lower carriage assemblies may or may not be connected by a bearing at the time of importation. The upper carriage assembly may also include a separate counterweight tray and counterweights, which allow the crane to maintain balance while lifting heavy loads, as well as a gantry, which helps lift the boom and counterweights during installation, although the counterweight tray, counterweights, and gantry are not required to be attached for the upper

carriage assembly to be a subject assembly. The boom butt may or may not be attached to the upper carriage assembly at the time of entry.

Hoisting assembly. The hoisting assembly, housed within the upper carriage assembly and lattice boom assembly, powers the lifting and lowering of loads and typically consists of a hoisting line of high strength steel cable, a hoist motor, hoist brakes, hoisting drums, and a hook block formed from steel sheaves, which helps distribute the load on the hoisting line and increases lifting capacity. The main hoisting line typically runs from the hoist drums, housed in the upper carriage assembly, up through the lattice boom (which may or may not house additional hoist drums) and hook block.

Jib assemblies. Jib assemblies are optional components that can be added to the top end of the boom to provide the crane with greater reach. Similar to lattice boom assemblies, jib assemblies typically consist of interlocking sections of welded steel pipe, arranged in a "V" or "W" lattice pattern. Jib assemblies can consist of either fixed jib, which extends from the main lattice boom at a fixed angle, or a luffing jib, which can be raised or lowered by the operator through a separate set of controls.

Importation of any of these assemblies, whether assembled or unassembled, constitutes unfinished lattice boom crawler cranes for purposes of this investigation. Inclusion of other components not identified as comprising the finished or unfinished lattice boom crawler cranes and lattice boom crawler crane assemblies do not remove the products from the scope.

Processing of lattice boom crawler cranes and lattice boom crawler crane assemblies such as welding, joining, bolting, painting, coating, finishing, or assembly, either in the country of manufacture of the in-scope product or in a third country does not remove the product from the scope. Lattice boom crawler cranes and lattice boom crawler crane assemblies subject to this investigation include those that are produced in the subject country whether assembled with other components in the subject country or in a third country. Processing or completion of finished and unfinished lattice boom crawler cranes and the covered lattice boom crawler crane assemblies either in the subject country or in a third country does not remove the product from the scope.

Lattice boom crawler cranes subject to this investigation are typically classifiable under subheading 8426.49.00 of the Harmonized Tariff Schedule of the United States (HTSUS).

Lattice boom crawler crane assemblies may also be classified under subheading 8426.49.00, or may be classified under statistical reporting numbers 8425.19.0000, 8431.49.1060, or 8431.49.1090 of the HTSUS. While the HTSUS subheadings are provided for convenience and customs purposes, the written description of the merchandise under investigation is dispositive.

Background—The final phase of this investigation is being scheduled pursuant to section 731(b) of the Tariff Act of 1930 (19 U.S.C. 1673d(b)), as a result of the affirmative preliminary determination by Commerce 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 investigation was requested in petitions filed on April 10, 2025, by The Manitowoc Company, Inc., Milwaukee, WI.

For further information concerning the conduct of this phase of the investigation, 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 investigation 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 this investigation 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 investigation 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 investigation.

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 this investigation

available to authorized applicants under the APO issued in the investigation, 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 investigation. A party granted access to BPI in the preliminary phase of the investigation 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 this investigation will be placed in the nonpublic record on May 19, 2026, 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 this investigation beginning at 9:30 a.m. on June 3, 2026. Requests to appear at the hearing should be filed in writing with the Secretary to the Commission on or before May 28, 2026. 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 a remote witness due to illness or a positive COVID-19 test result may be submitted by 3:00 p.m. 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 June 1, 2026. Parties shall file and serve written testimony and presentation slides in connection with their presentation at the hearing by no later than noon on June 2, 2026. 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 5:15 p.m. on May 28, 2026. 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 5:15 p.m. on June 10, 2026. In addition, any person who has not entered an appearance as a party to the investigation may submit a written statement of information pertinent to the subject of the investigation, including statements of support or opposition to the petition, on or before 5:15 p.m. on June 10, 2026. On June 25, 2026, 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 5:15 p.m. on June 29, 2026, 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 investigation must be served on all other parties to the investigation (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: This investigation is 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: February 9, 2026.

Lisa Barton,

Secretary to the Commission.

[FR Doc. 2026-02760 Filed 2-10-26; 8:45 am]

BILLING CODE 7020-02-P

DEPARTMENT OF JUSTICE

[OMB Number 1103-0102]

Agency Information Collection Activities; Proposed eCollection eComments Requested; Reinstatement Without Change to a Previously Approved Collection; COPS Progress Report

AGENCY: Office of Community Oriented Policing Services, Department of Justice.

ACTION: 30-Day notice.

SUMMARY: The Office of Community Oriented Policing Services, Department of Justice (DOJ), will be submitting the following information collection request to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995.

DATES: Comments are encouraged and will be accepted for 30 days until March 13, 2026.

FOR FURTHER INFORMATION CONTACT: If you have comments especially on the estimated public burden or associated response time, suggestions, or need a copy of the proposed information collection instrument with instructions or additional information, please contact: Cory D. Randolph, Two Constitution Square, 145 N Street NE, Suite, (202) 353-947, or cory.randolph2@usdoj.gov.

SUPPLEMENTARY INFORMATION: The proposed information collection was previously published in the **Federal Register** on December 3, 2025, 90 FR 55764, allowing a 60-day comment period. Written comments and suggestions from the public and affected agencies concerning the proposed collection of information are encouraged. Your comments should address one or more of the following four points:

- 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;
- 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;

- Enhance the quality, utility, and clarity of the information to be collected; and/or
- 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.

Written comments and recommendations for this 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 information collection or the OMB Control Number 1103–0119. This information collection request may be viewed at www.reginfo.gov. Follow the instructions to view Department of Justice, information collections currently under review by OMB.

DOJ seeks PRA authorization for this information collection for three (3) years. OMB authorization for an ICR cannot be for more than three (3) years without renewal. The DOJ notes that information collection requirements submitted to the OMB for existing ICRs receive a month-to-month extension while they undergo review.

Overview of This Information Collection

1. *Type of Information Collection:* Reinstatement of a previously approved collection.

2. *Title of the Form/Collection:* COPS Progress Report.

3. *Agency form number, if any, and the applicable component of the Department of Justice sponsoring the collection:* OMB #1103–0102 DOJ Components: COPS.

4. *Affected public who will be asked or required to respond, as well as a brief abstract:* Affected—Law Enforcement Agencies.

Abstract: Under the Violent Crime and Control Act of 1994, the U.S. Department of Justice COPS Office requires programmatic progress reports from active COPS grantees in order to monitor each program, project or activity funded by the COPS Office.

Obligation to Respond: Mandatory.

5. *Total Estimated Number of Respondents:* 4,800.

6. *Estimated Time per Respondent:* 25 minutes.

7. *Frequency:* Quarterly.

8. *Total Estimated Annual Time Burden:* 2,000 Burden Hours.

9. *Total Estimated Annual Other Costs Burden:* \$515,900.

If additional information is required, contact: Darwin Arceo, Department Clearance Officer, Enterprise Portfolio Management, Justice Management Division, United States Department of Justice, Two Constitution Square, 145 N Street NE, 4W–218, Washington, DC 20530.

Darwin Arceo,

Department Clearance Officer for PRA, U.S. Department of Justice.

[FR Doc. 2026–02720 Filed 2–10–26; 8:45 am]

BILLING CODE 4410–AT–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[NASA Document Number: 26–008]

Notice of Intent To Grant an Exclusive, Co-Exclusive or Partially Exclusive Patent License

AGENCY: National Aeronautics and Space Administration (NASA).

ACTION: Notice of intent to grant exclusive, co-exclusive or partially exclusive patent license.

SUMMARY: NASA hereby gives notice of its intent to grant an exclusive, co-exclusive or partially exclusive patent license to practice the inventions described and claimed in the patents and/or patent applications listed in **SUPPLEMENTARY INFORMATION** below.

DATES: The prospective exclusive, co-exclusive or partially exclusive license may be granted unless NASA receives written objections including evidence and argument, no later than February 26, 2026 that establish that the grant of the license would not be consistent with the requirements regarding the licensing of federally owned inventions as set forth in the Bayh-Dole Act and implementing regulations. Competing applications completed and received by NASA no later than February 26, 2026 will also be treated as objections to the grant of the contemplated exclusive, co-exclusive or partially exclusive license. Objections submitted in response to this notice will not be made available to the public for inspection and, to the extent permitted by law, will not be released under the Freedom of Information Act.

ADDRESSES: *Objections and Further Information:* Written objections relating to the prospective license or requests for

further information may be submitted to Agency Counsel for Intellectual Property, NASA Headquarters at Email: hq-patentoffice@mail.nasa.gov. Questions may be directed to Phone: (202) 358–0646.

SUPPLEMENTARY INFORMATION: NASA intends to grant an exclusive, co-exclusive, or partially exclusive patent license in the United States to practice the inventions described and claimed in: U.S. Patent No. 11,622,062 B1 for an invention titled “Ruggedized Miniaturized Infrared Camera System for Aerospace Environments” to Outpost Technologies, Inc., having its principal place of business in Huntsville, Alabama. The fields of use may be limited. NASA has not yet made a final determination to grant the requested license and may deny the requested license even if no objections are submitted within the comment period.

This notice of intent to grant an exclusive, co-exclusive or partially exclusive patent license is issued in accordance with 35 U.S.C. 209(e) and 37 CFR 404.7(a)(1)(i). The patent rights in these inventions have been assigned to the United States of America as represented by the Administrator of the National Aeronautics and Space Administration. The prospective license will comply with the requirements of 35 U.S.C. 209 and 37 CFR 404.7.

Information about other NASA inventions available for licensing can be found online at <http://technology.nasa.gov>.

Olivia Scheuer,

Senior Counsel for Intellectual Property, National Aeronautics and Space Administration.

[FR Doc. 2026–02713 Filed 2–10–26; 8:45 am]

BILLING CODE 7510–13–P

NUCLEAR REGULATORY COMMISSION

[NRC–2025–2161]

Duke Energy Carolinas, LLC; Belews Creek; Early Site Permit Application

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice; receipt.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) is providing public notice each week, for four consecutive weeks of receipt and availability of an application for an early site permit (ESP) from Duke Energy Carolinas, LLC for the Belews Creek site located in Stokes County, North Carolina.

DATES: February 11, 2026.

ADDRESSES: Please refer to Docket ID NRC–2025–2161 when contacting the NRC about the availability of information regarding this document. You may obtain publicly available information related to this document using any of the following methods:

- *Federal Rulemaking Website:* Go to <https://www.regulations.gov> and search for Docket ID NRC–2025–2161. Address questions about Docket IDs in *Regulations.gov* to Bridget Curran; telephone: 301–415–1003; email: Bridget.Curran@nrc.gov. For technical questions, contact the individual(s) listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.

- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may obtain publicly available documents online in the ADAMS Public Documents collection at <https://www.nrc.gov/reading-rm/adams.html>. To begin the search, select "Begin ADAMS Public Search." For problems with ADAMS, please contact the NRC's Public Document Room (PDR) reference staff at 1–800–397–4209, at 301–415–4737, or by email to PDR.Resource@nrc.gov. The Belews Creek Early Site Permit Application package is available in ADAMS under Accession No. ML25364A004.

- *NRC's PDR:* The PDR, where you may examine and order copies of publicly available documents, is open by appointment. To make an appointment to visit the PDR, please send an email to PDR.Resource@nrc.gov or call 1–800–397–4209 or 301–415–4737, between 8 a.m. and 4 p.m. eastern time (ET), Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Emmanuel Sayoc, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–415–4084; email: Emmanuel.Sayoc@nrc.gov.

SUPPLEMENTARY INFORMATION:

I. Discussion

On December 30, 2025, Duke Energy Carolinas, LLC filed with the NRC, pursuant to Section 103 of the Atomic Energy Act and part 52 of title 10 of the *Code of Federal Regulations* (10 CFR), "Licenses, Certifications, and Approvals for Nuclear Power Plants," an application for an ESP for the Belews Creek site located in Stokes County, North Carolina. By issuance of **Federal Register** notice of Receipt and Availability on January 7, 2026, (91 FR 542), and in ADAMS under Accession No. ML25352A121, the staff also acknowledged receipt of the application.

In accordance with subpart A of 10 CFR part 52, "Early Site Permits," an applicant may seek an ESP separate from the filing of an application for a construction permit (CP) or combined license (COL). The ESP process allows resolution of issues relating to siting. At any time during the period of an ESP, the ESP holder may reference the ESP in an application for a CP or COL. These notices are being provided in accordance with the requirements in 10 CFR 50.43(a)(3).

A subsequent **Federal Register** notice will be issued addressing the acceptability of the tendered ESP application for docketing and provisions for participation of the public in the ESP process.

Dated: January 29, 2026.

For the Nuclear Regulatory Commission.

Michelle Hayes,

Chief, Licensing and Regulatory Infrastructure Branch, Division of New and Renewed Licenses, Office of Nuclear Reactor Regulation.

[FR Doc. 2026–02689 Filed 2–10–26; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 50–410; NRC–2026–0199]

Constellation Energy Generation, LLC; Nine Mile Point Nuclear Station, Unit 2; Exemption

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice; issuance.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) issued an exemption in response to a request dated January 29, 2025, as supplemented on June 9, 2025, from Constellation Energy Generation, LLC, that authorizes leak rate testing of the main steam isolation valves at a pressure lower than the calculated peak containment internal pressure related to the Nine Mile Point, Unit 2, design basis accident loss-of-coolant accident as specified in the Technical Specifications.

DATES: The exemption was issued on February 3, 2026.

ADDRESSES: Please refer to Docket ID NRC–2026–0199 when contacting the NRC about the availability of information regarding this document. You may obtain publicly available information related to this document using any of the following methods:

- *Federal Rulemaking Website:* Go to <https://www.regulations.gov> and search for Docket ID NRC–2026–0199. Address questions about Docket IDs in

Regulations.gov to Bridget Curran; telephone: 301–415–1003; email: Bridget.Curran@nrc.gov. For technical questions, contact the individual listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.

- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may obtain publicly available documents online in the ADAMS Public Documents collection at <https://www.nrc.gov/reading-rm/adams.html>. To begin the search, select "Begin ADAMS Public Search." For problems with ADAMS, please contact the NRC's Public Document Room (PDR) reference staff at 1–800–397–4209, at 301–415–4737, or by email at PDR.Resource@nrc.gov. The exemption request, dated January 29, 2025, is available in ADAMS under Accession No. ML25029A181.

- *NRC's PDR:* The PDR, where you may examine and order copies of publicly available documents, is open by appointment. To make an appointment to visit the PDR, please send an email to PDR.Resource@nrc.gov or call 1–800–397–4209 or 301–415–4737, between 8 a.m. and 4 p.m. eastern time (ET), Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT:

Richard V. Guzman, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–415–1030; email: Richard.Guzman@nrc.gov.

SUPPLEMENTARY INFORMATION: The text of the exemption is attached.

Dated: February 9, 2026.

For the Nuclear Regulatory Commission.

Richard Guzman,

Senior Project Manager, Plant Licensing Branch I, Division of Operating Reactor Licensing, Office of Nuclear Reactor Regulation.

Attachment—Exemption

NUCLEAR REGULATORY COMMISSION

Docket No. 50–410

Constellation Energy Generation, LLC

Nine Mile Point Nuclear Station, Unit 2

Exemption

I. Background

Constellation Energy Generation, LLC (CEG, the licensee), is the holder of Renewed Facility Operating License No. NPF–69, which authorizes operation of the Nine Mile Point Nuclear Station (Nine Mile Point), Unit 2, a boiling-water reactor located in Scriba, New York (6 miles northeast of Oswego, New York). The license provides, among other things, that the facility is subject to all rules, regulations, and orders of the U.S. Nuclear Regulatory Commission (NRC, Commission) now or hereafter in effect.

II. Request/Action

By application dated January 29, 2025 (ML25029A181), as supplemented on June 9, 2025 (ML25155B825), the licensee, pursuant to 10 CFR 50.12, "Specific exemptions," requested an exemption from the requirements of Title 10 of the *Code of Federal Regulations* (10 CFR), Part 50, Appendix J, Paragraph III.C.2 to allow leak rate testing of the main steam isolation valves (MSIVs) at a reduced test pressure for Nine Mile Point, Unit 2. The licensee stated that continued compliance results in undue costs, and increased dose and industrial hazards that are significantly more than those incurred by other similarly situated plants. The application also requested a license amendment to revise Technical Specification (TS) 3.6.1.3, "Primary Containment Isolation Valves (PCIVs)," Surveillance Requirement (SR) 3.6.1.3.12, to reduce the MSIV test pressure and the associated maximum allowable leakage limit for Nine Mile Point, Unit 2. The license amendment request is addressed separately.

The regulation at 10 CFR 50.54(o) requires primary reactor containments for water-cooled power reactors, other than those for which the certifications required under 10 CFR 50.82(a)(1) or 52.110(a)(1) have been submitted, to meet the requirements of Appendix J to 10 CFR part 50, "Leakage Rate Testing of Containment of Water-Cooled Nuclear Power Plants." Appendix J establishes containment leakage test requirements, schedules, and acceptance criteria for verifying the leak-tight integrity of the primary reactor containment and systems and components that penetrate the containment. Appendix J provides two options for meeting this requirement: Option A and Option B. In 1996 the NRC staff approved a request for the then-licensee to follow Option B. (ML011440067).

As an initial matter, the NRC staff notes that the licensee requested an exemption from Paragraph III.C.2 but that Option B does not have a Paragraph III.C.2. Option A, however, does have a Paragraph III.C.2. The equivalent Option B requirement is found in Option B, Paragraph III.B. As the licensee follows Option B, the NRC staff cannot grant the licensee an exemption from an Option A requirement. Consequently, the NRC staff is, on its own initiative, considering granting the licensee an exemption from Option B, Paragraph III.B. Given that the two provisions require the same test and the exemption does not affect the portions of the provisions that are different, the NRC staff further notes that this exemption is substantively identical to the requested exemption. This change does not change the underlying analysis; it only affects provision from which the exemption is granted. As such, the NRC staff is relying on the analysis the licensee submitted to support the original exemption request.

As described in Option B, Paragraph I, the purposes of these tests are to ensure that (1) leakage through these containments or systems and components penetrating these containments does not exceed allowable leakage rates specified in the technical specifications, and (2) integrity of the containment structure is maintained during its service life. Option B, Paragraph III.B of

10 CFR part 50, Appendix J, requires licensees to perform Type C pneumatic tests to measure containment isolation valve leakage rates to ensure the integrity of the overall containment system as a barrier to fission product release to reduce the risk from reactor accidents. The MSIVs are a type of containment isolation valve. The tests required by Option B, Paragraph III.B must demonstrate that the sum of the leakage rates at accident pressure of Type B tests, and pathway leakage rates from Type C tests, is less than the performance criterion (La) with margin, as specified in the Technical Specification. Option B, Paragraph II defines La as the maximum allowable leakage rate at pressure Pa as specified in the Technical Specifications. Option B, Paragraph II, defines Pa as the calculated peak containment internal pressure related to the design basis loss-of-coolant accident as specified in the Technical Specifications. This exemption, if granted, would, in effect, allow the licensee to perform the Type C tests for the MSIVs at the requested reduced pressure rather than at Pa. According to the licensee, testing at the reduced pressure allows the test conditions to be reliably established while maintaining conservatism in the measurement of valve leakage.

The technical analysis necessary to support the proposed change to associated surveillance requirement (TS SR 3.6.1.3.12) and the associated maximum allowable leakage limit for Nine Mile Point, Unit 2 is documented in a separate safety evaluation for the related license amendment request (ML26008A004).

III. Discussion

Pursuant to 10 CFR 50.12(a), the Commission may, upon application by any interested person or upon its own initiative, grant exemptions from the requirements of 10 CFR part 50 when (1) the exemptions are authorized by law, will not present an undue risk to the public health and safety, and are consistent with the common defense and security and (2) special circumstances are present. Under 10 CFR 50.12(a)(2), special circumstances are present when at least one of the following six conditions are met:

- (i) Application of the regulation in the particular circumstances conflicts with other rules or requirements of the Commission; or
- (ii) Application of the regulation in the particular circumstances would not serve the underlying purpose of the rule or is not necessary to achieve the underlying purpose of the rule; or
- (iii) Compliance would result in undue hardship or other costs that are significantly in excess of those contemplated when the regulation was adopted, or that are significantly in excess of those incurred by others similarly situated; or
- (iv) The exemption would result in benefit to the public health and safety that compensates for any decrease in safety that may result from the grant of the exemption; or

(v) The exemption would provide only temporary relief from the applicable regulation and the licensee or applicant has made good faith efforts to comply with the regulation; or

(vi) There is present any other material circumstance not considered when the regulation was adopted for which it would be in the public interest to grant an exemption. If such condition is relied on exclusively for satisfying the special circumstances requirement, the exemption may not be granted under the Executive Director for Operations has consulted with the Commission.

A. The Exemption Is Authorized by Law

If granted, the exemption would authorize leak testing of the MSIVs at a pressure lower than the calculated peak containment internal pressure related to Nine Mile Point, Unit 2's design basis accident loss-of-coolant accident as specified in the Technical Specifications (Pa). Pursuant to 10 CFR 50.12(a), the NRC may grant exemptions from the requirements of 10 CFR part 50, including Appendix J, when the exemptions are authorized by law. An exemption is authorized by law when it is not expressly prohibited by statute or regulation. The NRC staff has determined that no provisions in law expressly prohibit or otherwise restrict the NRC staff from granting the exemption. Accordingly, the NRC staff concludes that the exemption is authorized by law.

B. The Exemption Presents No Undue Risk to Public Health and Safety

Type C pneumatic tests used to measure containment isolation valve leakage rates, including MSIVs, are performed to verify the integrity of the overall containment system as a barrier to fission product release and to reduce the risk associated with postulated reactor accidents. The Nine Mile Point, Unit 2 MSIVs are designed with an angled orientation in the main steam lines to enhance sealing capability in the direction of postulated accident conditions. Testing between the MSIVs is an NRC-acceptable testing method and provides conservative results. Testing the inboard valve in the reverse direction is conservative because the direction of pressurization applies a force opposite to the valve seating forces. In addition, due to the orientation of the MSIVs, testing the outboard valves in the direction of postulated accident conditions results in pressurization forces that act in the direction of the valve seating forces and, therefore, provide enhanced sealing. These are the directions in which the Nine Mile Point, Unit 2 inboard and outboard MSIVs are tested.

As seen in non-public operating experience, testing of the inboard and outboard MSIVs by pressurizing the volume between the valves at full test pressure lifts the disc of the inboard valve, due to the orientation of the inboard MSIV, resulting in a meaningless test. By pressurizing the volume between the valves at a reduced pressure of greater than or equal to 25 psig, lifting the disc of the inboard valve is avoided. Based on the above-mentioned operating experience, this approach ensures a satisfactory test of the outboard MSIV in the same direction as under LOCA conditions to confirm that the leak rate is within the maximum pathway leakage conditions. Based on its technical judgement, the NRC staff determined that this operating experience is

relevant here because it involves the same types of valves with this orientation. In its exemption request, the licensee stated that when leak rate testing is performed at a reduced pressure, it would conservatively assign the total measured leakage through both valves to the penetration. This is conservative because it means the licensee will assign the combined leakage value to each valve, leading to a higher measured leakage than if both valves were measured separately and had their individual leakages assigned to them. Further, this procedure is consistent with the TS surveillance requirement, which the NRC staff reviewed in the related license amendment request mentioned above.

Therefore, based on the above, the proposed exemption to allow MSIV leak rate testing at a reduced pressure enables the licensee to obtain valid and reliable test results while maintaining a conservative determination of leakage through the valves. Therefore, the NRC staff finds that conducting MSIV leak rate testing at a reduced test pressure of greater than or equal to 25 psig ensures the operability of the MSIVs and their capability to maintain containment isolation integrity under postulated accident conditions. Accordingly, based on the considerations discussed above, the NRC staff concludes that the proposed exemption would not result in an undue risk to the public health and safety.

C. The Exemption Is Consistent With the Common Defense and Security

As discussed above, the exemption would permit leak testing of the MSIVs at a pressure lower than the calculated peak containment pressure. This change in MSIV test pressure is not related to security considerations. The exemption would not alter any site security features, procedures, staffing, or other security-related matters. Therefore, the exemption does not affect the common defense and security, and the NRC staff concludes that the exemption is consistent with the common defense and security.

D. Special Circumstances

The regulation under 10 CFR 50.12(a)(2) states, in part, that “[t]he Commission will not consider granting an exemption unless special circumstances are present,” and describes, in 10 CFR 50.12(a)(i) through (vi), the conditions under which special circumstances exist. In Section II of the licensee’s exemption request, the licensee stated that two of the six special circumstances listed in 10 CFR 50.12(a)(2) are applicable to the exemption, as follows:

- 10 CFR 50.12(a)(2)(ii): Application of the regulation in the particular circumstances would not serve the underlying purpose of the rule or is not necessary to achieve the underlying purpose of the rule.
- 10 CFR 50.12(a)(2)(iv): The exemption would result in benefit to the public health and safety that compensates for any decrease in safety that may result from the grant of the exemption;

The underlying purpose of 10 CFR part 50, Appendix J, Option B is to ensure that (a) leakage through these containments or systems and components penetrating these

containments does not exceed allowable leakage rates specified in the technical specifications; and (b) integrity of the containment structure is maintained during its service life.

Operating experience has shown that, due to the orientation of the MSIVs, testing at the inboard and outboard valves simultaneously at Pa by pressurizing the volume between the valves does not accurately reflect the isolation capabilities of the valves. The inability to achieve proper testing conditions when pressurizing between the inboard and outboard valves at Pa necessitates reperforming the leak rate testing. This is done by conducting the tests in the accident direction at Pa to accurately evaluate individual valve performance which leads to additional occupational radiation exposure.

In contrast, non-public industry operating experience, discussed when assessing whether there is an undue risk to public health and safety, has demonstrated that simultaneous testing of the inboard and outboard MSIVs by pressurizing the volume between the valves at a reduced pressure of 25 psig is effective in establishing proper test conditions. This means that testing at 25 psig is sufficient to ensure that (a) leakage through these containments or systems and components penetrating these containments does not exceed allowable leakage rates specified in the technical specifications; and (b) integrity of the containment structure is maintained during its service life. Therefore, requiring the MSIV test pressure at Pa is not necessary to achieve the underlying purpose of the 10 CFR part 50, Appendix J.

Because compliance with the requirement to perform MSIV leak rate testing at the peak calculated containment internal pressure is not necessary to achieve the underlying purpose of the rule, the NRC staff finds that the special circumstances specified in 10 CFR 50.12(a)(2)(ii) are present. Accordingly, the NRC staff concludes that special circumstances exist to support the granting of the exemption. Since the presence of one special circumstance is sufficient to support the granting of an exemption under 10 CFR 50.12(a)(2), the NRC staff did not further evaluate whether the special circumstances described in 10 CFR 50.12(a)(2)(iv) are present.

E. Environmental Considerations

A categorical exclusion for inspection and surveillance requirements is provided in 10 CFR 51.22(c)(25)(vi)(C), provided that the criteria in 10 CFR 51.22(c)(25)(i) through (v) are satisfied. In its review of the exemption request, and for the reasons discussed when concluding that there would be no undue risk to the public health and safety, the NRC staff determined that, pursuant to 10 CFR 51.22(c)(25), granting the exemption: (i) does not involve a significant hazards consideration because it does not result in a significant reduction in a margin of safety, create the possibility of a new or different kind of accident from any accident previously evaluated, or involve a significant increase in the probability or consequences of an accident previously evaluated; (ii) would not result in a significant change in the types or significant increase in the

amounts of effluents that may be released offsite, because the exemption does not alter or create additional pathways for effluent release; (iii) would not result in a significant increase in individual or cumulative occupational or public radiation exposure, because the exemption does not introduce new or increased radiological hazards; (iv) would not result in significant construction impacts, because the exemption does not involve construction activities; and (v) would not increase the potential for or consequences of radiological accidents. Based on the above, NRC determined that the exemption meets the eligibility criteria for the categorical exclusion set forth in 10 CFR 51.22(c)(25). Therefore, in accordance with 10 CFR 51.22(b), no environmental impact statement or environmental assessment need be prepared in connection with this exemption request.

IV. Conclusions

Accordingly, the NRC staff has determined that, pursuant to 10 CFR 50.12, the exemption is authorized by law, will not present an undue risk to the public health and safety, and is consistent with the common defense and security. Also, special circumstances are present. Therefore, the NRC staff hereby grants CEG an exemption from the requirement of 10 CFR part 50, Appendix J, Option B, Paragraph III.B to allow leak rate testing of the MSIVs at a reduced test pressure at Nine Mile Point, Unit 2.

This exemption is effective upon issuance. Dated: February 3, 2026.

For the Nuclear Regulatory Commission.

/RA/

Aida Rivera-Varona, Acting Director, Division of Operating Reactor Licensing, Office of Nuclear Reactor Regulation.

[FR Doc. 2026–02770 Filed 2–10–26; 8:45 am]

BILLING CODE 7590–01–P

POSTAL REGULATORY COMMISSION

[Docket Nos. MC2026–164 and K2026–164]

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:* February 17, 2026.

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:

Table of Contents

- 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).*: MC2026-164 and K2026-164; *Filing Title*: USPS Request to Add Priority Mail Express, Priority Mail & USPS Ground Advantage Contract 1489 to the Competitive

Product List and Notice of Filing Materials Under Seal; *Filing Acceptance Date*: February 6, 2026; *Filing Authority*: 39 U.S.C. 3642, 39 CFR 3035.105, and 39 CFR 3041.310; *Public Representative*: Christopher Mohr; *Comments Due*: February 17, 2026.

III. Summary Proceeding(s)

None. See Section II for public proceedings.

This Notice will be published in the **Federal Register**.

Ashley Demchak,

Alternate Federal Register Liaison.

[FR Doc. 2026-02725 Filed 2-10-26; 8:45 am]

BILLING CODE 7710-FW-P

POSTAL SERVICE

Product Change—Priority Mail Express, 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:* February 11, 2026.

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.
01/27/26	PME-PM-GA 1480	MC2026-152	K2026-152
02/04/26	PME-PM-GA 1481	MC2026-154	K2026-154
02/04/26	PME-PM-GA 1482	MC2026-155	K2026-155
02/04/26	PME-PM-GA 1483	MC2026-156	K2026-156
02/04/26	PME-PM-GA 1484	MC2026-157	K2026-157
02/04/26	PME-PM-GA 1485	MC2026-158	K2026-158
02/04/26	PME-PM-GA 1486	MC2026-159	K2026-159
01/30/26	PM 952	MC2026-160	K2026-160
02/03/26	PME-PM-GA 1487	MC2026-161	K2026-161
02/03/26	PME-PM-GA 1488	MC2026-162	K2026-162
02/05/26	PM 953	MC2026-163	K2026-163
02/06/26	PME-PM-GA 1489	MC2026-164	K2026-164

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).

Documents are available at
www.prc.gov.

Sean C. Robinson,

Attorney, Corporate and Postal Business Law.

[FR Doc. 2026-02658 Filed 2-10-26; 8:45 am]

BILLING CODE 7710-12-P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34-104781; File No. SR-PEARL-2026-07]

Self-Regulatory Organizations; MIAx PEARL, LLC; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Amend the MIAx Pearl Equities Fee Schedule Concerning the Quoting Requirements for the Market Quoting Program

February 6, 2026.

Pursuant to the provisions of 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 January 30, 2026, MIAx PEARL, LLC (“MIAx Pearl” or “Exchange”) filed with the Securities and Exchange Commission (“Commission”) a proposed rule change as described in Items I, II, and III 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

The Exchange proposes to amend the fee schedule (the “Fee Schedule”) applicable to MIAx Pearl Equities, an equities trading facility of the Exchange, to amend one of the quoting requirements for the Market Quoting Program (described below).

The text of the proposed rule change is available on the Exchange’s website at <https://www.miaxglobal.com/markets/us-options/pearl-options/rule-filings> and at MIAx Pearl’s principal office.

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 Exchange 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 of these statements may be examined at the

places specified in Item IV below. The Exchange 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 Exchange proposes to amend Section 1)d) of the Fee Schedule to amend one of the quoting requirements for the Market Quoting Program.

In January 2026, the Exchange adopted the Market Quoting Program to provide an enhanced rebate for executions of orders in securities priced at or above \$1.00 per share during the Early,³ Regular,⁴ and Late Trading Sessions⁵ (together “all trading sessions”) that add displayed liquidity to the Exchange across all Tapes and where the Equity Member⁶ meets certain market quality measures in a certain number of securities.⁷

Currently, under the Market Quoting Program, the Exchange provides an enhanced rebate of (\$0.0026)⁸ per share for executions of orders in securities priced at or above \$1.00 per share that add displayed liquidity to the Exchange across all Tapes in all trading sessions for an Equity Member that achieves a “Percent Time at NBBO”⁹ of at least 50% in at least 750 securities that are multi-listed securities on the Exchange during the relevant month. The Liquidity Indicator Codes applicable to this rebate are as follows: AA, EA, FA, AB, EB, FB, AC, EC, and FC.¹⁰ Equity Members who achieve and receive this

rebate will not be eligible for the NBBO Setter Additive Rebate¹¹ or NBBO First Joiner Additive Rebate.¹² Equity Members will receive the higher rebate of either the tiered rebates set forth in the NBBO Setter Plus Table under the NBBO Setter Plus Program¹³ or the enhanced rebate provided by the Market Quoting Program. The Exchange notes that the enhanced rebate provided under the Market Quoting Program does not apply to executions of orders in securities priced below \$1.00 per share across all Tapes.

The Exchange now proposes to amend one of the quoting requirements for the Market Quoting Program. Specifically, the Exchange proposes to amend the minimum number of the securities in which the Equity Member needs to achieve a Percent Time at NBBO of at least 50% that are multi-listed securities on the Exchange during the relevant month, from 750 to 900, in order to qualify for the Market Quoting Program.

The proposed change is to incentivize Equity Members to promote price discovery and market quality by quoting at the NBBO for a significant portion of each month in a larger number of securities across all Tapes, thereby benefitting investors by providing improved trading conditions for all market participants through narrower bid-ask spreads and increased depth of liquidity available at the NBBO in these securities. The Exchange notes that the

¹¹ The NBBO Setter Additive Rebate is an additive rebate of (\$0.00035) per share for executions of orders in securities priced at or above \$1.00 per share that set the NBB or NBO on MIAx Pearl Equities with a minimum size of a round lot. Equity Members must execute at least 0.015% of NBBO Set Volume as a percentage of TCV during the relevant month to qualify for this rebate. See Fee Schedule, Section 1(c). “NBBO Set Volume” means the ADAV in all securities of an Equity Member that sets the NBB or NBO on MIAx Pearl Equities. See *id.* “TCV” means total consolidated volume calculated as the volume in shares reported by all exchanges and reporting facilities to a consolidated transaction reporting plan for the month for which the fees apply. *Id.*

¹² The NBBO First Joiner Additive Rebate is an additive rebate of (\$0.0001) per share for executions of orders in securities priced at or above \$1.00 per share that bring MIAx Pearl Equities to the established NBB or NBO with a minimum size of a round lot. Equity Members must execute at least 0.015% of NBBO Set Volume as a percentage of TCV during the relevant month to qualify for this rebate. See *Id.*

¹³ In general, the NBBO Setter Plus Program provides enhanced rebates for Equity Members that add displayed liquidity in securities priced at or above \$1.00 per share in all Tapes based on increasing volume thresholds and increasing market quality levels. See Fee Schedule, Section 1(c), NBBO Setter Plus Table. The Exchange will continue calculating the rebates for Equity Members who qualify for the enhanced rebates set forth in the NBBO Setter Plus Program under Section 1(c) of the Fee Schedule. Equity Members will not need to opt in any of the rebate programs offered by the Exchange.

¹ 15 U.S.C. 78s(b)(1).

² 17 CFR 240.19b-4.

³ The term “Early Trading Session” shall mean the time between 4:00 a.m. and 9:30 a.m. Eastern Time. See Exchange Rule 1901.

⁴ The term “Regular Trading Session” shall mean the time between the completion of the Opening Process or Contingent Open as defined in Exchange Rule 2615 and 4:00 p.m. Eastern Time. See Exchange Rule 1901.

⁵ The term “Late Trading Session” shall mean the time between 4:00 p.m. and 8:00 p.m. Eastern Time. See Exchange Rule 1901.

⁶ The term “Equity Member” is a Member authorized by the Exchange to transact business on MIAx Pearl Equities. See Exchange Rule 1901.

⁷ See Securities Exchange Act Release No. 104583 (January 13, 2026) 91 FR 2223 (January 16, 2026) (SR-PEARL-2025-53).

⁸ Rebates are indicated by parentheses. See the General Notes section of the Fee Schedule.

⁹ “Percent Time at NBBO” means the aggregate of the percentage of time during regular trading hours where a Member has a displayed order of at least one round lot at the national best bid (“NBB”) or national best offer (“NBO”). For the avoidance of doubt, only orders that are at the NBB or NBO during the Regular Trading Session count towards the Percent Time at NBBO calculation. See Fee Schedule, Definitions.

¹⁰ See Fee Schedule, Sections 1(a)–(b).

amended Market Quoting Program would be comparable to other quoting-based incentives offered by other exchanges, which offer pricing incentives applicable to a specific set of securities based on a member's market quality measurement over a specified period of time.¹⁴

Implementation

The proposed change is effective beginning February 1, 2026.¹⁵

2. Statutory Basis

The Exchange believes that its proposal to amend its Fee Schedule is consistent with Section 6(b) of the Act¹⁶ in general, and furthers the objectives of Section 6(b)(4) of the Act¹⁷ in particular, in that the proposed changes are an equitable allocation of reasonable fees and other charges among the Exchange's Equity Members and issuers and other persons using its facilities. The Exchange also believes that the proposal is consistent with the objectives of Section 6(b)(5)¹⁸ requirements that the rules of an exchange be designed to prevent fraudulent and manipulative acts and practices, and to promote just and

equitable principles of trade, to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest, and, particularly, is not designed to permit unfair discrimination between customers, issuers, brokers, or dealers.

The Exchange operates in a highly fragmented and competitive market in which market participants can readily direct their order flow to competing venues if they deem fee levels at a particular venue to be excessive or incentives to be insufficient. More specifically, the Exchange is only one of seventeen registered equities exchanges, and there are a number of alternative trading systems and other off-exchange venues, to which market participants may direct their order flow. For the month of December 2025, based on publicly available information, no single registered equities exchange had more than approximately 14.63% of the total market share of executed volume of equities trading.¹⁹ Thus, in such a low-concentrated and highly competitive market, no single equities exchange possesses significant pricing power in the execution of order flow. For the month of December 2025, the Exchange represented 0.75% of the total market share of executed volume of equities trading.²⁰ The Commission and the courts have repeatedly expressed their preference for competition over regulatory intervention in determining prices, products, and services in the securities markets. In Regulation NMS, the Commission highlighted the importance of market forces in determining prices and SRO revenues and also recognized that current regulation of the market system "has been remarkably successful in promoting market competition in its broader forms that are most important to investors and listed companies."²¹

The Exchange believes that the ever-shifting market share among the exchanges from month to month demonstrates that market participants can shift order flow or discontinue to reduce use of certain categories of products, in response to new or different pricing structures being

introduced into the market.

Accordingly, competitive forces constrain the Exchange's transaction fees and rebates, and market participants can readily trade on competing venues if they deem pricing levels at those other venues to be more favorable. The Exchange believes the proposal reflects a reasonable and competitive pricing structure designed to continue to incentivize market participants to increase their quoting at the NBBO (or better) on the Exchange, which will enhance market quality in both a broad manner and in a targeted manner with respect to the Market Quoting Program, which the Exchange believes would promote price discovery and enhance liquidity and market quality on the Exchange to the benefit of all Equity Members and market participants.

The Exchange believes that the proposed change to amend Market Quoting Program to modify the minimum number of the securities in which the Equity Member needs to achieve a Percent Time at NBBO of at least 50% that are multi-listed securities on the Exchange during the relevant month, from 750 to 900, is reasonable because, as described above, such change is designed to encourage Equity Members to increase their order flow, including in the form of displayed, NBBO-setting orders under the proposed required criteria, as applicable, to the Exchange. The Exchange believes, in turn, this will promote price discovery, enhance liquidity and market quality, and contribute to a more robust and well-balanced market ecosystem on the Exchange to the benefit of all Equity Members and market participants. In addition, the Exchange believes its proposal is reasonable and consistent with an equitable allocation of fees to pay a higher rebate than the base rebate for executions of orders in securities priced at or above \$1.00 per share during all trading sessions that add displayed liquidity to the Exchange across all Tapes to Equity Members that qualify for the Market Quoting Program because of the additional commitment to market quality reflected in the proposed quoting requirements.

The Exchange notes that volume and quoting-based incentives have been widely adopted by exchanges, including the Exchange, and are reasonable, equitable and not unfairly discriminatory because they are open to all Equity Members on an equal basis and provide additional benefits that are reasonably related to the value to an exchange's market quality associated with higher levels of market activity,

¹⁴ See MEMX LLC ("MEMX") Equities Fee Schedule, Additive Rebates section, available at <https://info.memxtrading.com/equities-trading-resources/us-equities-fee-schedule/> (providing additive rebate of \$0.0002 per share for a member that has an NBBO time of at least 50% in an average of at least 500 Tape C securities per trading day during the month); see also, e.g., Securities Exchange Act Release Nos. 102789 (April 8, 2025) 90 FR 15600 (April 14, 2025) (SR-MEMX-2025-09) (Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Amend the Exchange's Equities Fee Schedule Concerning Additive Rebates); see also 77846 (May 17, 2016) 81 FR 32356 (May 23, 2016) (SR-BatsBZX-2016-18) (Notice of filing and immediate effectiveness of a proposed rule change to Rules 15.1(a) and (c) in order to implement a Tape B Quoting Tier).

¹⁵ On September 18, 2024, the Securities and Exchange Commission ("Commission") adopted several amendments to Regulation NMS in order to increase the transparency of exchange fees and rebates. See Securities Exchange Act Release No. 101070 (Sept. 18, 2024), 89 FR 81620 (Oct. 8, 2024) (File No. S7-30-22) (Regulation NMS: Minimum Pricing increments, Access Fees, and Transparency of Better Priced Orders.) ("Rule 610(d) Adopting Release"). New Regulation NMS Rule 610(d) provides that "[a] national securities exchange shall not impose, nor permit to be imposed, any fee or fees, or provide, or permit to be provided, any rebate or other remuneration, for the execution of an order in an NMS stock that cannot be determined at the time of execution." See 17 CFR 242.610(d). While this proposal to amend one of the quoting requirements for the Market Quoting Program is effective beginning February 1, 2026, Equities Members who meet the new qualification criteria in February 2026 would not receive the enhanced rebate of (\$0.0026) per share for qualifying executions (described above) until March 1, 2026.

¹⁶ 15 U.S.C. 78f(b).

¹⁷ 15 U.S.C. 78f(b)(4).

¹⁸ 15 U.S.C. 78f(b)(5).

¹⁹ See the "Market Share" section of the Exchange's website, available at <https://www.miaxglobal.com/> (last visited January 28, 2026).

²⁰ *Id.*

²¹ See Securities Exchange Act Release No. 51808 (June 9, 2005), 70 FR 37499 (June 29, 2005).

such as higher levels of liquidity provision and/or growth patterns, and the introduction of higher volumes of orders into the price and volume discovery process. Furthermore, as noted above, the Market Quoting Program is similar in structure and purpose to pricing programs in place at other exchanges that are designed to enhance market quality.²² The Market Quoting Program provides a higher rebate for executions of displayed orders at or above \$1.00 per share where the Equity Member achieves minimum quoting standards, including minimum quoting at the NBBO in the proposed larger number of securities.

For the reasons discussed above, the Exchange submits that the proposal satisfies the requirements of Sections 6(b)(4) and 6(b)(5) of the Act in that it provides for the equitable allocation of reasonable dues, fees and other charges among its Equity Members and other persons using its facilities and is not designed to unfairly discriminate between customers, issuers, brokers, or dealers. As described more fully below in the Exchange's statement regarding the burden on competition, the Exchange believes that its transaction pricing is subject to significant competitive forces, and that the Market Quoting Program is appropriate to address such forces.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed change will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act. Instead, as discussed above, the proposal is intended to enhance market quality on the Exchange in a larger number of securities and to incentivize market participants to direct additional order flow to the Exchange, thereby enhancing liquidity and market quality on the Exchange to the benefit of all Equity Members and market participants. As a result, the Exchange believes the proposal would enhance its competitiveness as a market that attracts actionable orders, thereby making it a more desirable destination venue for its customers. For these reasons, the Exchange believes that the proposal furthers the Commission's goal in adopting Regulation NMS of fostering competition among orders, which promotes "more efficient pricing of individual stocks for all types of orders, large and small."²³

Intramarket Competition

The Exchange does not believe that the proposal will impose any burden on intra-market competition not necessary or appropriate in furtherance of the purposes of the Act. As discussed above, the Exchange believes that the proposal would incentivize Equity Members to promote price discovery and market quality by quoting at the NBBO for a significant portion of each month in a larger number of securities across all Tapes, thereby contributing to a deeper and more liquid market to the benefit of all market participants and enhancing the attractiveness of the Exchange as a trading venue. The Exchange, in turn, believes this will continue to encourage market participants to direct additional order flow to the Exchange. The opportunity to qualify for the Market Quoting Program and thus receive the corresponding enhanced rebate for executions of orders in securities priced at or above \$1.00 per share during all trading sessions that add displayed liquidity to the Exchange across all Tapes would be available to all Equity Members that meet the proposed criteria for the Market Quoting Program in any month. As such, the Exchange believes the proposed change would not impose any burden on intramarket competition that is not necessary or appropriate in furtherance of the purposes of the Act.

Intermarket Competition

The Exchange believes its proposal will benefit competition as the Exchange operates in a highly competitive market. Equity Members have numerous alternative venues they may participate on and direct their order flow to, including seventeen other equities exchanges and numerous alternative trading systems and other off-exchange venues. As noted above, no single registered equities exchange currently has more than approximately 14.63% of the total market share of executed equities volume. Thus, in such a low-concentrated and highly competitive market, no single equities exchange possesses significant pricing power in the execution of order flow. Moreover, the Exchange believes that the ever-shifting market share among the exchanges from month to month demonstrates that market participants can shift order flow in response to new or different pricing structures being introduced to the market. Accordingly, competitive forces constrain the Exchange's transaction fees and rebates generally, including with respect to executions of all orders in securities priced at or above \$1.00 per share

during all trading sessions that add displayed or non-displayed liquidity to the Exchange across all Tapes. Market participants can readily choose to send their orders to other exchanges and off-exchange venues if they deem fee levels at those other venues to be more favorable. As described above, the proposed change is to encourage additional order flow and quoting activity on the Exchange and to promote market quality through pricing incentives that are comparable to incentives in place at other exchanges.²⁴ Accordingly, the Exchange believes the proposal would not burden, but rather promote intermarket competition by enabling it to better compete with other exchanges that offer similar incentives to market participants that enhance market quality and/or achieve certain quoting requirements.

Additionally, the Commission has repeatedly expressed its preference for competition over regulatory intervention in determining prices, products, and services in the securities markets. Specifically, in Regulation NMS, the Commission highlighted the importance of market forces in determining prices and SRO revenues and, also, recognized that current regulation of the market system "has been remarkably successful in promoting market competition in its broader forms that are most important to investors and listed companies."²⁵ The fact that this market is competitive has also long been recognized by the courts. In *NetCoalition v. Securities and Exchange Commission*, the D.C. circuit stated: "[n]o one disputes that competition for order flow is 'fierce.' . . . As the SEC explained, '[i]n the U.S. national market system, buyers and sellers of securities, and the broker-dealers that act as their routing agents, have a wide range of choices of where to route orders for execution'; [and] 'no exchange can afford to take its market share percentages for granted' because 'no exchange possess a monopoly, regulatory or otherwise, in the execution of order flow from broker dealers'"²⁶ Accordingly, the Exchange does not believe that this proposal would impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

²⁴ See *supra* note 14.

²⁵ See Securities Exchange Act Release No. 51808 (June 9, 2005), 70 FR 37496, 37499 (June 29, 2005).

²⁶ See *NetCoalition v. SEC*, 615 F.3d 525, 539 (D.C. Cir. 2010) (quoting Securities Exchange Act Release No. 59039 (December 2, 2008), 73 FR 74770, 74782–83 (December 9, 2008) (SR–NYSE–2006–21)).

²² See *supra* note 14.

²³ See *supra* note 21.

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 foregoing rule change has become effective pursuant to Section 19(b)(3)(A)(ii) of the Act,²⁷ and Rule 19b-4(f)(2)²⁸ thereunder. 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 shall institute proceedings to determine whether the proposed rule 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-PEARL-2026-07 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-PEARL-2026-07. 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 filing 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-PEARL-2026-07 and should be submitted on or before March 4, 2026.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.²⁹

Sherry R. Haywood,
Assistant Secretary.

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SECURITIES AND EXCHANGE COMMISSION

[Release No. 34-104778; File No. SR-MIAX-2026-05]

Self-Regulatory Organizations: Miami International Securities Exchange, LLC; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Amend Exchange Rule 531 To Establish the New Purge Liquidity Taker Report

February 6, 2026.

Pursuant to the provisions of 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 January 26, 2026, Miami International Securities Exchange, LLC ("MIAX" or "Exchange") filed with the Securities and Exchange Commission ("Commission") a 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

The Exchange proposes to amend Exchange Rule 531 to establish the new "Purge Liquidity Taker Report". The text of the proposed rule change is available on the Exchange's website at <https://www.miaxglobal.com/markets/us-options/all-options-exchanges/rule-filings> and at MIAX's principal office.

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 Exchange 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 of these statements may be examined at the places specified in Item IV below. The Exchange 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 Exchange proposes to amend Exchange Rule 531, Reports and Market Data Products, to establish the new "Purge Liquidity Taker Report" (the "Report"). The proposed Report will be an optional product³ available to Market Makers.⁴ The Exchange proposes that the rule text for the Report will be under subparagraph (d) to Exchange Rule 531 and current subparagraph (d) will be renumbered to subparagraph (e).⁵

Report Content

The proposed Report will be a daily report that provides a Market Maker (referred to as the "Recipient Member") with the liquidity response/taker time details for executions against quotes⁶ entered by the Recipient Member that are resting on the Simple Order Book⁷ that occur before and after the receipt of a purge⁸ message sent by the Recipient Member, where that Recipient Member attempted to cancel such resting quote within certain timeframes described in proposed Exchange Rule 531(d)(2), described below. It is important to note that the content of the Report will be

³ The Exchange intends to submit a separate filing with the Securities and Exchange Commission ("Commission") pursuant to Section 19(b)(1) of the Act to propose fees for the Report.

⁴ See Exchange Rule 100.

⁵ The purpose of this change is to provide consistency within the Rulebook. Currently, subparagraphs (a)–(c) of Exchange Rule 531 provide the rule text for the three Liquidity Taker Event Reports offered by the Exchange (Simple Orders, Complex Orders, and Resting Simple Orders), and subparagraph (d) provides the rule text for the Open-Close Report. The proposed Report is similar in nature and provides similar information as the Exchange's various Liquidity Taker Event Reports; accordingly, the Exchange believes it provides better consistency throughout the Rulebook to include the rule text for the proposed Report immediately following the rule text for the Liquidity Taker Event Reports.

⁶ See Exchange Rule 100.

⁷ See Exchange Rule 518(a)(17).

⁸ Purge messages are sent over purge ports, which support only quote mass cancel messages. See MIAX Options Exchange User Manual, Version 1.0.0, Section 5.01 (dated December 12, 2023), available at https://www.miaxglobal.com/miax_options_user_manual.pdf.

²⁷ 15 U.S.C. 78s(b)(3)(A)(ii).

²⁸ 17 CFR 240.19b-4(f)(2).

²⁹ 17 CFR 200.30-3(a)(12).

¹ 15 U.S.C. 78s(b)(1).

² 17 CFR 240.19b-4.

specific to the Recipient Member and the Report will not include any information related to any Member⁹ other than the Recipient Member, other than certain information about the resting quote described below. The Exchange will restrict all other market participants, including the Recipient Member, from receiving another market participant's data.

Proposed subparagraph (d)(1) of Exchange Rule 531 would describe the content of the proposed Report and delineate which information would be provided regarding the resting quote, the purge message that was sent by the Recipient Member and the next response that successfully executed against the resting quote.

Resting Quote and Contra-Side Response Information. Proposed Exchange Rule 531(d)(1)(i) would provide that the following information would be included in the Report regarding the resting quote and contra-side response: (A) the time of execution of a contra-side response against a resting quote; (B) symbol; (C) origin type (e.g., Priority Customer,¹⁰ Market Maker); (D) side (buy or sell); (E) displayed price and size of the resting quote;¹¹ (F) resting liquidity identification number (a unique reference number assigned to a new quote at the time of receipt); and (G) trade reference number (unique reference number assigned to a trade at the time of execution).

Execution Against the Resting Quote Information. Proposed Exchange Rule 531(d)(1)(ii) would provide that the following information would be included in the Report regarding the execution of the resting quote: (A) MBBO¹² at the time of the execution;¹³

and (B) the ABBO¹⁴ at the time of execution.¹⁵

Purge Message(s) Sent by Recipient Member Information. Proposed Exchange Rule 531(d)(1)(iii) would provide that the following information would be included in the Report regarding the purge message(s) sent by the Recipient Member to cancel the resting quote: (A) Recipient Member identifier; (B) the time a purge message was received by the Exchange; (C) the time difference between the time the first response that executes against the resting quote was received by the Exchange and the time that the purge message that was sent by the Recipient Member to cancel that resting quote was received by the Exchange; (D) the time difference between the time the purge message that was sent by the Recipient Member to cancel the resting quote was received by the Exchange and the time of the next response that executes against a resting quote was received by the Exchange, after the initial purge message; (E) size and type of each response submitted by the contra-side that executes against the resting quote before and after the purge message is sent by the Recipient Member; and (F) purge message identifier (a unique identifier attached to the purge message sent by the Recipient Member).

Timeframe for Data Included in Report

Proposed Exchange Rule 531(d)(2) would describe the timeframes covered by the proposed Report. Proposed Exchange Rule 531(d)(2)(i) would provide that for the purge message sent by the Recipient Member to cancel the resting quote after the response that executes against that resting quote is received by the Exchange pursuant to paragraph (d)(1)(iii)(C) above, the Report will include the data listed in proposed paragraph (d)(1) of Exchange Rule 531 within 100 microseconds from the time the resting quote was executed against to the Exchange's receipt of the purge message.¹⁶ Proposed Exchange Rule

531(d)(2)(ii) would provide that for the purge message sent by the Recipient Member to cancel the resting quote before the next response that executes against that resting quote was received by the Exchange pursuant to paragraph (d)(1)(iii)(D) above, the Report will include the data listed in proposed paragraph (d)(1) of Exchange Rule 531 within 200 microseconds from the time the Exchange received the purge message to when the Exchange receives the next execution.¹⁷

Scope of Data Included in the Report

Proposed Exchange Rule 531(d)(3) would provide that the proposed Report will only include trading data related to the Recipient Member and will not include any other Member's trading data other than that listed in proposed paragraphs (1)(i) and (ii) of proposed Exchange Rule 531(d), as described above.

Historical Data

Proposed Exchange Rule 531(d)(4) would specify that the proposed Report will contain historical data from the previous trading day and will be available after the end of the trading day, generally on a T+1 basis.

Like for the existing reports (i.e., the Liquidity Taker Event Report—Simple Orders, Liquidity Taker Event Report—Complex Orders, and Liquidity Taker Event Report—Resting Simple Orders),¹⁸ the Exchange believes the additional data points from the matching engine described above for the proposed Report may also help Market Makers gain a better understanding about their interactions with the Exchange. The Exchange believes the proposed Report will provide Market Makers with an opportunity to improve quote cancel success, particularly as market conditions change throughout

engine by the Exchange before Market Maker A's purge message, Member B's order executes against Market Maker A's quotes. The proposed Report would provide Market Maker A the data points necessary for that firm to calculate by how much time they missed canceling all or a subset of their quotes for that particular symbol.

¹⁷ For example, Market Maker A provides two-sided quotes in a particular symbol and determines to send a purge message to cancel all or a subset of quotes in that symbol. Within 200 microseconds of Market Maker A's purge message, Member B sends a marketable order to execute against Market Maker A's resting quotes. Because Member B's order (or part of that order) is processed at the matching engine by the Exchange before Market Maker A's purge message, Member B's order executes against some (or all) of Market Maker A's quotes. The proposed Report would provide Market Maker A the data points necessary for that firm to calculate by how much time they missed cancelling all or a subset of their quotes for that particular symbol.

¹⁸ See Exchange Rules 531(a)–(c).

⁹ See Exchange Rule 100.

¹⁰ See Exchange Rule 100.

¹¹ The Exchange notes that the displayed price and size are also disseminated via the Exchange's proprietary data feeds and the Options Price Reporting Authority ("OPRA"). The Exchange also notes that the displayed price of the resting order may be different than the ultimate execution price. This may occur when a resting order is displayed and ranked at different prices upon entry to avoid a locked or crossed market.

¹² The term "MBBO" means the best bid or offer on the Exchange. See Exchange Rule 100.

¹³ Exchange Rule 531(d)(1)(ii)(A) would further provide that if multiple contra-side responses execute against a resting quote, only the MBBO at the time of the execution against the first response will be included.

¹⁴ The term "ABBO" or "Away Best Bid or Offer" means the best bid(s) or offer(s) disseminated by other Eligible Exchanges (defined in Exchange Rule 1400(g)) and calculated by the Exchange based on market information received by the Exchange from OPRA. See Exchange Rule 100.

¹⁵ Exchange Rule 531(d)(1)(ii)(B) would further provide that if multiple contra-side responses execute against a resting quote, only the ABBO at the time of the execution against the first response will be included.

¹⁶ For example, Market Maker A provides two-sided quotes in a particular symbol and Member B, at some point thereafter, submits a marketable order to execute against Market Maker A's resting quotes. Within 100 microseconds of submission of Member B's order, Market Maker A sends a purge message to cancel all or a subset of the quotes. Because Member B's order is processed at the matching

the day and Market Makers seek to update their quotes accordingly. The proposed Report will increase transparency and democratize information so that all firms that subscribe to the Report have access to the same information on an equal basis, even for firms that do not have the appropriate resources to generate a similar report regarding interactions with the Exchange. Like the existing reports, none of the components of the proposed Report include real-time market data.

Like the existing reports,¹⁹ the proposed Report will be a Member-specific report and will help Market Makers to better understand how to best improve success rates with respect to canceling their quotes, which may help reduce exposure and manage risk. Like the existing reports,²⁰ the Exchange proposes to provide the Report on a T+1 basis. The proposed Report will be specific and tailored to the Member that is subscribed to the Report and any data included in the Report that relates to a Member other than the Member receiving the Report will be anonymized.

The data information contained within the proposed Report is similar to the data provided in reports that currently are offered by other exchanges.²¹ The Exchange notes that a difference between the proposed Report and the Missed Cancels Report offered by Cboe BZX and Cboe EDGX is that the proposed Report is specific to Market Makers attempting to cancel quotes while the Missed Cancels Report provides response details concerning messages for individual order cancellations, mass cancels, and purge order messages.²² The Exchange tailored

the proposed Report specifically to response details for Market Makers attempting to cancel quotes because Market Makers have expressed the most interest in learning about their interactions with the Exchange when attempting to cancel quotes. Further, order-entering Members have other means to cancel their orders before execution without the need to submit a purge message. For example, Members may use Immediate-or-Cancel (“IOC”) orders to ensure immediate execution in whole or part upon the Exchange’s receipt of that order with the remainder of the order being cancelled.²³

Implementation

The Exchange will issue an Alert to market participants regarding the implementation date of the proposed rule change.

2. Statutory Basis

The Exchange believes the proposed rule change is consistent with the Act and the rules and regulations thereunder applicable to the Exchange and, in particular, the requirements of Section 6(b) of the Act.²⁴ Specifically, the Exchange believes the proposed rule change is consistent with the Section 6(b)(5)²⁵ requirements that the rules of an exchange be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest. This proposal is in keeping with those principles in that it promotes increased transparency through the dissemination of the optional Report to those interested in subscribing to receive the data. Additionally, the Exchange believes the proposed rule change is consistent with the Section 6(b)(5)²⁶

requirement that the rules of an exchange not be designed to permit unfair discrimination between customers, issuers, brokers, or dealers.

The Exchange also believes this proposal is consistent with Section 6(b)(5) of the Act because it protects investors and the public interest and promotes just and equitable principles of trade by providing investors with a new option for receiving market data as requested by potential purchasers. The proposed rule change would benefit investors by facilitating their prompt access to the value-added information that is included in the proposed Report. The establishment of the proposed Report will promote just and equitable principles of trade because it would provide latency information in a systematized way and standardized format to any Member that chooses to subscribe to the proposed Report. As discussed, the proposed Report is not a real-time market data product, but rather provides only historical data for the previous trading day, generally on a T+1 basis. In addition, the data in the proposed Report regarding incoming purge messages that failed to cancel resting quotes would be specific to the Recipient Member. As noted above, no specific information about the resting quotes on the Exchange’s Simple Order Book will be provided and any information relating to another Member would be anonymized.

The proposed Report is designed for Market Makers that are interested in gaining insight into latency in connection with their purge messages that failed to cancel resting quotes. The Exchange believes that providing this optional data to interested market participants is consistent with facilitating transactions in securities, removing impediments to and perfecting the mechanism of a free and open market and a national market system, and, in general, protecting investors and the public interest because it provides additional information and insight to subscribing market participants regarding their quoting activity on the Exchange. More specifically, the proposed Report will provide greater visibility by showing how much time a purge message missed canceling a quote, particularly as market conditions change throughout the day and Market Makers attempt to cancel and replace quotes in certain symbols.

Like the existing reports,²⁷ the Exchange proposes to provide the Report on a voluntary basis and no Market Maker will be required to subscribe to the Report. The Exchange

¹⁹ See Exchange Rules 531(a)–(c).

²⁰ See Exchange Rules 531(a)–(c).

²¹ See, e.g., Cboe BZX Exchange, Inc. (“Cboe BZX”) Rulebook, Rule 21.15(b)(7)(2) (Missed Cancels Report) (providing the “. . . liquidity response time details for executions of orders and quotes that rest on the book where the Member receiving the report attempted to cancel a resting order or quote within an Exchange-determined period of time (not to exceed 1 millisecond) after receipt of the first attempt to execute against that resting order or quote and within an Exchange-determined period of time (not to exceed 100 microseconds) before receipt of the first attempt to execute against that resting order or quote.”) and Cboe EDGX Exchange, Inc. (“Cboe EDGX”) Rulebook, Rule 21.15(b)(7)(2) (Missed Cancels Report); see also Securities Exchange Act Release Nos. 102239 (January 17, 2025), 90 FR 8064 (January 23, 2025) (SR–CboeBZX–2025–004) and 102240 (January 17, 2025), 90 FR 8067 (January 23, 2025) (SR–CboeEDGX–2025–002).

²² See Securities Exchange Act Release Nos. 102239 (January 17, 2025), 90 FR 8064 (January 23, 2025) (SR–CboeBZX–2025–004) (footnote 8 in the rule filing) and 102240 (January 17, 2025), 90 FR 8067 (January 23, 2025) (SR–CboeEDGX–2025–002) (footnote 9 in the rule filing).

²³ See Exchange Rule 516(c). Members may also avail themselves of several optional order protections offered by the Exchange. See Risk Protections Guide, Section 2.b., available at https://www.miaxglobal.com/miax_exchange_group_options_risk_guide.pdf. Members can learn additional information about their order interactions with the Exchange by subscribing to one or more of the Exchange’s Liquidity Taker Event Reports (Simple Orders, Complex Orders, and/or Resting Simple Orders), which provide liquidity response time taker details for orders resting on the Exchange’s book for the Member receiving the report. See Exchange Rules 531(a)–(c).

²⁴ 15 U.S.C. 78f(b).

²⁵ 15 U.S.C. 78f(b)(5).

²⁶ *Id.*

²⁷ See Exchange Rules 531(a)–(c).

notes that there is no rule or regulation that requires the Exchange to produce, or that a Market Maker elect to receive, the Report. It is entirely a business decision of each Market Maker to subscribe to the Report. The Exchange proposes to offer the Report as a convenience to Market Makers to provide them with additional information regarding their purge message activity on the Exchange on a delayed basis after the close of regular trading hours. A Market Maker that chooses to subscribe to the Report may discontinue receiving the Report at any time if that Market Maker determines that the information contained in the Report is no longer useful.

The Exchange believes the proposed Report being tailored to Market Makers does not permit unfair discrimination between customers, issuers, brokers, or dealers because Market Makers have expressed the most interest in learning about their interactions with the Exchange when attempting to cancel quotes, while order-entering Members have not. As described above, order-entering Members have other means to cancel their orders before execution without the need to submit a purge message. For example, Members may enter IOC orders to ensure immediate execution in whole or part upon the Exchange's receipt of that order with the remainder of the order being cancelled.²⁸ If, in the future, Members request that the Exchange provide similar information as contained in the proposed Report for messages attempting to cancel resting orders, in addition to quotes, the Exchange will be able to update the proposed Report to provide that information.

In summary, the proposed Report will help to protect a free and open market by providing additional data (offered on an optional basis) to the marketplace and by providing investors with greater choices.²⁹ Additionally, the proposal would not permit unfair discrimination because the proposed Report will be available to all Exchange Market Makers. As mentioned above, other exchanges offer reports with similar

data information as the information contained within the proposed Report.³⁰

The Exchange also believes its proposal to renumber current subparagraph (d) to Exchange Rule 531 to now be subparagraph (e) promotes just and equitable principles of trade and removes impediments to and perfects the mechanism of a free and open market and a national market system because the proposed change will provide greater clarity to Members and the public regarding the Exchange's Rulebook once the rule text for the proposed Report becomes operative. The proposed Report is similar in nature and provides similar information as the Exchange's various Liquidity Taker Event Reports in Exchange Rules 531(a)–(c); accordingly, the Exchange believes the proposed change to provide the rule text for the proposed Report under subparagraph (d) and renumber current subparagraph (d) provides consistency throughout the Rulebook. It is in the public interest for the Exchange's Rulebook to be consistent to eliminate the potential for confusion.

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 Act, as amended. The Exchange believes that the proposed Report will enhance competition³¹ by providing a new option for receiving market data to Market Makers. The proposed Report will also further enhance competition between exchanges by allowing the Exchange to expand its product offerings to include a report that is similar to reports currently offered by other exchanges concerning their members' opportunities to improve order cancel success on those exchanges.³²

Additionally, the Exchange believes the proposed rule change does not impose any burden on intramarket competition that is not necessary or appropriate in furtherance of the purposes of the Act. Market participants are not required to purchase the proposed Report, and the Exchange is not required to make the Report available to market participants. Rather, the Exchange is voluntarily making the Report available, as requested by Market Maker, and Market Makers may choose to receive (and pay for) this data based on their own business needs. Potential

purchasers may request the data at any time if they believe it to be valuable or may decline to purchase such data.

The Exchange also believes its proposal to renumber current subparagraph (d) to Exchange Rule 531 to now be subparagraph (e) does not impose any burden on intramarket or intermarket competition that is not necessary or appropriate in furtherance of the purposes of the Act because the proposed change is not intended to address competitive issues but rather is concerned solely with ensuring the rules of the Exchange are consistent. The purpose of the proposed changes is to provide accuracy and consistency within the Exchange's Rulebook and eliminate the potential for confusion.

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

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; and (iii) become operative for 30 days after the date of the filing, or such shorter time as the Commission may designate, it has become effective pursuant to Section 19(b)(3)(A)(iii) of the Act³³ and subparagraph (f)(6) of Rule 19b–4 thereunder.³⁴

A proposed rule change filed under Rule 19b–4(f)(6)³⁵ normally does not become operative prior to 30 days after the date of the filing. However, pursuant to Rule 19b–4(f)(6)(iii),³⁶ the Commission may designate a shorter time if such action is consistent with the protection of investors and the public interest. The Exchange requests that the Commission waive the 30-day operative delay so that the proposed rule change may become operative immediately upon filing. The Exchange states that it believes that the proposed changes will not adversely impact investors and will permit the Exchange to immediately

²⁸ See Exchange Rule 516(c). Members can learn additional information about their order interactions with the Exchange by subscribing to one or more of the Exchange's Liquidity Taker Event Reports (Simple Orders, Complex Orders, and/or Resting Simple Orders), which provide liquidity response time taker details for orders resting on the Exchange's book for the Member receiving the report. See Exchange Rules 531(a)–(c).

²⁹ See Sec. Indus. Fin. Mkts. Ass'n (SIFMA), Initial Decision Release No. 1015, 2016 SEC LEXIS 2278 (ALJ June 1, 2016) (finding the existence of vigorous competition with respect to non-core market data).

³⁰ See *supra* note 21.

³¹ See *id.*

³² See *supra* note 21.

³³ 15 U.S.C. 78s(b)(3)(A)(iii).

³⁴ 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization 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.

³⁵ 17 CFR 240.19b–4(f)(6).

³⁶ 17 CFR 240.19b–4(f)(6)(iii).

offer the proposed Report to Market Makers. The Exchange also states that other exchanges offer reports with similar data information as the information contained within the proposed Report.³⁷ For these reasons, and because the proposal raises no new or novel legal or regulatory issues, the Commission finds that waiver of the 30-day operative delay is consistent with the protection of investors and the public interest. Accordingly, the Commission waives the 30-day operative delay and designates the proposed rule change to be operative upon filing.³⁸

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 shall institute proceedings to determine whether the proposed rule 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 (<http://www.sec.gov/rules/sro.shtml>); or
- Send an email to rule-comments@sec.gov. Please include File Number SR-MIAX-2026-05 on the subject line.

Paper Comments

- Send paper comments in triplicate to Vanessa Countryman, Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549-1090.

All submissions should refer to file number SR-MIAX-2026-05. 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 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-MIAX-2026-05 and should be submitted on or before March 4, 2026.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.³⁹

Sherry R. Haywood,

Assistant Secretary.

[FR Doc. 2026-02674 Filed 2-10-26; 8:45 am]

BILLING CODE 8011-01-P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34-104777; File No. SR-NYSE-NAT-2026-02]

Self-Regulatory Organizations; NYSE National, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Amend the Connectivity Fee Schedule

February 6, 2026.

Pursuant to Section 19(b)(1) ¹ of the Securities Exchange Act of 1934 ("Act") ² and Rule 19b-4 thereunder,³ notice is hereby given that, on January 28, 2026, NYSE National, Inc. ("NYSE National" or "Exchange") filed with the Securities and Exchange Commission ("Commission") the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the self-regulatory organization. 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

The Exchange proposes to amend the note to the virtual routing and forwarding and virtual control circuit service in the Connectivity Fee Schedule ("Fee Schedule"). The proposed change is available on the Exchange's website at www.nyse.com and at the principal office of the Exchange.

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 of those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend the note to the virtual routing and forwarding ("VRF") and virtual control circuit ("VCC") service in the Fee Schedule.

Currently, the Fee Schedule includes VCC services between the Mahwah, New Jersey data center ("MDC") ⁴ and the New York Stock Exchange LLC, NYSE American LLC, and NYSE Arca, Inc. trading floors ("Trading Floors") ⁵ (each, a "TF VCC"), as well as between two Users ⁶ in the MDC or a between a User inside the MDC and another party or the same User outside of the MDC at a remote access center.⁷ The Fee

⁴ Through its Fixed Income and Data Services ("FIDS") business, Intercontinental Exchange, Inc. ("ICE") operates the MDC. The Exchange and the Affiliate SROs (as defined below) are indirect subsidiaries of ICE.

⁵ "Trading Floor" is used as defined in, as applicable, NYSE Rule 6A (Trading Floor), NYSE American Scope of Terms (17), and NYSE Arca Rule 1 (Definitions), Floor, Trading Floor and Options Trading Floor. NYSE National, Inc. and NYSE Texas, Inc. do not have trading floors. See Securities Exchange Act Release No. 103546 (July 25, 2025), 90 FR 35950 (July 30, 2025) (SR-NYSE-2025-12, SR-NYSEAMER-2025-21, SR-NYSEARCA-2025-29, SR-NYSETEX-2025-03, and SR-NYSE-NAT-2025-07).

⁶ For purposes of the Exchange's colocation services, a "User" means any market participant that requests to receive colocation services directly from the Exchange. See Securities Exchange Act Release No. 83351 (May 31, 2018), 83 FR 26314 at n.9 (June 6, 2018) (SR-NYSE-NAT-2018-07). As specified in the Fee Schedule, a User that incurs colocation fees for a particular colocation service pursuant thereto would not be subject to colocation fees for the same colocation service charged by the New York Stock Exchange LLC, NYSE American LLC, NYSE Arca, Inc., and NYSE Texas, Inc. (together, the "Affiliate SROs"). Each Affiliate SRO has submitted substantially the same proposed rule change to propose the change described herein. See SR-NYSE-2026-03, SR-NYSEAMER-2026-07, SR-NYSEARCA-2026-06, and SR-NYSETEX-2026-01.

⁷ See Securities Exchange Act Release Nos. 101578 (November 12, 2024), 89 FR 90794

³⁷ See *supra* note 21.

³⁸ For purposes only of waiving the 30-day operative delay, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. See 15 U.S.C. 78c(f).

³⁹ 17 CFR 200.30-3(a)(12), (59).

¹ 15 U.S.C. 78s(b)(1).

² 15 U.S.C. 78a.

³ 17 CFR 240.19b-4.

Schedule also includes VRF services between the MDC and the Trading Floors.⁸

A User that has two TF VCCs is subject to fees for two VCCs. However, in some cases only one of a User's two TF VCCs would be able to be active at a given time. More specifically, a User could have two TF VCCs that connect the MDC and the User's or third party's equipment on a Trading Floor. Two networks operate on each Trading Floor. To ensure resiliency, a User may choose to connect through two different Trading Floor networks. If the two TF VCCs are connected to different Trading Floor networks, only one such network is active at a given time. As a result, the User would not be able to use both TF VCCs at the same time. A User may nonetheless have such a set-up because it is more resilient than either having just one TF VCC or having two TF VCCs that connect to the same Trading Floor network.

The Exchange wants to encourage the use of two TF VCCs that connect through two different Trading Floor networks (each, a "Resilient TF VCC"), as it is a more resilient set-up than if they are through the same network. Accordingly, the Exchange proposes to charge for the two Resilient TF VCCs as if they were one TF VCC.

To make the change, the Exchange proposes to amend the footnote to the VCC description in the Fee Schedule as follows (additions italicized):

* A virtual control circuit ("VCC") is between the Mahwah data center and a single end point, including a Trading Floor, while a virtual routing and forwarding service ("VRF") can be between the Mahwah data center and one or more Trading Floors. If the User chooses VCCs or a combination of a VCC and a VRF for connectivity to several Trading Floors, it will be charged separately for each connection, *provided that two VCCs from the Mahwah data center to the same Trading Floor will be subject to one VCC charge so long as only one VCC is able to be active at a given time.* If the User chooses one VRF for connectivity to multiple trading floors, the User will be charged for one connection.

The proposed language includes the modifying phrase "so long as only one VCC is able to be active at a given time" to clarify that if a User has two TF VCCs that use the same network, the User will

be subject to two charges, since the TF VCCs may be active at the same time.

General

Currently, no User has a Resilient TF VCC, and so no User would benefit from the change.

The proposed rule change would not apply differently to distinct types or sizes of market participants. Rather, it would apply to all Users equally. As is currently the case, the Fee Schedule would be applied uniformly to all Users. FIDS expects that the proposed rule change will not result in any new Users.

Use of the services proposed in this filing are completely voluntary and available to all Users on a non-discriminatory basis.

The proposed change is not otherwise intended to address any other issues relating to co-location services and/or related fees, and the Exchange is not aware of any problems that customers would have in complying with the proposed change.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6(b) of the Act,⁹ in general, and furthers the objectives of Section 6(b)(5) of the Act,¹⁰ in particular, because it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest and because it is not designed to permit unfair discrimination between customers, issuers, brokers, or dealers. The Exchange further believes that the proposed rule change is consistent with Section 6(b)(4) of the Act,¹¹ because it provides for the equitable allocation of reasonable dues, fees, and other charges among its members and issuers and other persons using its facilities and does not unfairly discriminate between customers, issuers, brokers, or dealers.

The Exchange believes that the proposed rule change is reasonable and equitable because it is designed to foster the resilience of TF VCCs. Currently, there are no Users with Resilient TF VCCs, and the Exchange believes that charging for two Resilient TF VCCs as

if they were one TF VCC may motivate Users to have Resilient TF VCCs. Moreover, as only one Resilient TF VCC can be in use at any one time, no User will benefit from having two Resilient TF VCCs in use while only paying for one.

The Exchange believes that it is reasonable and equitable to amend the note to the Fee Schedule to clarify that, provided that the User has two TF VCCs from the MDC to the same Trading Floor, the User will be subject to one TF VCC charge so long as only one TF VCC is able to be active at a given time. By so amending the note, the Exchange would make it easier for potential purchasers of the service to assess what connectivity will best serve them. The Exchange believes that it is reasonable and equitable that, if a User has two TF VCCs that are active at the same time, for example by using the same Trading Floor network, the User will continue to be subject to two charges.

Nor does the Exchange have a competitive advantage over any third-party competitors by virtue of the fact that it owns and operates the MDC's meet-me-rooms. Currently, 17 telecommunications service providers ("Telecoms")¹² operate in the meet-me-rooms and provide a variety of circuit choices. It is in the Exchange's best interest to set the fees that Telecoms pay to operate in the meet-me-rooms at a reasonable level¹³ so that market participants, including Telecoms, will maximize their use of the MDC. By setting the meet-me-room fees at a reasonable level, the Exchange encourages Telecoms to participate in the meet-me-rooms and to sell circuits to Users for connecting into and out of the MDC. These Telecoms then compete with each other by pricing such circuits at competitive rates. These competitive rates for circuits help draw in more Users and Hosted Customers to the MDC, which directly benefits the Exchange by increasing the customer base to whom the Exchange can sell its colocation services, which include cabinets, power, ports, and connectivity to many third-party data feeds, and because having more Users and Hosted Customers leads, in many cases, to greater participation on the Exchange. In this way, by setting the meet-me-room fees at a level attractive to telecommunications firms, the Exchange spurs demand for all of the services it

(November 18, 2024) (SR-NYSE-NAT-2022-28), and 103546 (July 25, 2025), 90 FR 35950 (July 30, 2025) (SR-NYSE-2025-12, SR-NYSE-AMER-2025-21, SR-NYSE-ARCA-2025-29, SR-NYSE-TEX-2025-03, and SR-NYSE-NAT-2025-07).

⁸ *Id.*

⁹ 15 U.S.C. 78f(b).

¹⁰ 15 U.S.C. 78f(b)(5).

¹¹ 15 U.S.C. 78f(b)(4).

¹² Telecoms are licensed by the Federal Communications Commission and are not required to be, or be affiliated with, a member of the Exchange or an Affiliate SRO.

¹³ See Securities Exchange Act Release No. 98002 (July 26, 2023), 88 FR 50232 (August 1, 2023) (SR-NYSE-NAT-2023-12).

sells at the MDC, while setting the meet-me-room fees too high would negatively affect the Exchange's ability to sell its services at the MDC.¹⁴ Accordingly, there are real constraints on the meet-me-room fees the Exchange charges, such that the Exchange does not have an advantage in terms of costs when compared to third parties that enter the MDC through the meet-me-rooms to provide services to compete with the Exchange's services.

The Exchange believes that the proposed change provides for the equitable allocation of reasonable dues, fees, and other charges among its members and issuers and other persons using its facilities and does not unfairly discriminate between customers, issuers, brokers, or dealers because it is not designed to permit unfair discrimination between market participants. Rather, it would apply to all market participants equally. All Users that have two Resilient TF VCCs, *i.e.* that connect to the same TF and use different networks and so are not able to be active at the same time, would be charged as if they had one TF VCC. All Users that have two TF VCCs that are not resilient, for example that use the same Trading Floor network, will continue to be subject to two charges.

There is no limit on the number of Resilient TF VCCs a User may obtain. Accordingly, a User could have two Resilient TF VCCs to each Trading Floor, or a number of Resilient TF VCCs to one Trading Floor.

The Exchange believes its proposal is not unfairly discriminatory. The proposed change does not apply differently to distinct types or sizes of market participants. Rather, it applies to all market participants equally. The purchase of any proposed service is completely voluntary and the Fee Schedule will be applied uniformly to all market participants.

For the reasons above, the proposed change does not unfairly discriminate between or among market participants that are otherwise capable of satisfying any applicable co-location fees, requirements, terms, and conditions established from time to time by the Exchange.

For these reasons, the Exchange believes that the proposal is consistent with the Act.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange believes that the proposal will not impose any burden on

competition that is not necessary or appropriate in furtherance of the purposes of Section 6(b)(8) of the Act.¹⁵

The proposed change would not impose a burden on competition among national securities exchanges or among members of the Exchange. Rather, it would encourage Users to have resilient VCCs between the MDC and the Trading Floors. The Exchange believes that amending the note to the Fee Schedule would make it easier for potential purchasers of the service to assess what connectivity will best serve them.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Pursuant to Section 19(b)(3)(A)(ii) of the Act,¹⁶ and Rule 19b-4(f)(2) thereunder¹⁷ the Exchange has designated this proposal as establishing or changing a due, fee, or other charge imposed on any person, whether or not the person is a member of the self-regulatory organization, which renders the proposed rule change effective upon filing. 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.

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-NYSENAT-2026-02 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-NYSENAT-2026-02. 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 filing 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-NYSENAT-2026-02 and should be submitted on or before March 4, 2026.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.¹⁸

Sherry R. Haywood,

Assistant Secretary.

[FR Doc. 2026-02673 Filed 2-10-26; 8:45 am]

BILLING CODE 8011-01-P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #21336 and #21337; ALASKA Disaster Number AK-20016]

Presidential Declaration Amendment of a Major Disaster for the State of Alaska

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 2.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for the State of Alaska (FEMA-4893-DR), dated October 22, 2025.

Incident: Severe Storms, Flooding, and remnants of Typhoon Halong.

DATES: Issued on February 3, 2026.

Incident Period: October 8, 2025 through October 13, 2025.

Physical Loan Application Deadline Date: February 20, 2026.

Economic Injury (EIDL) Loan Application Deadline Date: July 22, 2026.

ADDRESSES: Visit the MySBA Loan Portal at <https://lending.sba.gov> to apply for a disaster assistance loan.

FOR FURTHER INFORMATION CONTACT: Jennifer Talarico, Office of Disaster Recovery and Resilience, U.S. Small

¹⁴ See *id.* at 50235. Importantly, the Exchange is prevented from making any alteration to its meet-me-room services or fees without filing a proposal for such changes with the Commission.

¹⁵ 15 U.S.C. 78f(b)(8).

¹⁶ 15 U.S.C. 78s(b)(3)(A)(ii).

¹⁷ 17 CFR 240.19b-4.

¹⁸ 17 CFR 200.30-3(a)(12).

Business Administration, 409 3rd Street SW, Suite 6050, Washington, DC 20416, (202) 205-6734.

SUPPLEMENTARY INFORMATION: The notice of the President's major disaster declaration for the State of ALASKA, dated October 22, 2025, is hereby amended to include the following areas as adversely affected by the disaster:

Primary Areas (Physical Damage and Economic Injury Loans):
Kashunamiut Regional Educational Attendance Area, Yupiit Regional Educational Attendance Area, and the City of Saint Mary's.

All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Number 59008)
(Authority: 13 CFR 123.(b).)

James Stallings,

Associate Administrator, Office of Disaster Recovery & Resilience.

[FR Doc. 2026-02766 Filed 2-10-26; 8:45 am]

BILLING CODE 8026-09-P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #21435; CALIFORNIA Disaster Number CA-20041 Declaration of Economic Injury]

Administrative Declaration of an Economic Injury Disaster for the State of California

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is notice of an Economic Injury Disaster Loan (EIDL) declaration for the state of California dated February 6, 2026.

Incident: 2025 Late December Storms.

DATES: Issued on February 6, 2026.

Incident Period: December 16, 2025 through December 26, 2025.

Economic Injury (EIDL) Loan

Application Deadline Date: November 6, 2026.

ADDRESSES: Visit the MySBA Loan Portal at <https://lending.sba.gov> to apply for a disaster assistance loan.

FOR FURTHER INFORMATION CONTACT: Sharon Henderson, Office of Disaster Recovery and Resilience, U.S. Small Business Administration, 409 3rd Street SW, Suite 6050, Washington, DC 20416, (202) 205-6734.

SUPPLEMENTARY INFORMATION: Notice is hereby given as a result of the Administrator's EIDL declaration, applications for disaster loans may be submitted online using the MySBA Loan Portal <https://lending.sba.gov> or in person at other locally announced

locations. For further assistance please contact the SBA disaster assistance customer service center by email at disastercustomerservice@sba.gov or by phone at 1-800-659-2955. If you are deaf, hard of hearing, or have a speech disability, please dial 7-1-1 to access telecommunications relay services.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Mono, Santa Barbara.

Contiguous Counties:

California: Alpine, Fresno, Inyo, Kern, Madera, San Luis Obispo, Tuolumne, Ventura.

Nevada: Douglas, Esmeralda, Lyon, Mineral.

The Interest Rates are:

	Percent
Business and Small Agricultural Cooperatives without Credit Available Elsewhere	4.000
Private Non-Profit Organizations without Credit Available Elsewhere	3.625

The number assigned to this disaster for economic injury is 214350.

The states which received an EIDL declaration are California, Nevada.

(Catalog of Federal Domestic Assistance Number 59008)

(Authority: 13 CFR 123.3(b).)

James Stallings,

Associate Administrator, Office of Disaster Recovery & Resilience.

[FR Doc. 2026-02717 Filed 2-10-26; 8:45 am]

BILLING CODE 8026-09-P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #21338 and #21339; ALASKA Disaster Number AK-20017]

Presidential Declaration Amendment of a Major Disaster for Public Assistance Only for the State of Alaska

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 1.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for Public Assistance Only for the State of Alaska (FEMA-4893-DR), dated October 22, 2025.

Incident: Severe Storms, Flooding, and remnants of Typhoon Halong.

DATES: Issued on February 3, 2026.

Incident Period: October 8, 2025 through October 13, 2025.

Physical Loan Application Deadline Date: March 5, 2026.

Economic Injury (EIDL) Loan Application Deadline Date: July 22, 2026.

ADDRESSES: Visit the MySBA Loan Portal at <https://lending.sba.gov> to apply for a disaster assistance loan.

FOR FURTHER INFORMATION CONTACT: Jennifer Talarico, Office of Disaster Recovery and Resilience, U.S. Small Business Administration, 409 3rd Street SW, Suite 6050, Washington, DC 20416, (202) 205-6734.

SUPPLEMENTARY INFORMATION: The notice of the President's major disaster declaration for Private Non-Profit organizations in the State of Alaska, dated October 22, 2025, is hereby amended to extend the deadline for filing applications for physical damages as a result of this disaster to March 5, 2026. This notice is further amended to include the following areas as adversely affected by the disaster.

Primary Areas: Bering Strait Regional Educational Attendance Area, Iditarod Area Regional Educational Attendance Area, Kashunamiut Regional Educational Attendance Area, Pribilof Regional Educational Attendance Area, Yukon-Koyukuk Regional Educational Attendance Area, Yupiit Regional Educational Attendance Area, and the City of Saint Mary's.

All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Number 59008)

(Authority: 13 CFR 123.3(b).)

James Stallings,

Associate Administrator, Office of Disaster Recovery & Resilience.

[FR Doc. 2026-02718 Filed 2-10-26; 8:45 am]

BILLING CODE 8026-09-P

DEPARTMENT OF STATE

[Delegation of Authority No. 614]

Delegation of Authority Under Presidential Proclamation 10998 "Restricting and Limiting the Entry of Foreign Nationals To Protect the United States" and Related INA 212(f) Presidential Proclamations

By virtue of the authority vested in the Secretary of State by the laws of the United States, including Section 1 of the State Department Basic Authorities Act, as amended (22 U.S.C. 2651a), the Presidential Proclamation of December 16, 2025 ("PP 10998"), the Presidential Proclamation of June 4, 2025 ("PP 10949") as continued and supplemented by PP 10998, and any subsequent

Presidential Proclamations that continue or supplement PP 10998 or PP 10949, I hereby delegate to the Assistant Secretary for Consular Affairs, to the extent authorized by law, the authority under sections 6(d) through 6(f) of PP 10998, sections 4(c) and 4(d) of PP 10949 as continued and supplemented by PP 10998, and relevant authority in subsequent Proclamations to determine that travel by a foreign national would serve a United States national interest.

The Secretary, Deputy Secretary, Deputy Secretary for Management and Resources, and the Under Secretary for Management may exercise any function or authority delegated by this delegation. The authorities delegated herein may be redelegated, to the extent authorized by law.

This delegation of authority supersedes Delegation of Authority 588 and will be published in the **Federal Register**.

Dated: January 28, 2026.

Marco Rubio,

Secretary of State, U.S. Department of State.

[FR Doc. 2026-02762 Filed 2-10-26; 8:45 am]

BILLING CODE 4710-06-P

DEPARTMENT OF STATE

Delegation of Authority No. 613

Delegation of Authority

Executive Order 14204

By the virtue of the authority vested in the Secretary of State, including section 1 of the State Department Basic Authorities Act (22 U.S.C. 2651a), and E.O. 14204 of February 7, 2025, I hereby delegate to the Under Secretary for Foreign Assistance, Humanitarian Affairs, and Religious Freedom, to the extent authorized by law, the authority under section 3 of E.O. 14204 to permit the provision of foreign aid or assistance that, in the discretion of the relevant agency head, is necessary or appropriate.

Any act, executive order, regulation, or procedure subject to, or affected by, this delegation shall be deemed to be such act, executive order, regulation, or procedure as amended from time to time.

The Secretary, the Deputy Secretary, or the Deputy Secretary for Management and Resources may at any time exercise any authority or function delegated herein.

This delegation of authority shall be published in the **Federal Register**.

Dated: December 15, 2025.

Marco Rubio,

Secretary of State, U.S. Department of State.

[FR Doc. 2026-02752 Filed 2-10-26; 8:45 am]

BILLING CODE 4710-26-P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

[Docket No. **FAA-2026-1344**]

RIN 2120-AL84

Agency Information Collection Activities: Requests for Comments; Clearance of a Renewed Approval of Information Collection: Flight Operations Quality Assurance (FOQA) Program; Correction

AGENCY: Federal Aviation Administration (FAA), U.S. Department of Transportation (DOT).

ACTION: Notice; correction.

SUMMARY: On January 28, 2026, FAA published a notice and request for comments titled “Agency Information Collection Activities: Requests for Comments; Clearance of a Renewed Approval of Information Collection: Flight Operations Quality Assurance (FOQA) Program.” That notice and request for comments incorrectly stated the docket number. This notice corrects the docket number.

DATES: Applicable February 11, 2026.

FOR FURTHER INFORMATION CONTACT: Sean C. Denniston, Flight Standards, Office of Safety Standards, Safety Management Branch (AFS-940), Federal Aviation Administration, Office of Safety Standards, 800 Independence Avenue SW, Washington, DC 20591; email sean.denniston@faa.gov.

SUPPLEMENTARY INFORMATION: On January 28, 2026, FR Doc. 2026-01658, “Agency Information Collection Activities: Requests for Comments; Clearance of a Renewed Approval of Information Collection: Flight Operations Quality Assurance (FOQA) Program” notice was published in the **Federal Register**, at 91 FR 3766. After publication, the FAA discovered that the docket number was incorrect. This was not the FAA’s intent. The old docket number FAA-2120-0660 has been removed and replaced by the new docket number FAA-2026-1344.

Issued in Washington, DC.

Hugh J. Thomas,

Acting Executive Director, Flight Standards Service.

[FR Doc. 2026-02716 Filed 2-10-26; 8:45 am]

BILLING CODE 4910-13-P

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

[Docket No. **NHTSA-2025-0128**]

Agency Information Collection Activities; Notice and Request for Comment; Drive-Mode Design Best Practices

AGENCY: National Highway Traffic Safety Administration (NHTSA), Department of Transportation (DOT).

ACTION: Notice and request for comments on a request for approval of a new information collection.

SUMMARY: NHTSA invites public comments about our intention to request approval from the Office of Management and Budget (OMB) for a new information collection. Before a Federal agency can collect certain information from the public, it must receive approval from OMB. Under procedures established by the Paperwork Reduction Act of 1995, before seeking OMB approval, Federal agencies must solicit public comment on proposed collections of information, including extensions and reinstatement of previously approved collections. This document describes a collection of information for which NHTSA intends to seek OMB approval on a one-time voluntary experiment which will examine how different drive mode implementations affect driver attention and performance compared to standard interfaces.

DATES: Comments must be submitted on or before April 13, 2026.

ADDRESSES: You may submit comments identified by the Docket No. NHTSA-2025-0128 through any of the following methods:

- **Electronic submissions:** Go to the Federal eRulemaking Portal at <http://www.regulations.gov>. Follow the online instructions for submitting comments.

- **Fax:** (202) 493-2251.

- **Mail or Hand Delivery:** Docket Management, U.S. Department of Transportation, 1200 New Jersey Avenue SE, West Building, Room W12-140, Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except on Federal holidays. To be sure someone is there to help you, please call (202) 366-9322 before coming.

Instructions: All submissions must include the agency name and docket number for this notice. Note that all comments received will be posted without change to <http://www.regulations.gov>, including any

personal information provided. Please see the Privacy Act heading below.

Privacy Act: Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (65 FR 19477–78) or you may visit <https://www.transportation.gov/privacy>.

Docket: For access to the docket to read background documents or comments received, go to <http://www.regulations.gov> or the street address listed above. Follow the online instructions for accessing the dockets via internet.

FOR FURTHER INFORMATION CONTACT: For additional information or access to background documents, contact Starla Weaver, Office of Vehicle Crash Avoidance and Electronic Controls Research, Human Factors Division (NSR–310), W46–424, 202–366–7409, National Highway Traffic Safety Administration, U.S. Department of Transportation, 1200 New Jersey Avenue SE, Washington, DC 20590.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), before an agency submits a proposed collection of information to OMB for approval, it must first publish a document in the **Federal Register** providing a 60-day comment period and otherwise consult with members of the public and affected agencies concerning each proposed collection of information. The OMB has promulgated regulations describing what must be included in such a document. Under OMB's regulation (at 5 CFR 1320.8(d)), an agency must ask for public comment on the following: (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, including the validity of the methodology and assumptions used; (c) how to enhance the quality, utility, and clarity of the information to be collected; and (d) how to minimize the burden of the collection of information on those who are to respond, including 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 compliance with these

requirements, NHTSA asks for public comments on the following proposed collection of information for which the agency is seeking approval from OMB.

Title: Drive-Mode Design Best Practices.

OMB Control Number: New.

Form Number(s): NHSTA Form 2112, 2113, 2114, and 2115.

Type of Request: Approval of a new information collection request.

Type of Review Requested: Regular.

Requested Expiration Date of

Approval: Three years from date of approval.

Summary of the Collection of Information: The National Highway Traffic Safety Administration (NHTSA) of the U.S. Department of Transportation is seeking approval for a one-time voluntary information collection from 96 licensed drivers of various ages for a research study which will examine how different drive mode implementations affect driver attention and performance compared to standard interfaces. NHTSA expects to provide screening questionnaires to 300 potential participants in the greater Phoenix area to determine their eligibility for this experiment. Recruiting participants for this study has an estimated burden of approximately 75 hours for the screening questions. The data collection will include a test track component and a cones course component, in which 36 participants are estimated to be eligible and interested in each. (While the goal is 36 final participants per experiment, the research team will ensure eligibility and interest of up to 96 participants total to account for potential attrition and replacement). The test track experiment has a total expected burden of 128 hours, and the cones course experiment has a total expected burden of 104 hours. In the test track experiment, participants will perform tasks on a mobile phone in a stationary vehicle, while wearing occlusion glasses, and while driving around a test track. In the cones course experiment, participants will perform tasks while driving through a cones course. Across both experiments, data will be collected by the experimenter who will provide instructions to the participant and will observe participant performance; using GoPro cameras that will monitor the participant and the driving environment; and using the Ergoneers Dikablis Glasses X eye-tracking system, which will record gaze position, pupil diameter, and blink behavior. The total expected burden for this collection is 331 hours. NHTSA will use this information to produce a technical report that will provide summary

figures and tables, as well as the results of statistical analysis of the information. No identifying information or individual responses will be reported. The technical report will be shared with NHTSA and the Department of Transportation. Members of the general public would have access to the aggregated information when written reports are published. This project involves approval by an institutional review board, which the contractor will obtain before contacting potential participants. This collection will be used to generate evidence-based best practices for the design of future drive mode applications and functionalities for mobile phones operating independently of in-vehicle systems.

Description of the Need for the Information and Proposed Use of the Information: Driver distraction remains a significant safety threat, claiming thousands of lives annually, according to the latest data from the National Highway Traffic Safety Administration (NHTSA).¹ NHTSA has implemented a multi-faceted approach to combat this issue, including public awareness campaigns like “Put the Phone Away or Pay,” increased law enforcement visibility,² and the development of Driver Distraction Guidelines for in-vehicle electronic device design.³

A key focus of the NHTSA Distraction Guidelines has been addressing visual-manual distractions, which are a major safety concern with in-vehicle systems.⁴ The guidelines established test protocols and acceptance criteria for

¹ National Center for Statistics and Analysis. (2024). *Distacted driving in 2022* (Report No. DOT HS 813 559). National Highway Traffic Safety Administration.

² Chaudhary, N.K., Connolly, J., Tison, J., Solomon, M., & Elliott, K. (2015). *Evaluation of the NHTSA distracted driving high-visibility enforcement demonstration projects in California and Delaware*. (Report No. DOT HS 812 108). National Highway Traffic Safety Administration.

³ National Highway Traffic Safety Administration. (2013). *Visual-manual NHTSA driver distraction guidelines for in-vehicle electronic devices* (**Federal Register** Vol. 78, No. 81). Washington, DC.

National Highway Traffic Safety Administration. (2014). *Visual-manual NHTSA driver distraction guidelines for in-vehicle electronic devices* (**Federal Register** Vol. 79, No. 179). Washington, DC.

⁴ Fitch, G.A., Soccolich, S.A., Guo, F., McClafferty, J., Fang, Y., Olson, R.L., Perez, M.A., Hanowski, R.J., Hankey, J.M., & Dingus, T.A. (2013). *The impact of hand-held and hands-free cell phone use on driving performance and safety-critical event risk*. (Report No. DOT HS 811 757). National Highway Traffic Safety Administration. Klauer, S.G., Dingus, T.A., Neale, V.L., Sudweeks, J.D., & Ramsey, D.J. (2006). *The impact of driver inattention on near-crash/crash risk: An analysis using the 100-car naturalistic driving study data*. (Report No. DOT HS 810 594). National Highway Traffic Safety Administration.

measuring this type of distraction.⁵ In 2016, NHTSA proposed expanding these guidelines to include portable and aftermarket devices.⁶ This proposal advocated for pairing smartphones with vehicle systems, contributing to the widespread adoption of platforms like Apple CarPlay and Android Auto. NHTSA also promoted “drive mode” for unpaired mobile phones, defining it as a simplified user interface designed for safe driving.⁷ To further refine its research agenda, NHTSA convened a Distraction Action Forum in August 2024.

Drive mode limits phone functionality and simplifies the human-machine interface (HMI).

This collection will provide answers to NHTSA’s objectives for this task order, which include determining how the interface of cell phones and electronic devices differ when operating in drive mode relative to their standard operations, determining what changes in functionality occur when drive mode is enabled, determining how much variability exists across different driver mode implementations, determining how well drive mode interfaces and functionality comply with the recommendations in the NHSTA Driver Distraction Guidelines, and identifying what factors influence user acceptance and use of drive mode. This collection will be used to investigate how drive

mode implementations impact driver attention and performance as compared to their standard interfaces. NHTSA will use the information gathered to produce a technical report that presents the results of the study. The technical report will provide summary statistics and tables, as well as the results of data analysis of the information, but it will not include any personally identifiable information. The technical report will be published to the National Transportation Library and available to the general public. The report may also be of interest to a variety of stakeholders, including automotive manufacturers, suppliers, researchers, safety advocates, and regulators. The study results will provide NHTSA with valuable information to support initiatives to generate evidence-based best practices for the design of future drive mode applications and functionalities for mobile phones operating independently of in-vehicle systems. The results support the agency’s mission to reduce the number of deaths, injuries, and economic losses resulting from motor vehicle crashes related to driver distraction on U.S. roads.

Affected Public: Study volunteers in the Phoenix, Arizona area between the ages of 18 and 60. Of the selected participants, equal numbers of males and females will be recruited.

Estimated Number of Respondents: The study anticipates screening 300 potential participants to obtain 96 individuals who meet the inclusion criteria. It is estimated that approximately 35% of those who begin the screening questionnaire will be eligible and will agree to participate in the study. While the goal is 36 final participants per experiment, (72 participants total) the research team will ensure eligibility and interest of up to 96 participants total to account for potential attrition and data loss.

Frequency: This is a one-time information collection, and there will be no recurrence.

Estimated Total Annual Burden Hours: 111.

The annual estimated burned is 111 hours. This estimate includes 25 hours for 100 potential participants to complete the initial screening. The annual burden estimate also includes 8 hours for 32 participants to review the consent form. An additional 43 hours are estimated for the 16 annual participants in the test track experiment and 35 hours for the 16 annual participants in the cones course experiment. The total burden is the sum of the burden across screening, consenting, and completing the test track or cones course drive. The details are presented in Table 1 and Table 2 below:

TABLE 1—TOTAL STUDY BURDEN HOURS

Form No.	Information collection	Number of respondents	Time per response (minutes)	Frequency of response	Total burden hours	Total opportunity costs
NHTSA 2112	Screening Questionnaire	300	15	1	75	\$3,082
NHTSA 2113 & 2115	Informed Consent	96	15	1	24	986
NHTSA 2114	Study Drive (Test Track)	48	160	1	128	5,260
NHTSA 2114	Study Drive (Cones Course)	48	130	1	104	4,273
Total .....	.....	.....	.....	.....	331	13,901

TABLE 2—ANNUAL BURDEN ESTIMATES

Form No.	Information collection	Number of respondents	Time per response (minutes)	Opportunity cost per response	Frequency of response	Total burden hours	Total opportunity costs
NHTSA 2112	Screening Questionnaire.	100	15	\$10.27	1	25	\$1,027
NHTSA 2113 & 2115 ..	Informed Consent.	32	15	10.27	1	8	329
NHTSA 2114	Study Drive (Test Track).	16	160	109.57	1	43	1,753

⁵ National Highway Traffic Safety Administration. (2013). *Visual-manual NHTSA driver distraction guidelines for in-vehicle electronic devices* (Federal Register Vol. 78, No. 81). Washington, DC.

⁶ National Highway Traffic Safety Administration. (2016). *Visual-manual NHTSA driver distraction guidelines for portable and aftermarket devices—Notice for Comment* (Federal Register Vol. 81, No. 233). Washington, DC.

⁷ National Highway Traffic Safety Administration. (2016). *Visual-manual NHTSA driver distraction guidelines for portable and aftermarket devices—Notice for Comment* (Federal Register Vol. 81, No. 233). Washington, DC.

TABLE 2—ANNUAL BURDEN ESTIMATES—Continued

Form No.	Information collection	Number of respondents	Time per response (minutes)	Opportunity cost per response	Frequency of response	Total burden hours	Total opportunity costs
NHTSA 2114	Study Drive (Cones Course).	16	130	89.03	1	35	1,424
Annual Estimates	.....	.....	.....	.....	111	4,533	

Estimated Total Annual Burden Cost: Participation in this study is voluntary, and there are no costs to respondents beyond the time spent completing the questionnaires and visits to the study facility. Further, there is no preparation of data required or expected of respondents, thus there are no record keeping costs to the respondents. Participants do not incur capital and start-up costs, nor do they incur fuel costs as the vehicles being driven are not the participants vehicles. Individuals will complete one study drive, either the test track drive or the cones course drive. For individuals who participate in the test track study, they will be offered \$375 as compensation for their participation. For individuals who participate in the cones course study, participants will be offered \$300 as compensation for completing the study requirements. Our experience indicates that anything less than the rate of \$150 per hour for total compensation would likely result in failure to recruit enough participants to provide adequate statistical power. This level of compensation is in line with past similar efforts given the activities it requires of participants.

Public Comments Invited: You are asked to comment on any aspects of this information collection, including (a) whether the proposed collection of information is necessary for the proper performance of the functions of the Department, including whether the information will have practical utility; (b) the accuracy of the Department's estimate of the burden of the proposed information collection; (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 the use of automated collection techniques or other forms of information technology.

(Authority: The Paperwork Reduction Act of 1995; 44 U.S.C. Chapter 35, as amended; 49 CFR 1.49; and DOT Order 1351.29A.)

Cem Hatipoglu,

Associate Administrator, Vehicle Safety Research.

[FR Doc. 2026–02657 Filed 2–10–26; 8:45 am]

BILLING CODE 4910–59–P

DEPARTMENT OF TRANSPORTATION

Pipeline and Hazardous Materials Safety Administration

[Docket No. PHMSA–2026–0397]

Pipeline Safety: Advisory Bulletin on Protecting Pipeline Integrity During Extreme Winter Weather, Rapid Thaw, and Geohazard Events

AGENCY: Pipeline and Hazardous Materials Safety Administration (PHMSA), Department of Transportation (DOT).

ACTION: Notice; issuance of advisory bulletin.

SUMMARY: PHMSA is issuing this advisory bulletin to all owners and operators of gas and hazardous liquid pipeline facilities to highlight safety risks associated with extreme winter weather. This includes impacts from heavy snowfall, ice expansion within pipeline facilities, flooding related to winter thaw, and frost heave resulting from sustained, unusually cold temperatures. This bulletin emphasizes the need for winterizing facilities in anticipation of cold weather events and heightened monitoring of ground movement and external loads to ensure the continued safe operation of the Nation's energy infrastructure.

FOR FURTHER INFORMATION CONTACT: Owners and operators of pipelines subject to regulation by PHMSA should contact the appropriate PHMSA Region Office. The PHMSA Region Offices and their contact information are as follows:

- **Eastern Region:** 609–771–7800 (Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Ohio, Pennsylvania,

Rhode Island, Vermont, Virginia, and West Virginia).

- **Southern Region:** 404–832–1147 (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, Puerto Rico, South Carolina, and Tennessee).

- **Central Region:** 816–329–3800 (Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, and Wisconsin).

- **Southwest Region:** 713–272–2859 (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas).

- **Western Region:** 720–963–3160 (Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, Oregon, Utah, Washington, and Wyoming).

Owners and operators of intrastate pipelines should contact the appropriate State pipeline safety authority. A list of State pipeline safety authorities is available at www.napsr.org.

SUPPLEMENTARY INFORMATION: The winter of 2025–2026 has brought record-breaking snowfall and unusually low temperatures to many regions across the United States. PHMSA is aware that certain parts of the country are experiencing temperatures significantly below historical norms. These extreme conditions present unique risks to pipeline systems that may not have been originally designed for sustained sub-zero environments or the rapid changes associated with a winter thaw.

I. Identified Safety Threats

1. Heavy Snowfall and Ice Accumulation

Excessive snow and ice accumulation can impose significant external loads on above-ground pipeline facilities, including tank roofs, valves, regulators, and meter sets. Heavy snow can also block essential vents for pressure relief valves or gas regulators, potentially leading to overpressure conditions or the accumulation of hazardous vapors in confined spaces.

2. Rapid Winter Thaw and Flooding

As temperatures rise following heavy snowfall, the resulting “winter thaw” often leads to localized flooding and

high-water velocity in rivers and streams. This presents several risks:

- *Scour and Erosion*: Rapidly moving water can expose buried pipelines or undermine the supports of above-ground facilities.

- *Buoyancy*: Flooding can exert upward pressure on large-diameter pipelines, potentially causing them to shift or float if the soil cover is saturated or eroded.

3. Frost Heave and Ground Movement

Sustained cold temperatures may lead to deep frost penetration. In areas currently experiencing unusually cold temperatures, the soil may be subject to frost heave—the upward swelling of soil during freezing conditions. Impacts of frost heave may include:

- *Unusual Stress/Strain*: When soil freezes and expands, it exerts significant longitudinal and lateral forces on the pipe.

- *Geohazard Impact*: Pipelines in these areas may be subject to unusual stress or strain due to ground movement. If the pipeline is constrained by rigid “stress-based” design or legacy repairs, these forces can lead to buckling, girth weld failure, or the propagation of existing cracks.

4. Ice Expansion

Ice expansion—specifically, frost heave and the freezing of trapped water inside components causing damage to valves, pipes, and fittings—is the primary cause of cold-weather failures reported to PHMSA. Instrumentation and control lines are also highly vulnerable during extreme temperature changes.

II. Advisory Bulletin (ADB-2026-03)

To: Owners and Operators of Gas and Hazardous Liquid Pipeline Facilities.

Subject: Pipeline Safety: Protecting Pipeline Integrity During Extreme Winter Weather, Rapid Thaw, and Geohazard Events.

Advisory: Owners and operators are advised to consider implementing the following measures:

- *Accelerate Field Patrols*: Conduct aerial and ground patrols in areas with heavy snow and ice accumulation or emerging flood conditions to identify exposed pipe, leaning equipment, or blocked vents.

- *Monitor Unusual Cold Zones*: Operators in regions experiencing temperatures well below their typical design thresholds should consider evaluating the potential for frost heave. Use instrumentation where available to monitor for unexpected strain or displacement.

- *Review Geohazard Plans*: Update geohazard management plans to account

for rapid thaw cycles. Ensure response teams are staged in areas where historical data suggests high vulnerability to washouts or flooding.

- *Inspect Above-Ground Facilities*: Clear snow and ice from essential safety equipment, including emergency shutdown valves, relief vents, and instrumentation. Verify that snow removal equipment (e.g., plows) has not accidentally struck or damaged pipeline components.

- *Winterize Above-Ground Facilities*: Drain water from valves, flanges, and piping prior to freezing conditions, keep control boxes dry and monitor for moisture, and ensure vulnerable components are upgraded to models designed for cold weather.

- *Communication with Emergency Responders*: Maintain clear lines of communication with local officials as weather conditions transition from freezing to thaw, ensuring a coordinated response to any localized energy crises.

III. Regulatory Oversight

Owners and operators are reminded that under 49 Code of Federal Regulations (CFR) 192.613 and 195.401, they must have a procedure for continuing surveillance of their facilities to determine and take appropriate action concerning changes in conditions. Extreme weather events constitute a change in condition that may require a proactive safety response.

PHMSA notes that this advisory bulletin does not have the force and effect of law and is not meant to bind owners, operators, or the public in any way.

Issued in Washington, DC, under authority delegated in 49 CFR 1.97.

Linda Daugherty,

Acting Associate Administrator for Pipeline Safety.

[FR Doc. 2026-02666 Filed 2-10-26; 8:45 am]

BILLING CODE 4910-60-P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Agency Information Collection Activities; Comment Request on Proceeds of Bonds Used for Reimbursement

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 April 13, 2026 to be assured of consideration.

ADDRESSES: Direct all written comments to Andres Garcia, Internal Revenue Service, Room 6526, 1111 Constitution Avenue NW, Washington, DC 20224, or by email to p.ra.comments@irs.gov. Include “OMB Control No. 1545-1226” in the subject line of the message.

FOR FURTHER INFORMATION CONTACT:

Requests for additional information or copies of this collection should be directed to Jason Schoonmaker, (801) 620-6008.

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, and viewable on relevant websites. For this reason, please do not include in your comments information of a confidential nature, such as sensitive personal information. 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: Proceeds of Bonds Used for Reimbursement.

OMB Control Number: 1545-1226.

Regulation Project Number: 26 CFR 1.150-2.

Abstract: This regulation clarifies when the allocation of bond proceeds to reimburse expenditures previously made by an issuer of the bond is treated as an expenditure of the bond proceeds. The issuer must express a reasonable official intent, on or prior to the date of payment, to reimburse the expenditure

in order to assure that the reimbursement is not a device to evade requirements imposed by the Internal Revenue Code with respect to tax exempt bonds. The information collection was added by TD 8394 under 26 CFR 1.103–18. TD 8476 removed 26 CFR 1.103–18 and moved the information collection to 26 CFR 150–2.

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 government, and not-for-profit institutions.

Estimated Number of Responses: 2,500.

Estimated Time per Response: 2 hours, 24 minutes.

Estimated Total Annual Burden Hours: 6,000.

Dated: February 6, 2026.

Jason M. Schoonmaker,

Tax Analyst.

[FR Doc. 2026–02664 Filed 2–10–26; 8:45 am]

BILLING CODE 4830–GV–P

DEPARTMENT OF VETERANS AFFAIRS

[Docket No. VA–2026–VACO–0001]

Monetary Allowance for Outer Burial Receptacles

AGENCY: Department of Veterans Affairs (VA).

ACTION: Notice.

SUMMARY: VA is providing notice of the monetary allowance amount payable for outer burial receptacles (OBR) for qualifying interments in a VA national cemetery or in a VA grant-funded veterans cemetery that occur during calendar year (CY) 2026. The allowance is equal to the average cost of Government-furnished graveliners less any administrative costs associated with processing and paying the allowance. The purpose of this notice is to inform interested parties of the average cost of Government-furnished graveliners, associated administrative costs, and the allowance amount payable for qualifying interments that occur in CY 2026.

DATES: This allowance amount is effective on January 1, 2026.

FOR FURTHER INFORMATION CONTACT: Fatorma Bolay, Senior Budget Analyst of Budget Execution Division, National Cemetery Administration, 202–461–6324.

SUPPLEMENTARY INFORMATION: Section 2306(e) of title 38, United States Code

(U.S.C.), authorizes VA to provide an OBR for each new grave used for casketed remains in an open VA national cemetery or in a cemetery that is the subject of a grant to a State or Tribal Organization under 38 U.S.C. 2408. Section 2306(e)(4) authorizes VA to administer this benefit using a voucher system or other system of reimbursement in situations where an OBR is purchased or provided in lieu of a Government-furnished graveliner. VA administers the OBR monetary allowance in accordance with 38 CFR 38.629, which specifies when payment of the monetary allowance is authorized and how the allowance amount is determined each year and requires VA to post the amount of the allowance in the Notices section of the **Federal Register**. This notice serves the purpose of meeting that requirement for CY 2026.

The allowance for qualified interments that occur during CY 2026 is equal to the average cost of Government-furnished graveliners in fiscal year (FY) 2025, less the administrative cost incurred by VA in processing and paying the allowance in lieu of the Government-furnished graveliner.

The average cost of Government-furnished graveliners is determined by taking VA's total cost during a fiscal year for single-depth graveliners that were procured for placement at the time of interment and dividing it by the total number of such graveliners procured by VA during that fiscal year. The calculation excludes both graveliners pre-placed in gravesites as part of cemetery gravesite development projects and all double-depth graveliners. Using this method of computation, the average cost was determined to be \$396.00 for FY 2025.

The administrative cost is based on the costs incurred by VA during CY 2025 that relate to processing and paying an allowance in lieu of the Government-furnished graveliner. This cost has been determined to be \$9.00.

Therefore, the allowance payable for qualifying interments occurring during CY 2026 is \$387.00.

Signing Authority

Douglas A. Collins, Secretary of Veterans Affairs, approved this document on February 6, 2026 and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication

electronically as an official document of the Department of Veterans Affairs.

Gabriela DeCuir,

*Alternate Federal Register Liaison Officer,
Department of Veterans Affairs.*

[FR Doc. 2026–02776 Filed 2–10–26; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[Docket No. VA–2026–VACO–0001]

Dependency and Indemnity Compensation Cost-of-Living Adjustments (COLA)

AGENCY: Department of Veterans Affairs (VA).

ACTION: Notice.

SUMMARY: As required by the Veterans' Compensation Cost-of-Living Adjustment Act of 2025, VA is hereby giving notice of COLA in certain benefit rates. These COLAs affect the Dependency and Indemnity Compensation (DIC) Program. The rate of adjustment is tied to the increase in Social Security benefits effective December 1, 2025, as announced by the Social Security Administration (SSA). SSA has announced an increase of 2.8%.

DATES: The increases in amounts became effective December 1, 2025.

FOR FURTHER INFORMATION CONTACT:

Janel Keyes, Assistant Director, Pension and Fiduciary Service, Veterans Benefits Administration, 202–632–8863.

SUPPLEMENTARY INFORMATION: Under the provisions of the Veterans' Compensation Cost-of-Living Adjustment Act of 2025 (Pub. L. 119–42), VA is required to increase, effective December 1, 2025, the benefit rates of DIC programs by the same percentage as increases in the benefit amounts payable under title II of the Social Security Act. VA is required to publish notice of the increased rates in the **Federal Register**.

The SSA has announced a 2.8% COLA increase in Social Security benefits effective December 1, 2025. Therefore, applying the same percentage, the following increased rates for the DIC program became effective December 1, 2025:

Dependency and Indemnity Compensation Monthly Payment Rates

*DIC Payable to a Surviving Spouse—
Veteran Death on or After January 1,
1993*

Basic Monthly Rate: \$1,699.36.

If at the time of the veteran's death, the veteran was in receipt of or entitled

to receive compensation for a service-connected disability rated totally disabling (including a rating based on individual unemployability) for a continuous period of at least 8 years immediately preceding death AND the surviving spouse was married to the veteran for those same 8 years, add: \$360.85.

For each dependent child under the age of 18, add: \$421.00.

If the surviving spouse is entitled to Aid and Attendance benefits, add \$421.00. If the surviving spouse is entitled to Housebound benefits, add \$197.22.

If the surviving spouse has one or more children under the age of 18 on the award per 38 U.S.C. 1311(f), add the 2-year transitional benefit of \$359.00.

DIC Payable to a Surviving Spouse—
Veteran death prior to January 1, 1993

Veteran paygrade	Amount payable
E-1(f)	\$1,699.36
E-2(f)	1,699.36
E-3(a, f)	1,699.36
E-4(f)	1,699.36
E-5(f)	1,699.36
E-6(f)	1,699.36
E-7(g)	1,758.09
E-8(g)	1,856.02
E-9(g)	1,935.72
E-9(b)	2,089.58
W-1(g)	1,794.49
W-2(g)	1,865.80
W-3(g)	1,920.33
W-4(g)	2,032.23
O-1(g)	1,794.49
O-2(g)	1,856.02
O-3(g)	1,983.26

Veteran paygrade	Amount payable
O-4	2,102.15
O-5	2,313.37
O-6	2,608.49
O-7	2,815.45
O-8	3,092.41
O-9	3,307.79
O-10	3,628.08
O-10(c)	3,893.83

(a) *Surviving spouse of Aviation Cadet or other service not covered by this table is paid the DIC rate for enlisted E-3.*

(b) *Veteran who served as Sergeant Major of the Army or Marine Corps, Senior Enlisted Advisor of the Navy, Chief Master Sergeant of the Air Force, or Sergeant Major of the Marine Corps, or as Master Chief Petty Officer of the Coast Guard.*

(c) *Veteran served as Chairman of the Joint Chiefs of Staff, Chief of Staff of the Army or Air Force, Chief of Naval Operations, Commandant of the Marine Corps, or as Commandant of the Coast Guard.*

(d) *If surviving spouse entitled to Aid and Attendance benefits, add \$421.00; if entitled to Housebound benefits, add \$197.22.*

(e) *Add \$421.00 for each child under 18.*

(f) *Add \$360.85 if veteran rated totally disabled for 8 continuous years prior to death and surviving spouse was married to veteran those same 8 years.*

(g) *Base rate is \$2,060.21 if veteran rated totally disabled 8 continuous years prior to death and surviving spouse was married to veteran those same 8 years.*

DIC Payable to Children

Surviving Spouse Entitled

For each child over the age of 18 who is attending an approved course of education, the rate is \$356.66.

For each child over the age of 18 who is helpless, the rate is \$717.50.

No Surviving Spouse Entitled

Number of children	Total payable	Each child's share
1	\$717.50	\$717.50
2	1,032.18	516.09
3	1,346.92	448.97

For each additional child, add \$255.95 to the total payable amount to be paid in equal shares to each child.

For each additional helpless child over 18, add \$421.00 to the amount payable to the helpless child.

Signing Authority

Douglas A. Collins, Secretary of Veterans Affairs, approved this document on February 6, 2026 and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Gabriela DeCuir,

*Alternate Federal Register Liaison Officer,
Department of Veterans Affairs.*

[FR Doc. 2026-02771 Filed 2-10-26; 8:45 am]

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FEDERAL REGISTER

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Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 600

Office of the Secretary

45 CFR Parts 153, 154, 155, et al.

Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 600

Office of the Secretary

45 CFR Parts 153, 154, 155, 156, and 158

[CMS–9883–P]

RIN 0938–AV62

Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program

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

ACTION: Proposed rule.

SUMMARY: This proposed rule contains provisions to improve implementation of the Patient Protection and Affordable Care Act, including payment parameters and provisions related to the HHS-operated risk adjustment and risk adjustment data validation (HHS–RADV) programs, as well as 2027 user fee rates for issuers offering qualified health plans (QHPs) through Federally-facilitated Exchanges (FfEs) and State-based Exchanges on the Federal platform (SBE–FPs). This proposed rule also includes provisions related to civil money penalties (CMPs) for noncompliant issuers and other responsible entities; standards governing agents, brokers, and web-brokers; the expansion and codification of hardship exemption eligibility; implementation of the State Exchange Improper Payment Measurement (SEIPM); provider access standards and essential community provider standards for QHP certification; QHP certification of non-network plans; a prohibition on issuers from including routine non-pediatric dental services as an Essential Health Benefit (EHB); cost-sharing flexibilities for catastrophic and individual market bronze plans; establishment of catastrophic plans with plan terms of up to 10 consecutive years; QHP issuer quality improvement strategies (QISs); revisions affecting which enrollees are included in Federal Basic Health Program (BHP) payment calculations to States; and seeks comment on potential adjustments to other Federal standards, including the Federal medical loss ratio (MLR) standard in the individual market. This proposed rule also includes

amendments to implement certain provisions of the Working Families Tax Cut (WFTC) legislation.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by March 13, 2026.

ADDRESSES: In commenting, please refer to file code CMS–9883–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <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–9883–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9883–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Jeff Wu, (301) 492–4305, Rogelyn McLean, (410) 786–1524, Grace Bristol, (410) 786–8437, for general information. Ayesha Anwar, (301) 448–3625, or Joshua Paul, (301) 492–4347, for matters related to HHS-operated risk adjustment and HHS-operated risk adjustment data validation.

Aaron Franz, (410) 786–8027 for matters related to user fees.

Brian Gubin, (410) 786–1659, for matters related to agent, broker, and web-broker guidelines.

Zarin Ahmed, (301) 492–4400, for matters related to enrollment of qualified individuals into QHPs and termination of Exchange enrollment or coverage for qualified individuals.

Ken Buerger, (410) 786–1190, for matters related to certification standards for QHPs, cost-sharing requirements, and dental coverage as EHB.

Kelly Carda, (312) 886–5210, or Cassandra Thompson, (667) 414–0870, for matters related to Provider Access standards.

Ariana Koenitzer, (410) 786–0724, or Samantha Nguyen Kella, (816) 426–6339, for matters related to Essential Community Provider Standards.

Ariana Koenitzer, (410) 786–0724, or Cassandra Thompson, (667) 414–0870, for matters related to QHP Certification of Non-Network Plans.

Nikolas Berkobien, (667) 290–9903, for matters related to standardized plan options, non-standardized plan option limits and exceptions.

Jenny Chen, (301) 492–5156, or Shilpa Gogna, (301) 492–4257, for matters related to State Exchange and State Exchange Blueprint requirements.

Rebecca Braun-Harrison, (667) 290–8846, or Nia Blasingame, (470) 890–4178, for matters related to civil money penalties of issuers and non-Federal governmental group health plans.

Preeti Hans, (301) 492–5144, for matters related to the Quality Improvement Strategy.

Beth Freshcorn, (410) 786–3831, for matters related to administrative actions against agents, brokers, and web-brokers.

Jennifer McIlvaine, (410) 786–0947, for matters related to the Basic Health Program.

Christina Whitefield, (301) 492–4172, for matters related to the medical loss ratio (MLR) program.

David Mlawsky, (410) 786–6851, for matters related to catastrophic plans with multi-year plan terms.

Jessica Veffer, (301) 492–4827, for matters related to expanding hardship exemptions for individuals ineligible for APTC or CSRs due to projected household income.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments:

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 comments received before the close of the comment period on the following website as soon as possible after they have been received: <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. We encourage commenters to include supporting facts, research, and evidence in their comments. When doing so, commenters are encouraged to provide citations to the published materials referenced, including active

hyperlinks. Likewise, commenters who reference materials which have not been published are encouraged to upload relevant data collection instruments, data sets, and detailed findings as a part of their comment. Providing such citations and documentation will assist us in analyzing the comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a summary of not more than 100 words in length of this proposed rule, in plain language, may be found at <https://www.regulations.gov/>.

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I. Executive Summary

We propose changes to the provisions and parameters implemented through prior rulemaking to implement the Patient Protection and Affordable Care Act and propose to implement new provisions.¹ These requirements are published under the authority granted to the Secretary of HHS (the Secretary) by the Affordable Care Act and the Public Health Service (PHS) Act.² In this document, we are proposing changes related to some of the Affordable Care Act provisions and parameters we previously implemented under the authority granted to the Secretary by Public Law (Pub. L.) 119–21, which CMS refers to as the Working

¹ The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Healthcare and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this rulemaking, the two statutes are referred to collectively as the “Patient Protection and Affordable Care Act” or “Affordable Care Act.”

² See sections 1301, 1302, 1311, 1312, 1313, 1321, 1331, and 1343 of the Affordable Care Act and section 2792 of the PHS Act.

Families Tax Cut (WFTC) legislation.³ Our goal with these requirements is providing quality, more affordable coverage to consumers while minimizing administrative burden and ensuring program integrity. The changes proposed in this rule are also intended to enhance the role of States in these programs, provide issuers and States with additional flexibilities, reduce unnecessary regulatory burden on interested parties, and improve affordability.

II. Background

A. Legislative and Regulatory Overview

Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) added a new title XXVII to the PHS Act to establish various reforms to the group and individual health insurance markets. These provisions of the PHS Act were later augmented by other laws, including the Affordable Care Act. Subtitles A and C of title I of the Affordable Care Act reorganized, amended, and added to the provisions of part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. The term “group health plan” includes both insured and self-insured group health plans.

In the upcoming sections, we summarize sections of the PHS Act, Affordable Care Act, and WFTC legislation that are relevant to this proposed rule.

Section 1301(a)(1)(B) of the Affordable Care Act directs all issuers of qualified health plans (QHPs) to cover the Essential Health Benefit (EHB) package described in section 1302(a) of the Affordable Care Act, including coverage of the services described in section 1302(b) of the Affordable Care Act, adherence to the cost-sharing limits described in section 1302(c) of the Affordable Care Act, and meeting the Actuarial Value (AV) levels established in section 1302(d) of the Affordable Care Act. Section 2707(a) of the PHS Act, which is effective for plan or policy years beginning on or after January 1, 2014, extends the requirement to cover the EHB package to non-grandfathered individual and small group health insurance coverage, irrespective of whether such coverage is offered through an Exchange. In addition, section 2707(b) of the PHS Act directs non-grandfathered group health plans to ensure that cost sharing under the plan does not exceed the limitations

³ The WFTC legislation (Pub. L. 119–21) was enacted on July 4, 2025.

described in section 1302(c)(1) of the Affordable Care Act.

Section 1302 of the Affordable Care Act provides for the establishment of an EHB package that includes coverage of EHB (as defined by the Secretary), cost-sharing limits, and AV requirements. The law directs that EHB 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.

Section 1302(b)(4)(A) through (D) of the Affordable Care Act 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 EHB based on age, life expectancy, disability, degree of medical dependency, or quality of life.

Section 1302(e) of the Affordable Care Act establishes that catastrophic coverage may only be offered to individuals who: (1) are under the age of 30 before the beginning of the plan year; (2) have been certified as exempt from the individual responsibility requirement because coverage is unaffordable; or (3) have been certified as experiencing a hardship with respect to obtaining coverage under a qualified health plan (QHP).

Section 1311(c) of the Affordable Care Act provides the Secretary the authority to issue regulations to establish criteria for the certification of QHPs. Among the criteria for certification that the Secretary must establish by regulation is that QHPs ensure a sufficient choice of providers (section 1311(c)(1)(B) of the Affordable Care Act) and include essential community providers that serve predominately low-income, medically underserved individuals (section 1311(c)(1)(C)). Section 1311(d)(4)(A) of the Affordable Care Act requires the Exchange to implement procedures for the certification, recertification, and decertification of health plans as QHPs, consistent with guidelines developed by the Secretary under section 1311(c) of the Affordable Care Act. Section 1311(e)(1) of the

Affordable Care Act 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 Affordable Care Act, 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 1311(c)(6)(C) of the Affordable Care Act directs the Secretary to require an Exchange to provide for special enrollment periods (SEPs) and section 1311(c)(6)(D) of the Affordable Care Act directs the Secretary to require an Exchange to provide for American Indians and Alaska Natives (AI/AN), as defined by section 4 of the Indian Health Care Improvement Act.

Section 1311(d)(3)(B) of the Affordable Care Act permits a State, at its option, to require QHPs to cover benefits in addition to EHB. This section also requires a State to make payments, either to the individual enrollee or to the issuer on behalf of the enrollee, to defray the cost of these additional State-required benefits.

Section 1312(c) of the Affordable Care Act generally requires a health insurance issuer to consider all enrollees in all health plans (except grandfathered health plans) offered by such issuer to be members of a single risk pool for each of its individual and small group markets. States have the option to merge the individual and small group market risk pools under section 1312(c)(3) of the Affordable Care Act.

Section 1312(e) of the Affordable Care Act 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 advance payments of the premium tax credit (APTC) and cost sharing reductions (CSRs) for QHPs sold through an Exchange.

Sections 1313 and 1321 of the Affordable Care Act 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 Affordable Care Act provides the Secretary with the authority to implement any measure or procedure that the Secretary determines is appropriate to reduce fraud and abuse in the administration of the Exchanges. Section 1321 of the Affordable Care Act

provides for State flexibility in the operation and enforcement of Exchanges and related requirements.

Section 1321(a) of the Affordable Care Act 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 Affordable Care Act, including such other requirements as the Secretary determines appropriate. When operating an FFE under section 1321(c)(1) of the Affordable Care Act, HHS has the authority under sections 1321(c)(1) and 1311(d)(5)(A) of the Affordable Care Act to collect and spend user fees. Office of Management and Budget (OMB) Circular No. A-25 Revised establishes Federal policy regarding user fees and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the public.⁴

Section 1321(d) of the Affordable Care Act provides that nothing in title I of the Affordable Care Act must be construed to preempt any State law that does not prevent the application of title I of the Affordable Care Act. Section 1311(k) of the Affordable Care Act specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations issued by the Secretary.

Section 1331 of the Affordable Care Act provides States with an option to establish a BHP. In the States that elect to operate a BHP, the BHP makes affordable health benefits coverage available for individuals under age 65 with household incomes between 133 percent and 200 percent of the FPL who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), or affordable employer-sponsored coverage, or for noncitizens whose income is equal to or below 200 percent of FPL but are ineligible for Medicaid benefits that at a minimum consist of the EHB described in section 1302(b) of the Affordable Care Act. For those States that have expanded Medicaid coverage under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act), the lower income threshold for BHP eligibility is effectively 138 percent of the FPL due to the application of a required 5 percent income disregard in determining the upper limits of Medicaid income eligibility (section 1902(e)(14)(I) of the Act).

Section 1343 of the Affordable Care Act establishes a permanent risk

⁴ See OMB, Circular No. A-25 Revised (1993). <https://www.whitehouse.gov/wp-content/uploads/2017/11/Circular-025.pdf>.

adjustment program to provide payments to health insurance issuers that attract higher-than-average risk enrollees, such as those with chronic conditions, funded by charges collected from those issuers that attract lower-than-average risk enrollees, thereby reducing incentives for issuers to avoid higher-risk enrollees. Section 1343(b) of the Affordable Care Act provides that the Secretary, in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. Consistent with section 1321(c) of the Affordable Care Act, the Secretary is responsible for operating the HHS risk adjustment program in any State that fails to do so.⁵

Section 1401(a) of the Affordable Care Act added section 36B to the Internal Revenue Code (the Code), which, among other things, requires that a taxpayer reconcile APTC for a year of coverage with the amount of the premium tax credit (PTC) the taxpayer is allowed for the year.

Section 1402 of the Affordable Care Act provides for, among other things, reductions in cost sharing for EHB for qualified low- and moderate-income enrollees in silver level QHPs offered through the individual market Exchanges. This section also provides for reductions in cost sharing for American Indians and Alaska Natives (AI/AN) enrolled in QHPs at any metal level.

Section 1411(f) of the Affordable Care Act requires the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Homeland Security, and the Commissioner of Social Security, to establish procedures for hearing and making decisions governing appeals of Exchange eligibility determinations. Section 1411(f)(1)(B) of the Affordable Care Act requires the Secretary to establish procedures to redetermine eligibility on a periodic basis, in appropriate circumstances, including eligibility to purchase a QHP through the Exchange and for APTC and CSRs.

Section 1411(g) of the Affordable Care Act allows the use of applicant information only for the limited purpose of, and to the extent necessary for, ensuring the efficient operation of the Exchange, including by verifying eligibility to enroll through the Exchange and for APTC and CSRs, and limits the disclosure of such information.

Section 1413 of the Affordable Care Act directs the Secretary to establish, subject to minimum requirements, a streamlined enrollment process for enrollment in QHPs and all insurance affordability programs.

Section 2718 of the PHS Act, as added by the Affordable Care Act, generally requires health insurance issuers to submit an annual medical loss ratio (MLR) report to HHS and provide rebates to enrollees if the issuers do not achieve specified MLR thresholds.

Section 5000A of the Code, as added by section 1501(b) of the Affordable Care Act, requires individuals to have minimum essential coverage (MEC) for each month, qualify for an exemption, or make an individual shared responsibility payment. Under the Tax Cuts and Jobs Act, which was enacted on December 22, 2017, the individual shared responsibility payment is reduced to \$0, effective for months beginning after December 31, 2018.

Notwithstanding that reduction, certain exemptions are still relevant to determine whether individuals aged 30 and above qualify to enroll in catastrophic coverage under §§ 155.305(h) and 156.155(a)(5).

Section 5000A(e) of the Internal Revenue Code defines exemptions from the individual shared responsibility penalty. Section 5000A(e)(5) of the Internal Revenue Code defines a hardship exemption as a situation in which an individual experiences difficulty obtaining QHP coverage and provides the HHS Secretary the authority to determine whether an individual has experienced a hardship.

Section 71301 of WFTC legislation amends 26 U.S.C. 36B(e), effective with respect to plan years beginning on or after January 1, 2027, to provide that a PTC is allowed for the coverage of a lawfully present individual only if the individual is an “eligible alien.”

Section 71302 of WFTC legislation removes subparagraph (B) of 26 U.S.C. 36B(c)(1), eliminating PTC eligibility for lawfully present individuals with income below 100 percent of the FPL who are ineligible for Medicaid due to their immigration status. Section 71302 is effective for taxable years beginning after December 31, 2025.

Section 71303 of WFTC legislation, effective for taxable years beginning after December 31, 2027, amends the definition of coverage month such that it would be imprudent to maintain a 2-year failure to file and reconcile (FTR) policy for 2028 and beyond, but it would not be legally prohibited to do so.

Section 71304 of WFTC legislation amends section 36B of the Code, effective with respect to plan years

beginning after December 31, 2025, such that a plan is not considered a QHP, and therefore no PTC is allowed for coverage under the plan, if the plan is enrolled in through a special enrollment period (SEP) that is based solely on the basis of an individual’s expected income to the FPL and not on a change in circumstance (an “income-based SEP”). This provision is effective January 1, 2026.

Section 71305 of WFTC legislation eliminates, effective for taxable years beginning after December 31, 2025, APTC repayment limits and requires individuals whose APTC exceeds their PTC to increase their tax liability by the amount of the excess.

Section 71307 of WFTC legislation amends the definition of “high deductible health plan” to include bronze and catastrophic plans, effective to months beginning after December 31, 2025.

1. Premium Stabilization Programs

The premium stabilization programs refer to the risk adjustment, risk corridors, and reinsurance programs established by the Affordable Care Act.⁶ For past rulemaking, we refer readers to the following rules:

- In the March 23, 2012 **Federal Register** (77 FR 17219) (Premium Stabilization Rule), we implemented the premium stabilization programs.

- In the March 11, 2013 **Federal Register** (78 FR 15409) (2014 Payment Notice), we finalized the benefit and payment parameters for the 2014 benefit year to expand the provisions related to the premium stabilization programs and set forth payment parameters in those programs.

- In the October 30, 2013 **Federal Register** (78 FR 65046), we finalized the modification to the HHS risk adjustment methodology related to community rating States.

- In the November 6, 2013 **Federal Register** (78 FR 66653), we issued a correcting amendment to the 2014 Payment Notice to address how an enrollee’s age for the risk score calculation would be determined under the HHS risk adjustment methodology.

- In the March 11, 2014 **Federal Register** (79 FR 13743) (2015 Payment Notice), we finalized the benefit and payment parameters for the 2015 benefit year to expand the provisions related to the premium stabilization programs, set forth certain oversight provisions, and

⁵ See Affordable Care Act section 1341 (transitional reinsurance program), Affordable Care Act section 1342 (risk corridors program), and Affordable Care Act section 1343 (HHS risk adjustment program).

⁶ See Affordable Care Act section 1341 (transitional reinsurance program), Affordable Care Act section 1342 (risk corridors program), and Affordable Care Act section 1343 (HHS risk adjustment program).

establish payment parameters in those programs.

- In the May 27, 2014 **Federal Register** (79 FR 30240), we announced the fiscal year 2015 sequestration rate for the HHS-operated risk adjustment program.

- In the February 27, 2015 **Federal Register** (80 FR 10749) (2016 Payment Notice), we finalized the benefit and payment parameters for the 2016 benefit year to expand the provisions related to the premium stabilization programs, set forth certain oversight provisions, and establish the payment parameters in those programs.

- In the March 8, 2016 **Federal Register** (81 FR 12203) (2017 Payment Notice), we finalized the benefit and payment parameters for the 2017 benefit year to expand the provisions related to the premium stabilization programs, set forth certain oversight provisions, and establish the payment parameters in those programs.

- In the December 22, 2016 **Federal Register** (81 FR 94058) (2018 Payment Notice), we finalized the benefit and payment parameters for the 2018 benefit year, added the high-cost risk pool parameters to the HHS risk adjustment methodology, incorporated prescription drug factors in the adult models, established enrollment duration factors for the adult models, and finalized policies related to the collection and use of enrollee-level External Data Gathering Environment (EDGE) data.

- In the April 17, 2018 **Federal Register** (83 FR 16930) (2019 Payment Notice), we finalized the benefit and payment parameters for the 2019 benefit year, created the State flexibility framework permitting States to request a reduction in risk adjustment State transfers calculated by HHS, and adopted a new error rate methodology for HHS–RADV adjustments to transfers.

- In the May 11, 2018 **Federal Register** (83 FR 21925), we issued a correction to the 2019 HHS risk adjustment coefficients in the 2019 Payment Notice.

- On July 27, 2018, consistent with 45 CFR 153.320(b)(1)(i), we updated the 2019 benefit year final HHS risk adjustment model coefficients to reflect an additional recalibration related to an update to the 2016 enrollee-level EDGE data set.⁷

- In the July 30, 2018 **Federal Register** (83 FR 36456), we adopted the 2017 benefit year HHS risk adjustment methodology as established in the final

rules issued in the March 23, 2012 (77 FR 17220 through 17252) and March 8, 2016 (81 FR 12204 through 12352) editions of the **Federal Register**. The final rule set forth an additional explanation of the rationale supporting the use of Statewide average premium in the State payment transfer formula for the 2017 benefit year, including the reasons why the program is operated by HHS in a budget-neutral manner. The final rule also permitted HHS to resume 2017 benefit year HHS risk adjustment payments and charges. HHS also provided guidance as to the operation of the HHS-operated risk adjustment program for the 2017 benefit year in light of the publication of the final rule.

- In the December 10, 2018 **Federal Register** (83 FR 63419), we adopted the 2018 benefit year HHS risk adjustment methodology as established in the final rules issued in the March 23, 2012 (77 FR 17219) and the December 22, 2016 (81 FR 94058) editions of the **Federal Register**. In the rule, we set forth an additional explanation of the rationale supporting the use of Statewide average premium in the State payment transfer formula for the 2018 benefit year, including the reasons why the program is operated by HHS in a budget-neutral manner.

- In the April 25, 2019 **Federal Register** (84 FR 17454) (2020 Payment Notice), we finalized the benefit and payment parameters for the 2020 benefit year, as well as the policies related to making the enrollee-level EDGE data available as a limited data set for research purposes and expanding the HHS uses of the enrollee-level EDGE data, approval of the request from Alabama to reduce HHS risk adjustment transfers by 50 percent in the small group market for the 2020 benefit year, and updates to HHS–RADV program requirements.

- On May 12, 2020, consistent with § 153.320(b)(1)(i), we issued the 2021 Benefit Year Final HHS Risk Adjustment Model Coefficients on the CCIIO website.⁸

- In the May 14, 2020 **Federal Register** (85 FR 29164) (2021 Payment Notice), we finalized the benefit and payment parameters for the 2021 benefit year, as well as adopted updates to the HHS risk adjustment models' hierarchical condition categories (HCCs) to transition to the 10th revision of the International Classification of Diseases (ICD–10) codes, approved the request from Alabama to reduce HHS risk

adjustment transfers by 50 percent in the small group market for the 2021 benefit year, and modified the outlier identification process under the HHS–RADV program.

- In the December 1, 2020 **Federal Register** (85 FR 76979) (Amendments to the HHS-Operated Risk Adjustment Data Validation Under the Patient Protection and Affordable Care Act's HHS-Operated Risk Adjustment Program (2020 HHS–RADV Amendments Rule)), we adopted the creation and application of Super HCCs in the sorting step that assigns HCCs to failure rate groups, finalized a sliding scale adjustment in HHS–RADV error rate calculation, and added a constraint for negative error rate outliers with a negative error rate. We also established a transition from the prospective application of HHS–RADV adjustments to apply HHS–RADV results to risk scores from the same benefit year as that being audited.

- In the May 5, 2021 **Federal Register** (86 FR 24140) (part 2 of the 2022 Payment Notice), we finalized a subset of proposals from the December 4, 2020 **Federal Register** (85 FR 78572) (the 2022 Payment Notice proposed rule), including policy and regulatory revisions related to the HHS-operated risk adjustment program, finalization of the benefit and payment parameters for the 2022 benefit year, and approval of the request from Alabama to reduce HHS risk adjustment transfers by 50 percent in the individual and small group markets for the 2022 benefit year. In addition, this final rule established a revised schedule of collections for HHS–RADV and updated the provisions regulating second validation audit (SVA) and initial validation audit (IVA) entities.

- On July 19, 2021, consistent with § 153.320(b)(1)(i), we released Updated 2022 Benefit Year Final HHS Risk Adjustment Model Coefficients on the CCIIO website, announcing some minor revisions to the 2022 benefit year final HHS risk adjustment adult model coefficients.⁹

- In the May 6, 2022 **Federal Register** (87 FR 27208) (2023 Payment Notice), we finalized revisions related to the HHS-operated risk adjustment program, including the benefit and payment parameters for the 2023 benefit year, HHS risk adjustment model recalibration, and policies related to the collection and extraction of enrollee-level EDGE data. We also finalized the

⁷ CMS. (2018 July, 27). *Updated 2019 Benefit Year Final HHS Risk Adjustment Model Coefficients*. <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Updtd-Final-HHS-RA-Model-Coefficients.pdf>.

⁸ CMS. (2020, May 12). *Final 2021 Benefit Year Final HHS Risk Adjustment Model Coefficients*. <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2021-Benefit-Year-Final-HHS-Risk-Adjustment-Model-Coefficients.pdf>.

⁹ CMS. (2021, July 19). *2022 Benefit Year Final HHS Risk Adjustment Model Coefficients*. <https://www.cms.gov/files/document/updated-2022-benefit-year-final-hhs-risk-adjustment-model-coefficients-clean-version-508.pdf>.

adoption of the interacted HCC count specification for the adult and child models, along with modified enrollment duration factors for the adult models, beginning with the 2023 benefit year.¹⁰ We also repealed the ability for States, other than prior participants, to request a reduction in HHS risk adjustment State transfers starting with the 2024 benefit year. We approved a 25 percent reduction to 2023 benefit year HHS risk adjustment transfers in Alabama's individual market and a 10 percent reduction to 2023 benefit year HHS risk adjustment transfers in Alabama's small group market. We finalized further refinements to the HHS–RADV error rate calculation methodology beginning with the 2021 benefit year.

- In the April 27, 2023 **Federal Register** (88 FR 25740) (2024 Payment Notice), we finalized the benefit and payment parameters for the 2024 benefit year, amended the EDGE discrepancy materiality threshold and data collection requirements, and reduced the risk adjustment user fee. For the 2024 benefit year, we approved 50 percent reductions to HHS risk adjustment transfers for Alabama's individual and small group markets and repealed prior participant States' ability to request reductions of their risk adjustment transfers for the 2025 benefit year and beyond. We finalized refinements to HHS–RADV program requirements, such as shortening the window to confirm SVA findings or file a discrepancy report, changing the HHS–RADV materiality threshold for random and targeted sampling, and no longer exempting exiting issuers from adjustments to risk scores and HHS risk adjustment transfers when they are negative error rate outliers. We announced the discontinuance of the Lifelong Permanent Condition List and Non-EDGE Claims in HHS–RADV beginning with the 2022 benefit year.

- In the April 15, 2024 **Federal Register** (89 FR 26218) (2025 Payment Notice), we finalized the benefit and payment parameters for the 2025 benefit year, including the 2025 risk adjustment models and updated the adjustment factors for the receipt of CSRs for the AI/AN subpopulation who are enrolled in zero and limited cost-sharing plans to improve prediction in the HHS risk adjustment models. In addition, we finalized that in certain cases, we may require a corrective action plan (CAP) to

address an observation identified in an HHS risk adjustment program audit.

- In the January 15, 2025 **Federal Register** (90 FR 4424) (2026 Payment Notice), we finalized the benefit and payment parameters for the 2026 benefit year, including the 2026 risk adjustment models and updated the adjustment factors, phased out the market pricing adjustment to the plan liability associated with Hepatitis C drugs, and incorporated of pre-exposure prophylaxis (PrEP) as an Affiliated Cost Factor (ACF) starting with the 2026 benefit year. Beginning with the 2025 benefit year, we excluded enrollees without HCCs from the IVA sample, removed the Finite Population Correction (FPC) from the IVA sampling methodology, and replaced the source of the Neyman allocation data used for HHS–RADV sampling with the most recent 3 consecutive years of HHS–RADV data. Beginning with the 2024 benefit year, we modified the SVA pairwise means test and increased the initial SVA subsample size. At § 156.1220(a), we established a new materiality threshold for HHS–RADV appeals.

2. Program Integrity

We have finalized program integrity standards related to the Exchanges and premium stabilization programs in two rules: the “first Program Integrity Rule” issued in the August 30, 2013 **Federal Register** (78 FR 54069), and the “second Program Integrity Rule” issued 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 (2019 Program Integrity Rule) issued in the December 27, 2019 **Federal Register** (84 FR 71674), as well as the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability final rule (2025 Marketplace Integrity and Affordability final rule) issued in the June 25, 2025 **Federal Register** (90 FR 27074).

In the May 6, 2022 **Federal Register** (87 FR 27208) (2023 Payment Notice), 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 implemented the improper payment pre-testing and assessment (IPPTA) requirements for State Exchanges to ensure adherence to the Payment Integrity Information Act of 2019. In addition, 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 application documentation requirements for agents, brokers, and web-brokers that assist Exchange consumers in FFE and SBE–FP States.

In the 2025 Payment Notice, issued in the April 15, 2024 **Federal Register** (89 FR 26218), we finalized that the CMS Administrator 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 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 certain circumstances until the incident, breach, or noncompliance are remedied or sufficiently mitigated to HHS' satisfaction.

3. Market Rules

In the February 27, 2013 **Federal Register** (78 FR 13406), we issued the health insurance market rules, including provisions related to the single risk pool. We clarified that issuers may make a plan-specific adjustment to the market-wide index rate that accounts for differences between catastrophic and non-catastrophic plans in expected average enrollee gross spending and expected average risk adjustment payment transfers. This plan-specific adjustment would be uniform across all of an issuer's catastrophic plans (that is, risk across all catastrophic plans must be pooled).

In that rule we also codified that a health plan is a catastrophic plan if it: (1) meets all applicable requirements for health insurance coverage in the individual market; (2) does not offer coverage at the bronze, silver, gold, or platinum levels of coverage (3) does not provide coverage of essential health benefits until the enrolled individual reaches the annual limitation in cost sharing; and (4) covers at least three primary care visits per year before reaching the deductible. A catastrophic plan may not impose any cost-sharing requirements for preventive services identified in section 2713 of the PHS Act. We also codified the statutory

¹⁰ On May 6, 2022, we also published the 2023 Benefit Year Final HHS Risk Adjustment Model Coefficients. CMS. (2022, May 6). 2023 Benefit Year Final HHS Risk Adjustment Model Coefficients. <https://www.cms.gov/files/document/2023-benefit-year-final-hhs-risk-adjustment-model-coefficients.pdf>.

eligibility criteria identified in section 1302(e)(2) of the Affordable Care Act.

We amended requirements related to index rates under the single risk pool provision in a final rule issued in the July 2, 2013 **Federal Register** (78 FR 39870). In the October 30, 2013 **Federal Register** (78 FR 65046), we clarified when issuers may establish and update premium rates. In the March 8, 2016 **Federal Register** (81 FR 12203), we clarified single risk pool provisions related to student health insurance coverage. We finalized minor adjustments to the single risk pool regulations in the 2018 Payment Notice, issued in the December 22, 2016 **Federal Register** (81 FR 94058).

4. Rate Review

In the May 23, 2011 **Federal Register** (76 FR 29963) (Rate Review Rule), we implemented a rate review program. We amended the provisions of the Rate Review Rule in final rules published in the September 6, 2011 **Federal Register** (76 FR 54969), the February 27, 2013 **Federal Register** (78 FR 13405), the May 27, 2014 **Federal Register** (79 FR 30239), the February 27, 2015 **Federal Register** (80 FR 10749), the March 8, 2016 **Federal Register** (81 FR 12203) and the December 22, 2016 **Federal Register** (81 FR 94058).

5. Exchanges

We requested comment relating to Exchanges in the August 3, 2010 **Federal Register** (75 FR 45584). We issued initial guidance to States on Exchanges on November 18, 2010. 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 Affordable Care Act, to provide competitive marketplaces for individuals and small employers to directly compare available private health insurance coverage options based on price, quality, and other factors. This included implementation of components of the Exchanges and standards for eligibility for Exchanges, as well as network adequacy and essential community provider (ECP) certification standards.

In the 2014 Payment Notice and the Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 interim final rule, issued in the March 11, 2013 **Federal Register** (78 FR 15541), we set forth standards related to Exchange user fees. We established an adjustment to the FFE user fee in the Coverage of Certain Preventive Services under the Affordable Care Act final rule, issued in the July 2, 2013 **Federal**

Register (78 FR 39869) (Preventive Services Rule).

In the 2016 Payment Notice, we also set forth the ECP certification standard at § 156.235, with revisions in the 2017 Payment Notice in the March 8, 2016 **Federal Register** (81 FR 12203) and the 2018 Payment Notice in the December 22, 2016 **Federal Register** (81 FR 94058).

In the 2018 Payment Notice, issued in the December 22, 2016 **Federal Register** (81 FR 94058), we set forth the standards for the request for reconsideration of denial of QHP certification specific to the FFEs at § 155.1090.

In an interim final rule, issued 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, issued in the December 22, 2016 **Federal Register** (81 FR 94058).

In the Market Stabilization final rule, issued in the April 18, 2017 **Federal Register** (82 FR 18346), we amended standards relating to SEPs and QHP certification. In the 2019 Payment Notice, issued in the April 17, 2018 **Federal Register** (83 FR 16930), we modified parameters around certain SEPs. In the April 25, 2019 **Federal Register** (84 FR 17454), the 2020 Payment Notice established a new SEP for certain individuals who become newly eligible for APTC.

In the May 14, 2020 **Federal Register** (85 FR 29164) (2021 Payment Notice), we finalized revisions to the parameters of SEPs and the quality rating information display standards for State Exchanges and amended the periodic data matching requirements.

In the January 19, 2021 **Federal Register** (86 FR 6138) (part 1 of the 2022 Payment Notice), we finalized only a subset of the proposals in the 2022 Payment Notice proposed rule. In the May 5, 2021 **Federal Register** (86 FR 24140), we issued part 2 of the 2022 Payment Notice. In the September 27, 2021 **Federal Register** (86 FR 53412) (part 3 of the 2022 Payment Notice), in conjunction with the Department of the Treasury, we finalized amendments to certain policies in part 1 of the 2022 Payment Notice.

In the May 6, 2022 **Federal Register** (87 FR 27208), we finalized changes to maintain the user fee rate for issuers offering plans through the FFEs and maintain the user fee rate for issuers offering plans through the SBE-FPs for the 2023 benefit year. We also finalized various policies to address certain agent, broker, and web-broker practices and

conduct. We also finalized updates to the requirement that all Exchanges conduct SEP verifications.

In the 2024 Payment Notice, issued in the April 27, 2023 **Federal Register** (88 FR 25740), we revised Exchange Blueprint approval timelines, lowered the user fee rate for QHPs in the FFEs and SBE-FPs, and amended re-enrollment hierarchies for enrollees. We finalized a requirement that all plans seeking certification on the Exchanges utilize a provider network. We also finalized policies to update FFE and SBE-FP standardized plan options; reduce the risk of plan choice overload on the FFEs and SBE-FPs by limiting the number of non-standardized plan options that issuers may offer through Exchanges on the Federal platform; and ensure correct QHP information. In addition, we amended coverage effective date rules, lengthened the SEP from 60 to 90 days for those who lose Medicaid coverage, and prohibited QHPs on FFEs and SBE-FPs from terminating coverage mid-year for dependent children who reach the applicable maximum age. We also finalized policies on verifying consumer income and permitting door-to-door assisters to solicit consumers. We finalized provider network and ECP policies for QHPs.

In the 2025 Payment Notice, issued in the April 15, 2024 **Federal Register** (89 FR 26218), we required a State seeking to operate a State Exchange to first operate an SBE-FP for at least one plan year, revised Exchange Blueprint requirements for States transitioning to a State Exchange, established additional minimum standards for Exchange call center operations, and required an Exchange to operate a centralized eligibility and enrollment platform on its website. We required State Exchanges and State Medicaid agencies to remit payment to HHS for their use of certain income data, amended re-enrollment hierarchies for enrollees enrolled in catastrophic coverage, revised the parameters around a State Exchange adopting an alternative open enrollment period, and extended the availability of a SEP for APTC-eligible qualified individuals with a projected annual household income no greater than 150 percent of the FPL. We finalized provider network adequacy policies applicable to such Exchanges for Plan Year (PY) 2026 and subsequent plan years. We finalized the policy to maintain FFE and SBE-FP standardized plan option metal levels from the 2024 Payment Notice and finalized an exceptions process to the limitation on non-standardized plan options in FFEs and SBE-FPs. We also finalized the

requirement for Exchanges to provide notification to enrollees or their tax filers who have failed to file their Federal income taxes and reconcile APTC for 1 tax year.

In the 2026 Payment Notice, published in the January 15, 2025 **Federal Register** (90 FR 4424), we codified a timeliness standard for State Exchanges to review and resolve enrollment data inaccuracies at § 155.400(d)(1), finalized at § 155.1000 that an Exchange may deny certification to any plan that does not meet the criteria at § 155.1000(c), and revised the standards at § 155.1090 for an issuer to request a reconsideration of a denial of certification specific to the FFEs. We also finalized publicly releasing certain data and information that State Exchanges submit to HHS, affirmed that CSR loading practices permitted by State regulators are permissible under Federal law to the extent that they are actuarially justified and the issuer does not receive reimbursement for such CSR, and finalized that we will only release a single, final version of the AV Calculator. We also updated the standardized plan option designs for PY 2026 to ensure these plans continue to have AVs within the permissible *de minimis* range for each metal level, amended § 156.201 to require issuers to meaningfully differentiate standardized plan options from one another, and finalized that HHS would conduct ECP certification reviews in States performing plan management functions beginning PY 2026. We also finalized updates affecting the exchanges in the 2025 Marketplace Integrity and Affordability final rule issued in the June 25, 2025 **Federal Register** (90 FR 27074).

6. Essential Health Benefits

We established requirements relating to EHB in the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule, which was issued in the February 25, 2013 **Federal Register** (78 FR 12834) (EHB Rule). We established at § 156.135(a) that AV is generally to be calculated using the AV Calculator developed and made available by HHS for a given benefit year. In the 2015 Payment Notice (79 FR 13743), we established at § 156.135(g) provisions for updating the AV Calculator in future plan years. In the 2017 Payment Notice (81 FR 12349), we amended the provisions at § 156.135(g) to allow for additional flexibility in our approach and options for updating of the AV Calculator.

In the 2025 Payment Notice, issued in the April 15, 2024 **Federal Register** (89

FR 26218), we revised § 155.170(a) to codify that benefits covered in a State's EHB-benchmark plan are not considered in addition to EHB, even if they had been required by State action taking place after December 31, 2011, other than for purposes of compliance with Federal requirements. We finalized three revisions to the standards for State selection of EHB-benchmark plans for benefit years beginning on or after January 1, 2026: revising the typicality standard at § 156.111 for States to demonstrate that their new EHB-benchmark plan provides a scope of benefits that is equal to that of a typical employer plan in the State; revising requirements such that States do not need to submit a formulary drug list as part of their application unless they are changing their prescription drug EHB; and consolidating options for States to change their EHB-benchmark plans. At § 156.115(d), we removed the prohibition on issuers from including 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.

7. Quality Improvement Strategy

We issued regulations in § 155.200(d) to direct Exchanges to evaluate quality improvement strategies, and § 156.200(b) to direct QHP issuers to implement and report on a quality improvement strategy or strategies consistent with section 1311(g) standards as QHP certification criteria for participation in an Exchange. In the 2016 Payment Notice, issued in the February 27, 2015 **Federal Register** (80 FR 10749), we finalized regulations at § 156.1130 to establish standards and the associated timeframe for QHP issuers to submit the necessary information to implement quality improvement strategy standards for QHPs offered through an Exchange. In the 2026 Payment Notice, published in the January 15, 2025 **Federal Register** (90 FR 4424), we finalized sharing summary-level QIS information publicly on an annual basis beginning on January 1, 2026, with information QHP issuers submit during the PY 2025 QHP Application Period.

8. Medical Loss Ratio (MLR)

We published a request for comment on section 2718 of the PHS Act in the April 14, 2010 **Federal Register** (75 FR

19297), and published an interim final rule with a 60-day comment period relating to the MLR program on December 1, 2010 (75 FR 74863). A final rule with a 30-day comment period was published in the December 7, 2011 **Federal Register** (76 FR 76573). An interim final rule with a 60-day comment period was published in the December 7, 2011 **Federal Register** (76 FR 76595). A final rule was published in the May 16, 2012 **Federal Register** (77 FR 28790). The MLR program requirements were amended in final rules published in the March 11, 2014 **Federal Register** (79 FR 13743), the May 27, 2014 **Federal Register** (79 FR 30339), the February 27, 2015 **Federal Register** (80 FR 10749), the March 8, 2016 **Federal Register** (81 FR 12203), the December 22, 2016 **Federal Register** (81 FR 94183), the April 17, 2018 **Federal Register** (83 FR 16930), the May 14, 2020 **Federal Register** (85 FR 29164), the May 5, 2021 **Federal Register** (86 FR 24140), and the May 6, 2022 **Federal Register** (87 FR 27208), and an interim final rule that was published in the September 2, 2020 **Federal Register** (85 FR 54820).

B. Summary of Major Provisions

The regulations outlined in this proposed rule would be codified in 42 CFR part 600, and 45 CFR parts 150, 153, 155, 156 and 158.

1. 42 CFR Part 600

We propose to make updates in 42 CFR 600.5 to align BHP regulations with section 71301 of the WFTC legislation. Section 71301 of the WFTC legislation amended section 36B of the Code to provide that a PTC is allowed for the QHP coverage of a noncitizen lawfully present only if he or she is an “eligible alien”, effective for plan years beginning on or after January 1, 2027. Because Federal BHP payments to States are based in part on the amount of PTC an individual enrolled in the BHP is eligible for and would have qualified for had he or she been enrolled in a QHP through an Exchange, only lawfully present noncitizens who are considered to be “eligible aliens” will generate Federal BHP payments to the State. We propose to add a new definition of “eligible noncitizen at 42 CFR 600.5, cross-referencing 45 CFR 155.20.

2. 45 CFR Part 153

In accordance with the OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2026, the HHS-operated risk adjustment program is subject to the fiscal year 2026

sequestration.¹¹ Therefore, the HHS-operated risk adjustment program will sequester payments made from fiscal year 2026 resources (that is, funds collected during the 2026 fiscal year) at a rate of 5.7 percent.

We propose to recalibrate the 2027 benefit year HHS risk adjustment models using the 2021, 2022, and 2023 benefit year enrollee-level EDGE data and solicit comment on whether we should retain separate risk adjustment transfer calculations under the State payment transfer formula for individual catastrophic plans and individual non-catastrophic plans. We also propose a risk adjustment user fee rate for the 2027 benefit year of \$0.20 per member per month (PMPM).

We propose to modify one intermediate step of the HHS–RADV error estimation methodology starting with 2025 benefit year HHS–RADV to add an additional scaling factor to appropriately estimate the proportion of the issuer's total plan liability risk score (PLRS) that is HCC-related after the removal of no HCC enrollees from the IVA sample beginning with 2025 benefit year HHS–RADV, as finalized in the 2026 Payment Notice (90 FR 4424).

3. 45 CFR Part 154

We propose to require issuers that intend to load rates to account for unpaid CSRs for the applicable rating year to submit certain information related to CSR loading in their Unified Rate Review Templates (URRTs) and the Actuarial Memoranda for each filing year in which CSRs are not funded beginning with PY 2027 rate filings.¹²

4. 45 CFR Part 155

We propose to remove the requirement at § 155.105(b)(4) that a State seeking to operate a State Exchange must first operate an SBE–FP for at least one plan year.

We propose to amend § 155.106(a)(2) to rescind the requirement that as part of a State's activities for its establishment of a State Exchange, the State must provide supporting documentation demonstrating progress toward meeting or implementing State Exchange Blueprint requirements, given preexisting processes per the State Blueprint Application¹³ for CMS to collect supporting documentation from

a State as part of a State Exchange implementation efforts.

We propose to amend § 155.170(a) to provide that beginning with PY 2027, a State-required benefit would be considered “in addition to EHB” (and thus not EHB) if it is: required by a State action taking place after December 31, 2011; applicable to the small group and/or individual markets; specific to required care, treatment, or services; and not required by State action for purposes of compliance with Federal requirements. Under this proposal, such State-required benefits would be considered in addition to EHB regardless of whether the required benefits are embedded in the State's EHB-benchmark plan. We also propose revisions to the regulatory text at §§ 155.170(a)(2) and 156.115(a) to align with this proposal.

We propose amendments to § 155.205(b) to amend the requirement that a State Exchange operate a centralized eligibility and enrollment consumer interface on the Exchange's website for an individual to submit a single streamlined eligibility application and subsequently select a QHP following a determination of eligibility. Under this proposal, a State Exchange could choose to operate a centralized eligibility and enrollment consumer interface on the Exchange's website through which individuals may submit an application and enroll in a QHP, or a State Exchange could provide such functionality exclusively through one or more State Exchange-approved consumer websites operated by a web-broker. . . .

We propose at § 155.221(k) that State Exchanges may elect a new EDE option (SBE–EDE option), in which a State Exchange could seek HHS approval to allow web-brokers to operate enrollment websites as the exclusive pathway through which consumers can apply, receive an eligibility determination from the Exchange, and purchase an individual market QHP offered through the Exchange with APTC and CSRs, if otherwise eligible.

We propose changes to the existing regulatory authority under § 155.220(j)(2)(ii) and (iii) to require agents, brokers, and web-brokers to use an HHS-approved and created consumer consent form to meet the eligibility application review requirements and consumer consent documentation requirements.¹⁴ Our proposal would eliminate the current flexibility, which allows agents, brokers, and web-brokers to use their own standards and templates for documentation

requirements, and instead sets a universal standard that requires agents, brokers, and web-brokers to use the HHS-approved and created consumer consent form.¹⁵ We also propose to revise § 155.220(j)(2)(ii) and (j)(2)(iii) to clarify what constitutes a consumer “taking an action” for eligibility application review and confirmation and providing consumer consent.

We propose several new provisions at § 155.220(j)(3) to establish more robust standards of conduct related to the marketing practices of agents, brokers, and web-brokers which would include examples of prohibited marketing practices. Furthermore, we propose to require agents, brokers, and web-brokers to provide HHS marketing documentation in response to monitoring, audit, and enforcement activities. We also propose to notify agents, brokers, and web-brokers that they may be held responsible for marketing content created, written, released, or otherwise produced by an entity on their behalf.

We propose to discontinue the vendor program, which allows for certain training and information verification functions to be provided by HHS-approved vendors. To accomplish this, we propose removing § 155.222.

We propose to make updates in § 155.20, § 155.305(f)(1), and § 155.320 to align Exchange regulations with section 71301 of the WFTC legislation. Section 71301 of the WFTC legislation amended section 36B of the Code to provide that PTC is allowed for the QHP coverage of a lawfully present noncitizen only if such noncitizen is an “eligible alien.” It also makes conforming amendments to section 1411 of the Affordable Care Act requiring Exchanges to verify applicants’ “eligible alien” status effective for taxable years beginning after December 31, 2026. We propose to add a new definition in § 155.20, to update our APTC eligibility regulations at § 155.305(f)(1), and to add to our verification regulations in § 155.320 to align Exchange eligibility and verification rules with section 71301 of the WFTC legislation. This proposal would also impact Federal payments to States effective January 1, 2027 for individuals enrolled in the BHP who are lawfully present noncitizens but are not “eligible aliens,” as Federal payments to States for these individuals are also no longer allowed.

¹¹ OMB. (2025). *OMB Report to the Congress on the BBEDCA 251A Sequestration for Fiscal Year 2026*. <https://www.whitehouse.gov/wp-content/uploads/2025/04/OMB-Report-to-the-Congress-on-the-BBEDCA-251A-Sequestration-for-Fiscal-Year-2026.pdf>.

¹² CMS 10379/OMB Control Number: 0938–1141.

¹³ CMS–10416/OMB control number: 0938–1172.

¹⁴ CMS–10840/OMB Control Number: 0938–1438.

¹⁵ For the current HHS-approved and created form, see CMS Model Consent Form for Marketplace Agents, Brokers, Web-brokers, and Agencies. Available at <https://www.cms.gov/files/document/cms-model-consent-form-marketplace-agents-and-brokers.pdf>.

To align Exchange regulations with section 71302 of the WFTC legislation, we propose to remove § 155.305(f)(2) and make conforming updates to § 155.320(c)(3)(iii)(A) and 155.420(d)(13). Section 71302 of the WFTC legislation amended section 36B(c) of the Code to provide that PTC is no longer allowed for noncitizens lawfully present in the United States who were ineligible for Medicaid due to their immigration status and have household income below 100 percent of the FPL. Removing § 155.305(f)(2) and updating § 155.320(c)(3)(iii)(A) would align Exchange APTC eligibility and verification rules with section 71302 of the WFTC legislation. This proposal would also impact Federal payments to States for individuals enrolled in the BHP who are ineligible for Medicaid due to their immigration status and with household income below 100 percent of the FPL, for whom Federal payments to States are also no longer allowed.

We propose to revise the failure to file and reconcile process at § 155.305(f)(4) such that Exchanges on the Federal platform would conduct the 1-year policy beginning in PY 2027. State Exchanges would have the option to conduct either the 1-year or 2-year policy in PY 2027, but would be required to conduct the 1-year policy beginning in PY 2028). Under the 1-year policy, if finalized, an Exchange 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 proposal would align with the statutory requirement in section 71303 of the WFTC legislation that effectively requires Exchanges to follow the 1-year policy as a requirement for a month to be a coverage month under section 36B of the Code as of PY 2028. We are also proposing to remove the notice requirement at § 155.305(f)(4)(ii) for PY 2027 to conform with the notice policy under the PY 2026 policy.

We seek comment on considerations for future policy development and implementation under section 71303 of the WFTC legislation, which imposes new requirements on Exchanges related to eligibility verification. Specifically, we seek comment on: operational considerations for interested parties; effective rollout and communications; required timelines for interested parties to comply with the law; anticipated complexity, costs, burden, enrollment

impacts; and any State-specific considerations.

We propose to revise § 155.320(c) such that all Exchanges are required to continue conducting the income verifications changes introduced in the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability final rule (90 FR 27074) (the 2025 Marketplace Integrity and Affordability final rule) in PY 2027 and beyond. Specifically, we propose updating § 155.320(c)(3)(iii) and § 155.320(c)(3)(vi)(C)(2) to extend the requirement indefinitely to create income data matching issues (DMIs) when trusted data sources indicate that projected consumer household income is under 100 percent of the FPL. Additionally, we propose removing § 155.320(c)(5), which outlines the requirement to accept the annual household income attestation when no tax data is returned for a household.

We seek comment on whether we should regulate the option for issuers to implement the fixed-dollar and/or gross percentage-based premium payment thresholds in § 155.400(g) for PY 2027 and beyond. Currently, issuers are only able to implement a net premium percentage-based premium threshold for PY 2026, and effective January 1, 2027, issuers will be able to implement the fixed-dollar and/or either net or gross premium percentage-based thresholds, which was finalized in the 2025 Marketplace Integrity and Affordability final rule.

We propose to remove § 155.420(d)(16) such that Exchanges would continue to be prohibited from offering the 150 percent FPL SEP in PY 2027 and beyond, in alignment with section 71304 of the WFTC legislation. We propose to make conforming amendments at §§ 155.420(a)(4)(ii)(D), 155.420(b)(2)(vii), and 155.420(a)(4)(iii).

We propose to revise § 155.420(g) to remove the restriction for Exchanges on the Federal platform to only conduct Special Enrollment Period Verification (SEPV) for Loss of Minimum Essential Coverage (MEC). We also propose to require Exchanges on the Federal platform to conduct SEPV for at least 75 percent of new enrollments. These proposals were finalized in the 2025 Marketplace Affordability and Integrity rule but were stayed in *City of Columbus et. al. v. Kennedy et. al.*¹⁶ We are therefore reproposing these provisions.

We propose to amend § 155.605 to codify and expand hardship exemption eligibility. Specifically, this proposal

would allow individuals who are ineligible for APTC or CSRs due to projected household income below 100 percent or above 250 percent of the FPL to qualify for a hardship exemption under § 155.605(d)(1)(iii). This change would allow individuals aged 30 and older who receive this hardship exemption to enroll in catastrophic coverage, if otherwise eligible.

We propose, for plan years beginning on or after January 1, 2027, to amend § 155.1050(a)(2) to remove the requirements at § 155.1050(a)(2)(i) and (ii) that State Exchanges and SBE-FPs establish and impose quantitative time and distance network adequacy standards that are at least as stringent as standards for QHPs participating on the FFEs and to no longer require State Exchanges and SBE-FPs to conduct quantitative network adequacy reviews to evaluate a plan's compliance with certain network adequacy standards under § 156.230 prior to certifying any plan as a QHP. Instead, we propose to restore the requirement at § 155.1050(a)(2) that State Exchanges and SBE-FPs ensure that each QHP provides sufficient access to providers in a manner that meets applicable standards consistent with § 156.230(a)(1)(ii) and (a)(1)(iii) for network plans, or proposed § 156.236(a) for non-network plans, as applicable. We also propose at new § 155.1050(d) to defer provider access reviews of QHP issuers, with or without a provider network, applying for certification as a QHP to be offered through the FFE to FFE States that elect to conduct such reviews, should the FFE State demonstrate sufficient authority and the technical capacity to conduct such reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program under proposed § 155.1050(d)(2) through (d)(4).

We propose to implement new requirements for an Effective Essential Community Provider Review Program by adding § 155.1051. Under this proposal, FFE States may elect to conduct their own ECP certification reviews of issuers with or without a provider network that are applying for certification to be offered as a QHP through an FFE, including in States performing plan management. In order to conduct their own reviews, we propose that FFE States would be required to demonstrate that they have sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective Essential Community Provider Review Program under proposed § 155.1051.

¹⁶ *City of Columbus v. Kennedy*, 796 F. Supp. 3d 123, 159–60 (D. Md. 2025).

We propose to amend § 155.1200(d) and add new paragraph (e) to permit State Exchanges to satisfy certain requirements of the independent external programmatic audit, as outlined in paragraph (d), by completing the SEIPM process that would be established at 45 CFR 155, subpart Q.

We propose to add new subpart Q (§§ 155.1600 through 1650) to establish the SEIPM program. The Payment Integrity Information Act of 2019 (PIIA) requires Federal agencies to annually review, measure, and report on the programs they administer that have been determined to be susceptible to significant improper payments. To satisfy the requirements of PIIA, we are proposing to measure improper payments of APTC that are administered by State Exchanges and to annually report statistically valid improper payment estimates in the HHS Agency Financial Report.

5. 45 CFR part 156

We propose the 2027 benefit year FFE and SBE-FP user fee rates of 2.5 percent and 2.0 percent of total monthly premiums, respectively.

We are pausing review of State applications to select EHB-benchmark plans in accordance with § 156.111. We are reviewing section 1302 of the Affordable Care Act and are considering future rulemaking to revise § 156.111 and EHB standards more broadly.

We propose to revise § 156.115(d) to prohibit issuers from including routine non-pediatric dental services as an EHB.

We propose to modify the requirements for catastrophic plans in § 156.155 to specify that a catastrophic plan has a plan term of either 1 year, or of multiple consecutive years not to exceed 10 years. We propose that catastrophic plans with terms of at least 2 years may utilize value-based insurance designs to offer benefits for preventive services pursuant to section 2713(c) of the PHS Act, without the beneficiary having to first satisfy their deductible or annual cost-sharing limitation. We also propose to amend § 156.130 to specify that, in the case of a catastrophic plan with a consecutive multi-year term, the annual limitation on cost sharing for the initial plan year of the contract may apply on an annual basis, or over the life of the contract. In the latter case, the limitation applicable to the specific plan year under each plan year of the coverage would be divided by 12 to determine the monthly limit on cost sharing under the plan. Further, we propose to amend § 156.80 to permit issuers of multi-year catastrophic plans to make a plan-level

adjustment to the index rate that reflects the length of the entire term.

To address an issue that has arisen in the implementation of section 1302(c) through (e) of the Affordable Care Act, we propose changes to the permissible cost-sharing parameters for individual market bronze plans through new proposed § 156.136 and to the required cost-sharing parameters for catastrophic plans through revisions to § 156.155(a)(3).

We propose to remove the following from our regulations effective beginning in PY 2027: the definition of “standardized options” at § 155.20; all requirements pertaining to standardized plan options at § 156.201; the differential display of standardized plan options on *HealthCare.gov* at § 155.205(b)(1); the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE-FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv); the annual design and publication of these standardized plan options in the applicable Payment Notice for each plan year; and non-standardized plan option limits and exceptions at § 156.202.

We propose to revise the network adequacy and ECP standards at §§ 156.230 and 156.235 to make clear that these sections contain the provider access standards for all individual market QHPs and stand-alone dental plans (SADPs) and all Small Business Health Options Program (SHOP) QHPs across all QHP issuers that use a network of providers. We also propose to revise these sections to remove the requirement that all QHPs must use a network of providers.

Additionally, we propose to revise § 156.230 to provide that HHS would continue to conduct network adequacy reviews using standards described at § 156.230 for QHP issuers that use a provider network in FFE States that do not elect to conduct such reviews, or in FFE States that HHS has determined do not satisfy the criteria to be considered to have an Effective Provider Access Review Program, as described at proposed § 155.1050(d). We also propose to add new § 156.236 to allow plans that do not use a network (non-network plans) to receive QHP certification by demonstrating that they ensure a sufficient choice of providers that accept the non-network plan’s benefit amount as payment in full, and reasonable and timely access to ECPs that accept the plan’s benefit amount as payment in full. Proposed § 156.236 would set forth provider access and ECP

standards for assessing whether non-network plans provide sufficient choice of providers.

For PY 2027 and subsequent plan years, we propose changes to the QHP certification requirements with respect to essential community providers (ECPs) included within a network plan issuer’s provider network. First, we propose to reduce the minimum percentage requirement from 35 to 20 percent for both medical QHP and SADP issuers, such that issuers would be required to contract with at least 20 percent of available ECPs in each plan’s service area to participate in the plan’s network, and separately, at least 20 percent of available Federally Qualified Health Centers (FQHCs) and 20 percent of available family planning providers that qualify as ECPs in the plan’s service area. Additionally, we propose to modify the narrative justification requirements at §§ 156.235(a)(3) and 156.235(b)(3) to be consistent with systems changes and existing QHP issuer ECP data submission requirements as part of ECP certification reviews.

We propose to modify § 156.480(c) to clarify HHS’ authority to audit or conduct a compliance review of an issuer that offers a QHP through an Exchange for the purposes of administering and providing oversight of the APTC, CSR, and user fee programs. We also propose that HHS may conduct a compliance review to assess issuers’ compliance with requirements related to these programs as needed or on an annual basis rather than only on an ad hoc basis.

We propose to amend § 156.805(b) to reiterate in § 156.805(b) that in determining the amount of CMPs, in addition to the factors HHS takes into account when determining a CMP amount listed in § 156.805(b)(1) through (3), HHS would identify the lawful purpose or purposes of the CMP. We also propose to amend the introductory text of § 150.317 to make corresponding edits with respect to the factors HHS considers when determining the amount of CMPs as enforcement remedies against issuers more broadly or other responsible entities, such as a non-Federal governmental plan sponsor that is subject to applicable PHS Act requirements. In addition, we propose to amend § 156.805(f) to reiterate that HHS has the authority to impose CMPs against issuers in a State Exchange or SBE-FP for an identified violation of any Exchange requirements applicable to issuers offering a QHP in an Exchange, when a State notifies HHS that it is not enforcing these requirements or HHS determines that a

State is failing to substantially enforce these requirements.

We propose to amend § 156.903 to provide the option for an administrative law judge (ALJ) to issue subpoenas, upon his or her own motion or at the request of a party, if reasonably necessary for the full presentation of a case and to add procedures governing the process for issuing subpoenas. We also propose to amend § 156.935 to ensure that the discovery provisions set forth therein do not apply to administrative appeals of proposed CMPs for violations identified through audits of the APTC, cost sharing reduction, or user fee programs conducted in accordance with § 156.480(c).

We propose to require QHP issuers to submit QISs addressing any two of the five topic areas listed in section 1311(g)(1) of the Affordable Care Act, without mandating which specific topics areas a QHP issuer would be required to address to meet the QIS statutory certification requirement, beginning with PY 2027.

We propose to amend § 156.1215(b) to provide that CMPs assessed against health coverage issuers and their affiliates under the same taxpayer identification (TIN) number would be subject to netting as part of HHS' integrated monthly payment and collection cycle. We also propose to amend § 156.1215(c) to provide that any amount owed to the Federal Government by an issuer and its affiliates for unpaid CMP amounts, after HHS nets amounts owed by the Federal Government, would be the basis for calculating the debt.

6. 45 CFR part 158

We solicit comment on the impact of the Federal MLR standard on individual market stability and whether HHS should use its authority under section 2718(b)(1)(A)(ii) of the PHS Act and § 158.301 to adjust the MLR standard in a State to promote individual market stability. We also solicit comment on whether and how to amend regulations allowing States to request an adjustment to the MLR standard in their individual market to reduce burden and encourage States to request adjustments as appropriate in their State markets.

III. Provisions of the Proposed Regulations

A. Part 150—CMS Enforcement in Group and Individual Insurance Markets

1. Factors CMS Uses To Determine the Amount of a Civil Money Penalty (CMP) (§ 150.317)

To align with the proposal discussed in section III.F.14 of this proposed rule, which would reiterate in § 156.805(b) what factors HHS considers when determining the amount of CMPs as enforcement remedies against QHP issuers in Exchanges, we propose a conforming amendment to § 150.317 introductory text to clarify that HHS, through CMS, will identify the lawful purpose or purposes of the penalty, and take into account the enumerated factors as appropriate for the circumstances. In proposing the conforming edits to § 150.317, we do not propose other changes to the legal bases and procedural processes for imposing CMPs.

We request comment on this proposal.

B. Part 153—Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

In subparts A, B, D, G, and H of part 153, we established standards for the administration of the risk adjustment program. The risk adjustment program is a permanent program created by section 1343 of the Affordable Care Act that transfers funds from issuers of risk adjustment covered plans that have lower-than-average risk enrollees to issuers of risk adjustment covered plans that have higher-than-average risk enrollees, which includes issuers with plans in the individual, small group, or merged markets, inside and outside the Exchanges. In accordance with § 153.310(a), a State that is approved or conditionally approved by the Secretary to operate an Exchange may establish a risk adjustment program or have HHS do so on the State's behalf.¹⁷ HHS did not receive any requests from States to operate risk adjustment for the 2027 benefit year. Therefore, HHS will operate risk adjustment in every State and the District of Columbia for the 2027 benefit year.

1. Sequestration

In accordance with the OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2026, the HHS-operated risk adjustment program is subject to the fiscal year 2026

sequestration.¹⁸ The Federal Government's 2026 fiscal year began on October 1, 2025. Therefore, the HHS-operated risk adjustment program is sequestered at a rate of 5.7 percent for payments made from fiscal year 2026 resources (that is, funds collected during the 2026 fiscal year).

HHS, in coordination with OMB, has determined that, under section 256(k)(6) of the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA),¹⁹ as amended, and the underlying authority for the HHS-operated risk adjustment program, the funds that are sequestered in fiscal year 2026 from the HHS-operated risk adjustment program will become available for payment to issuers in fiscal year 2027 without further congressional action. If Congress does not enact deficit reduction provisions that replace the Joint Committee reductions, the program would be sequestered in future fiscal years, and any sequestered funding would become available in the fiscal year following that year in which the funds were sequestered.

Additionally, we note that the Infrastructure Investment and Jobs Act²⁰ amended section 251A(6) of the BBEDCA to extend the sequestration first mandated under the Budget Control Act of 2011 for all non-exempt direct spending programs, including the HHS-operated risk adjustment program, through fiscal year 2031 at a rate of 5.7 percent per fiscal year.²¹

2. HHS Risk Adjustment (§ 153.320)

The HHS risk adjustment models predict plan liability for an average enrollee based on that person's age, sex, and diagnoses (also referred to as hierarchical condition categories (HCCs)), producing a risk score. The State payment transfer formula²² that is

¹⁸ OMB. (2025). *OMB Report to the Congress on the BBEDCA 251A Sequestration for Fiscal Year 2026*. <https://www.whitehouse.gov/wp-content/uploads/2025/04/OMB-Report-to-the-Congress-on-the-BBEDCA-251A-Sequestration-for-Fiscal-Year-2026.pdf>.

¹⁹ Public Law 99–177, 99 Stat. 1037 (1985).

²⁰ Public Law 117–58, section 90001(1), 135 Stat. 429, 1341 (2021), codified at 2 U.S.C. 901a(6)(B).

²¹ Section 251A(6)(B) of the Balanced Budget and Emergency Deficit Control Act, 2 U.S.C. 901a(6)(B), as amended, requires sequestration of non-exempt direct spending programs, excluding Medicare, through fiscal year 2031 at a uniform percentage calculated by OMB to be necessary to meet certain deficit reduction targets in fiscal year 2021. That uniform percentage was calculated to be 5.7 percent in the OMB Report to the Congress on the Joint Committee Reductions for Fiscal Year 2021.

²² The State payment transfer formula refers to part of the Federally certified risk adjustment methodology that applies in States where HHS is responsible for operating the program. The formula calculates payments and charges at the State market

Continued

¹⁷ See also 42 U.S.C. 18041(c)(1).

part of the HHS Federally certified risk adjustment methodology utilizes separate models for adults, children, and infants to account for clinical and cost differences in each age group.

In the adult and child models, the relative risk assigned to an individual's age, sex, and diagnoses are added together to produce an individual risk score. Additionally, to calculate enrollee risk scores in the adult models, we added enrollment duration factors beginning with the 2017 benefit year,²³ and prescription drug categories (RXC) beginning with the 2018 benefit year.²⁴ Starting with the 2023 benefit year, we removed the severity illness factors in the adult models and added interacted HCC count factors (that is, additional factors that express the presence of a severity or transplant HCC in combination with a specified number of total payment HCCs or HCC groups on the enrollee's record) to the adult and child models²⁵ applicable to certain severity and transplant HCCs (87 FR 27224 through 27228).²⁶ Starting with the 2026 benefit year (90 FR 4424 at 4438), we added a new type of model factor in the adult and child models to account for risk associated with non-demographic enrollee characteristics that do not indicate the presence of a specific active medical condition. We referred to the new type of factor as an "affiliated cost factor" (ACF), thereby distinguishing this new type of factor from RXCs and HCCs, which do indicate the presence of a specific active medical condition.

Infant risk scores are determined by inclusion in one of 25 mutually exclusive groups, based on the infant's maturity and the severity of diagnoses. If applicable, the risk score for adults, children, or infants is multiplied by a cost-sharing reduction (CSR) adjustment

risk pool level (prior to the calculation of the high-cost risk pool payments and charges that apply beginning with the 2018 benefit year). See, for example, 81 FR 94080.

²³ For the 2017 through 2022 benefit years, there is a set of 11 binary enrollment duration factors in the adult models that decrease monotonically from 1 to 11 months, reflecting the increased annualized costs associated with fewer months of enrollments. See, for example, 81 FR 94071 through 94074. These enrollment duration factors were replaced beginning with the 2023 benefit year with HCC-contingent enrollment duration factors for up to 6 months in the adult models. See, for example, 87 FR 27228 through 27230.

²⁴ For the 2018 benefit year, there were 12 RXCs, but starting with the 2019 benefit year, the two severity-only RXCs were removed from the adult models. See, for example, 83 FR 16941.

²⁵ See Table 1 for a list of factors in the adult models and Table 2 for a list of factors in the child models.

²⁶ Also see Table 3.

factor.²⁷ The enrollment-weighted average risk score of all enrollees in a particular risk adjustment covered plan (also referred to as the plan liability risk score (PLRS)) within a geographic rating area is one of the inputs into the State payment transfer formula, which determines the State transfer payment or charge that an issuer will receive or be required to pay for that plan for the applicable State market risk pool for a given benefit year. Thus, the HHS risk adjustment models predict average group costs to account for risk across plans, in keeping with the Actuarial Standards Board's Actuarial Standards of Practice for risk classification.

a. Data for HHS Risk Adjustment Model Recalibration for the 2027 Benefit Year

We propose to recalibrate the 2027 benefit year HHS risk adjustment models with the 2021, 2022, and 2023 benefit years' enrollee-level EDGE data. Consistent with the approach outlined in the 2020 Payment Notice (84 FR 17454, 17464), we propose to recalibrate the HHS risk adjustment models for the 2027 benefit year using only enrollee-level EDGE data, and to continue to use blended, or averaged, coefficients from

²⁷ For unique State-specific plans, we apply the CSR adjustment factors that correspond to each plan's AV. See, e.g., the 2025 Payment Notice, 89 FR at 26252–26253. However, a different approach is taken for States whose State-specific plans take the form of Medicaid expansion plans offered on the Exchange (for example, Arkansas), because these Medicaid-expansion plans are identical in all their parameters, including AV and degree of plan liability, to other plans offered on the Exchange in those States and are differentiated from their comparable plans only in eligibility criteria, plan enrollment selection, and sources of funding. *Ibid.* Footnote 79 of the 2025 Payment Notice (89 FR 26253), erroneously stated that, "we would use the proposed CSR adjustment factor of 1.12 for Arkansas 94 percent AV Medicaid-expansion plans and the proposed CSR adjustment factor that corresponds to the silver metal level zero cost sharing variants (that is, the proposed 1.46 CSR adjustment factor for zero cost sharing variants) for Arkansas 100 percent AV Medicaid-expansion plans in the plan liability risk score calculation." See https://regtap.cms.gov/reg_library.php?i=4690. Arkansas 100 percent AV Medicaid-expansion plan features remain more similar to the 94 percent silver plan variant than to the silver metal level zero cost sharing variant for AI/AN enrollees. Therefore, for both the 94 and 100 percent Medicaid-expansion plans in Arkansas, we use the same CSR adjustment factor of 1.12 used for the 94 percent silver plan variant CSR adjustment factor in the plan liability risk score calculation. We will continue to align the CSR adjustment factor for both the 94 and 100 percent Medicaid-expansion plans in Arkansas with the 94 percent silver plan variant CSR adjustment factor for the 2027 benefit year and beyond unless the AVs for these unique Arkansas-specific plans change. More information on the CSR factors used for CSR plan variants, including state program CSR variants, can be found in the applicable Risk Adjustment HHS-Developed Risk Adjustment Model Algorithm "Do It Yourself (DIY)" Software instructions, available at: <https://www.cms.gov/marketplace/resources/regulations-guidance#Premium-Stabilization-Programs>.

3 years of separately solved models for the 2027 benefit year model recalibration. Additionally, as outlined in the 2022 Payment Notice (86 FR 24140, 24152), we propose to use the 3 most recent consecutive years of enrollee-level EDGE data that are available at the time we estimate the draft recalibrated coefficients published in the proposed rule for the applicable benefit year.²⁸ We believe this promotes stability, meets the goal of the HHS-operated risk adjustment program, and allows issuers more time to incorporate this information when pricing their plans for the upcoming benefit year.

Consistent with our prior approach when a new benefit year of enrollee-level EDGE data becomes available,²⁹ we performed reviews of the 2023 benefit year enrollee-level EDGE data to identify potential anomalies prior to incorporating the 2023 benefit year enrollee-level EDGE data as part of the proposed recalibration of the HHS risk adjustment models. Our review did not identify systematic anomalies in the 2023 benefit year enrollee-level EDGE data. Therefore, after considering these analyses, we propose to determine coefficients for the 2027 benefit year HHS risk adjustment models based on a blend of separately solved coefficients from the 2021, 2022, and 2023 benefit years' enrollee-level EDGE data, with the costs of services identified from the data trended between the relevant year of data and the 2027 benefit year.^{30 31} The draft coefficients tables reflect the use of trended 2021, 2022, and 2023 benefit year enrollee-level EDGE data, as well as other HHS risk adjustment model updates (including, for example, the multi-year approach finalized in the 2026 Payment Notice (90 FR 4438 through 4440) to phase out the market

²⁸ Although we do receive the next year of enrollee-level EDGE data prior to the proposed rule, that data must go through several quality and analysis checks before it is useable for HHS risk adjustment model calibration.

²⁹ See, for example, the 2024 Payment Notice proposed rule (87 FR 78215 through 78216) and final rule (88 FR 25749 through 25753).

³⁰ Because EDGE data do not generally account for drug rebates per the EDGE Server Business Rules (ESBR) (available at https://regtap.cms.gov/reg_library.php?i=3765), for the purposes of risk adjustment recalibration, we also incorporate assumptions about drug rebates in our trending of prescription drug data.

³¹ We note that we apply some standard data exclusions to all years of enrollee-level EDGE data for the purposes of risk adjustment recalibration. For example, enrollees with at least one capitated claim in EDGE are excluded from recalibration because we have some concerns that the methods for computing and reporting derived amounts from capitated claims could be inconsistent across issuers and would not provide reliable or comparable data. See, e.g., the 2025 Payment Notice (89 FR 26252).

pricing adjustment to the plan liability associated with Hepatitis C drugs in the HHS risk adjustment models and align Hepatitis C drugs' trending with the trending approach for specialty drugs³²). However, we note that the draft coefficients could change between the proposed and final rule if we identify an error after publication of this proposed rule or if any proposed models are modified or not finalized in response to comments.³³ In addition, consistent with § 153.320(b)(1)(i), if we are unable to finalize the final coefficients in time for publication in the final rule, we would publish the final coefficients for the 2027 benefit

³² To begin this transition for the 2026 benefit year HHS risk adjustment models, we applied the specialty drug trend to 1 year of trending Hepatitis C treatment costs (that is, the trend from 2025 to 2026) for all 3 years of enrollee-level EDGE data used (that is, 2020, 2021, and 2022 benefit year enrollee-level EDGE data) in 2026 benefit year HHS risk adjustment model recalibration. To continue this transition for the 2027 benefit year HHS risk adjustment models, we would apply the specialty drug trend to 2 years of trending Hepatitis C treatment costs (that is, the trend from 2025 to 2026 and from 2026 to 2027) for all 3 years of enrollee-level EDGE data (that is, 2021, 2022, and 2023 benefit year enrollee-level EDGE data) proposed to be used in 2027 benefit year HHS risk adjustment model recalibration.

³³ If an error were identified after publication of a proposed rule or any proposed changes to the HHS risk adjustment models are modified or not finalized, updated coefficients would be published in the final rule or in guidance after the publication of the final rule consistent with § 153.320(b)(1)(i).

year in guidance soon after the publication of the final rule.

We seek comment on the proposal to determine 2027 benefit year coefficients for the HHS risk adjustment models based on a blend of separately solved coefficients from the 2021, 2022, and 2023 benefit year enrollee-level EDGE data.

b. Proposed List of Factors To Be Employed in the HHS Risk Adjustment Models (§ 153.320)

The proposed 2027 benefit year HHS risk adjustment model factors resulting from the equally weighted (averaged) blended factors from separately solved models using the 2021, 2022, and 2023 benefit year enrollee-level EDGE data are shown in Tables 1 through 6. The HHS risk adjustment adult, child, and infant models have been truncated to account for the high-cost risk pool payment parameters by removing 60 percent of costs above the \$1 million threshold.³⁴ Table 1 contains proposed factors for each adult model, including

³⁴ As finalized in the 2020 Payment Notice (84 FR 17466 through 17468), we will maintain the high-cost risk pool parameters for the 2020 benefit year and beyond, unless amended through notice-and-comment rulemaking. We do not propose changes to the high-cost risk pool parameters for the 2027 benefit year. Therefore, we will maintain the \$1 million threshold and 60 percent coinsurance rate for the 2027 benefit year.

the age-sex, HCC, RXC,³⁵ RXC-HCC interaction, interacted HCC count, ACF, and enrollment duration coefficients. Table 2 contains the proposed factors for each child model, including the age-sex, HCC, interacted HCC count, and ACF coefficients. Table 3 lists the proposed HCCs selected for the interacted HCC count factors that would apply to the HHS risk adjustment adult and child models. Table 4 contains the proposed factors for each HHS risk adjustment infant model. Tables 5 and 6 contain the HCCs included in the HHS risk adjustment infant models' maturity and severity categories, respectively.

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³⁵ In the 2026 Payment Notice, we incorrectly stated that for RXC eligibility (including medically administered injectable claims), a professional or outpatient medical claim does not need to have a risk adjustment eligible service code or bill type code. We subsequently updated the January 2025 version of the 2024 Benefit Year Risk Adjustment DIY software instructions (<https://www.cms.gov/files/document/cy2024-diy-instructions-01072025.pdf>) to reflect this erroneous statement. In the Final 2024 Risk Adjustment DIY software instructions updated April 9, 2025 (<https://www.cms.gov/files/document/cy2024-diy-instructions-04092025.pdf>), we corrected this error and clarified that the HCPCS-level file for RXC assignment can only be sourced from institutional inpatient and outpatient claims with RA-eligible bill types. We expect ACFs related to prescription drugs will be sourced using the same criteria as RXCs. We will announce changes to ESBR concerning RXC or ACF eligibility in future guidance documents or notice and comment rulemakings, as appropriate.

TABLE 1: Proposed Adult Risk Adjustment Model Factors for the 2027 Benefit Year

<i>Demographic Factors</i>						
	Age 21-24, Male	0.189	0.135	0.097	0.068	0.060
	Age 25-29, Male	0.201	0.142	0.100	0.067	0.059
	Age 30-34, Male	0.231	0.166	0.118	0.080	0.070
	Age 35-39, Male	0.252	0.183	0.130	0.088	0.076
	Age 40-44, Male	0.280	0.206	0.149	0.101	0.088
	Age 45-49, Male	0.322	0.244	0.183	0.132	0.118
	Age 50-54, Male	0.371	0.286	0.219	0.163	0.147
	Age 55-59, Male	0.413	0.322	0.250	0.188	0.171
	Age 60-64, Male	0.467	0.366	0.286	0.216	0.198
	Age 21-24, Female	0.278	0.196	0.132	0.082	0.067
	Age 25-29, Female	0.311	0.221	0.149	0.091	0.074
	Age 30-34, Female	0.384	0.288	0.209	0.144	0.126
	Age 35-39, Female	0.435	0.335	0.253	0.184	0.166
	Age 40-44, Female	0.484	0.379	0.292	0.216	0.195
	Age 45-49, Female	0.491	0.385	0.293	0.214	0.192
	Age 50-54, Female	0.506	0.397	0.302	0.219	0.197
	Age 55-59, Female	0.467	0.358	0.265	0.184	0.162
	Age 60-64, Female	0.467	0.355	0.260	0.177	0.154
<i>Diagnosis Factors</i>						
HCC001	HIV/AIDS	0.000	0.000	0.000	0.000	0.000
HCC002	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	8.520	8.314	8.233	8.129	8.123
HCC003	Central Nervous System Infections, Except Viral Meningitis	7.760	7.653	7.601	7.527	7.511
HCC004	Viral or Unspecified Meningitis	6.855	6.746	6.678	6.590	6.569
HCC006	Opportunistic Infections	8.110	8.053	7.995	7.916	7.892
HCC008	Metastatic Cancer	22.129	21.703	21.654	21.525	21.533
HCC009	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	12.286	11.994	11.925	11.798	11.789
HCC010	Non-Hodgkin Lymphomas and Other Cancers and Tumors	5.400	5.216	5.126	5.002	4.980
HCC011	Colorectal, Breast (Age < 50), Kidney, and Other Cancers	3.851	3.657	3.554	3.419	3.396
HCC012	Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	2.465	2.326	2.237	2.127	2.105
HCC013	Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.025	0.930	0.825	0.710	0.681
HCC018	Pancreas Transplant Status	5.506	5.552	5.642	5.734	5.757
HCC019	Diabetes with Acute Complications	0.189	0.145	0.102	0.060	0.050
HCC020	Diabetes with Chronic Complications	0.189	0.145	0.102	0.060	0.050
HCC021	Diabetes without Complication	0.189	0.145	0.102	0.060	0.050
HCC022	Type 1 Diabetes Mellitus, add-on to Diabetes HCCs 19-21	0.179	0.155	0.111	0.045	0.023
HCC023	Protein-Calorie Malnutrition	10.099	9.974	9.925	9.854	9.843
HCC026	Mucopolysaccharidosis	18.785	18.604	18.567	18.498	18.495
HCC027	Lipidoses and Glycogenosis	18.785	18.604	18.567	18.498	18.495
HCC029	Amyloidosis, Porphyrin, and Other Metabolic Disorders	5.455	5.353	5.299	5.229	5.216

HCC030	Adrenal, Pituitary, and Other Significant Endocrine Disorders	1.291	1.216	1.150	1.071	1.053
HCC034	Liver Transplant Status/Complications	5.506	5.552	5.642	5.734	5.757
HCC035_1 ^a	Acute Liver Failure/Disease, Including Neonatal Hepatitis	6.880	6.693	6.630	6.548	6.543
HCC035_2	Chronic Liver Failure/End-Stage Liver Disorders	2.234	2.070	2.000	1.906	1.896
HCC036	Cirrhosis of Liver	0.616	0.537	0.476	0.401	0.387
HCC037_1	Chronic Viral Hepatitis C	0.516	0.455	0.396	0.336	0.325
HCC037_2	Chronic Hepatitis, Except Chronic Viral Hepatitis C	0.516	0.455	0.396	0.336	0.325
HCC041	Intestine Transplant Status/Complications	5.506	5.552	5.642	5.734	5.757
HCC042	Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	10.409	10.234	10.209	10.146	10.144
HCC045	Intestinal Obstruction	4.795	4.594	4.499	4.369	4.350
HCC046	Chronic Pancreatitis	2.131	1.971	1.875	1.755	1.738
HCC047	Acute Pancreatitis	2.131	1.971	1.875	1.755	1.738
HCC048	Inflammatory Bowel Disease	3.007	2.889	2.788	2.652	2.614
HCC054	Necrotizing Fasciitis	6.731	6.567	6.536	6.475	6.470
HCC055	Bone/Joint/Muscle Infections/Necrosis	4.138	3.961	3.912	3.843	3.843
HCC056	Rheumatoid Arthritis and Specified Autoimmune Disorders	1.363	1.259	1.188	1.104	1.086
HCC057	Systemic Lupus Erythematosus and Other Autoimmune Disorders	0.355	0.286	0.198	0.098	0.069
HCC061	Osteogenesis Imperfecta and Other Osteodystrophies	1.753	1.635	1.546	1.437	1.415
HCC062	Congenital/Developmental Skeletal and Connective Tissue Disorders	1.753	1.635	1.546	1.437	1.415
HCC063	Cleft Lip/Cleft Palate	0.823	0.732	0.640	0.542	0.520
HCC066	Hemophilia	70.952	70.627	70.590	70.491	70.495
HCC067	Myelodysplastic Syndromes and Myelofibrosis	9.888	9.761	9.718	9.648	9.639
HCC068	Aplastic Anemia	9.888	9.761	9.718	9.648	9.639
HCC069	Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	9.888	9.761	9.718	9.648	9.639
HCC070	Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero	1.833	1.725	1.635	1.537	1.518
HCC071	Sickle-Cell Disorders, Except Sickle-Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia Major	1.457	1.397	1.348	1.292	1.279
HCC073	Combined and Other Severe Immunodeficiencies	4.364	4.272	4.239	4.184	4.176
HCC074	Disorders of the Immune Mechanism	4.364	4.272	4.239	4.184	4.176
HCC075	Coagulation Defects and Other Specified Hematological Disorders	2.167	2.085	2.024	1.948	1.930
HCC081	Drug Use with Psychotic Complications	1.479	1.349	1.232	1.092	1.059
HCC082	Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	1.479	1.349	1.232	1.092	1.059
HCC083	Alcohol Use with Psychotic Complications	0.857	0.746	0.647	0.533	0.507

HCC084	Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications	0.857	0.746	0.647	0.533	0.507
HCC087_1	Schizophrenia	2.215	2.050	1.928	1.784	1.757
HCC087_2	Delusional and Other Specified Psychotic Disorders, Unspecified Psychosis	2.087	1.932	1.803	1.645	1.611
HCC088	Major Depressive Disorder, Severe, and Bipolar Disorders	0.927	0.831	0.728	0.609	0.578
HCC090	Personality Disorders	0.666	0.587	0.487	0.377	0.343
HCC094	Anorexia/Bulimia Nervosa	1.855	1.749	1.663	1.555	1.529
HCC096	Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	9.243	9.207	9.184	9.155	9.144
HCC097	Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	0.779	0.715	0.659	0.596	0.581
HCC102	Autistic Disorder	0.670	0.590	0.496	0.397	0.367
HCC103	Pervasive Developmental Disorders, Except Autistic Disorder	0.666	0.587	0.487	0.377	0.343
HCC106	Traumatic Complete Lesion Cervical Spinal Cord	9.567	9.405	9.331	9.227	9.211
HCC107	Quadriplegia	9.567	9.405	9.331	9.227	9.211
HCC108	Traumatic Complete Lesion Dorsal Spinal Cord	6.337	6.186	6.106	5.994	5.975
HCC109	Paraplegia	6.337	6.186	6.106	5.994	5.975
HCC110	Spinal Cord Disorders/Injuries	4.665	4.482	4.406	4.296	4.280
HCC111	Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	6.067	5.909	5.822	5.707	5.686
HCC112	Quadriplegic Cerebral Palsy	0.975	0.868	0.773	0.658	0.631
HCC113	Cerebral Palsy, Except Quadriplegic	0.426	0.363	0.300	0.229	0.210
HCC114	Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	1.116	1.035	0.959	0.864	0.841
HCC115	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	4.927	4.844	4.822	4.783	4.779
HCC117	Muscular Dystrophy	1.362	1.272	1.191	1.094	1.070
HCC118	Multiple Sclerosis	2.461	2.331	2.253	2.151	2.131
HCC119	Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	1.362	1.272	1.191	1.094	1.070
HCC120	Seizure Disorders and Convulsions	0.929	0.840	0.758	0.660	0.637
HCC121	Hydrocephalus	8.919	8.823	8.773	8.704	8.689
HCC122	Nontraumatic Coma, Except Diabetic, Hepatic, or Hypoglycemic; Nontraumatic Brain Compression/Anoxic Damage	9.620	9.477	9.417	9.325	9.307
HCC123	Narcolepsy and Cataplexy	4.303	4.171	4.101	4.006	3.987
HCC125	Respirator Dependence/Tracheostomy Status	20.117	19.902	19.845	19.752	19.744
HCC126	Respiratory Arrest	7.858	7.659	7.579	7.478	7.472
HCC127	Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	7.858	7.659	7.579	7.478	7.472
HCC128	Heart Assistive Device/Artificial Heart	14.408	14.322	14.312	14.307	14.304

HCC129	Heart Transplant Status/Complications	14.408	14.322	14.312	14.307	14.304
HCC130	Heart Failure	1.628	1.543	1.490	1.421	1.407
HCC131	Acute Myocardial Infarction	4.410	4.188	4.129	4.044	4.047
HCC132	Unstable Angina and Other Acute Ischemic Heart Disease	3.261	3.073	2.986	2.868	2.856
HCC135	Heart Infection/Inflammation, Except Rheumatic	7.943	7.850	7.792	7.709	7.689
HCC137	Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders	2.004	1.911	1.843	1.763	1.745
HCC138	Major Congenital Heart/Circulatory Disorders	2.004	1.911	1.843	1.763	1.745
HCC139	Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders	2.004	1.911	1.843	1.763	1.745
HCC142	Specified Heart Arrhythmias	1.831	1.725	1.640	1.531	1.501
HCC145	Intracranial Hemorrhage	9.782	9.608	9.545	9.452	9.441
HCC146	Ischemic or Unspecified Stroke	1.438	1.326	1.258	1.173	1.161
HCC149	Cerebral Aneurysm and Arteriovenous Malformation	1.977	1.859	1.772	1.659	1.634
HCC150	Hemiplegia/Hemiparesis	2.618	2.497	2.459	2.405	2.403
HCC151	Monoplegia, Other Paralytic Syndromes	2.198	2.088	2.019	1.931	1.916
HCC153	Atherosclerosis of the Extremities with Ulceration or Gangrene	7.585	7.409	7.407	7.376	7.389
HCC154	Vascular Disease with Complications	4.906	4.756	4.694	4.605	4.591
HCC156	Pulmonary Embolism and Deep Vein Thrombosis	7.104	7.018	6.942	6.837	6.805
HCC158	Lung Transplant Status/Complications	11.333	11.261	11.238	11.227	11.221
HCC159	Cystic Fibrosis	2.992	2.873	2.799	2.714	2.700
HCC160	Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	0.615	0.539	0.454	0.360	0.334
HCC161_1	Severe Asthma	0.615	0.539	0.454	0.360	0.334
HCC161_2	Asthma, Except Severe	0.615	0.539	0.454	0.360	0.334
HCC162	Fibrosis of Lung and Other Lung Disorders	1.305	1.231	1.161	1.075	1.052
HCC163	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	6.880	6.765	6.706	6.629	6.616
HCC174	Exudative Macular Degeneration	1.231	1.115	0.988	0.838	0.804
HCC183	Kidney Transplant Status/Complications	5.506	5.552	5.642	5.734	5.757
HCC184	End Stage Renal Disease	17.965	17.541	17.668	17.485	17.544
HCC187	Chronic Kidney Disease, Stage 5	0.749	0.679	0.661	0.621	0.622
HCC188	Chronic Kidney Disease, Severe (Stage 4)	0.749	0.679	0.661	0.621	0.622
HCC203	Ectopic and Molar Pregnancy	1.438	1.302	1.131	0.927	0.875
HCC204	Miscarriage with Complications	0.638	0.554	0.420	0.253	0.193
HCC205	Miscarriage with No or Minor Complications	0.638	0.554	0.420	0.253	0.193
HCC207	Pregnancy with Delivery with Major Complications	3.610	3.349	3.031	2.654	2.581
HCC208	Pregnancy with Delivery with Complications	3.610	3.349	3.031	2.654	2.581
HCC209	Pregnancy with Delivery with No or Minor Complications	2.645	2.446	2.126	1.713	1.597

HCC210	(Ongoing) Pregnancy without Delivery with Major Complications	0.668	0.572	0.416	0.240	0.186
HCC211	(Ongoing) Pregnancy without Delivery with Complications	0.494	0.412	0.283	0.148	0.106
HCC212	(Ongoing) Pregnancy without Delivery with No or Minor Complications	0.023	0.000	0.000	0.000	0.000
HCC217	Chronic Ulcer of Skin, Except Pressure	1.351	1.259	1.205	1.140	1.131
HCC218	Extensive Third Degree Burns	28.529	28.296	28.253	28.168	28.162
HCC219	Major Skin Burn or Condition	2.661	2.532	2.452	2.356	2.337
HCC223	Severe Head Injury	16.085	15.926	15.853	15.744	15.724
HCC226	Hip and Pelvic Fractures	7.742	7.485	7.431	7.338	7.340
HCC228	Vertebral Fractures without Spinal Cord Injury	4.007	3.844	3.742	3.608	3.582
HCC234	Traumatic Amputations and Amputation Complications	4.272	4.112	4.068	3.998	3.995
HCC251	Stem Cell, Including Bone Marrow, Transplant Status/Complications	17.990	18.025	18.043	18.074	18.067
HCC253	Artificial Openings for Feeding or Elimination	5.400	5.276	5.237	5.177	5.172
HCC254	Amputation Status, Upper Limb or Lower Limb	0.923	0.828	0.775	0.708	0.699
<i>Interacted HCC Counts Factors</i>						
	Severe illness, 1 payment HCC	-5.506	-5.552	-5.642	-5.734	-5.757
	Severe illness, 2 payment HCCs	-5.381	-5.451	-5.529	-5.615	-5.630
	Severe illness, 3 payment HCCs	-4.624	-4.683	-4.671	-4.664	-4.645
	Severe illness, 4 payment HCCs	-4.046	-4.060	-3.933	-3.798	-3.740
	Severe illness, 5 payment HCCs	-3.634	-3.590	-3.359	-3.113	-3.027
	Severe illness, 6 payment HCCs	-3.188	-3.063	-2.734	-2.385	-2.275
	Severe illness, 7 payment HCCs	-2.710	-2.475	-2.060	-1.614	-1.485
	Severe illness, 8 payment HCCs	-2.359	-2.047	-1.553	-1.014	-0.870
	Severe illness, 9 payment HCCs	-0.965	-0.515	0.053	0.682	0.839
	Severe illness, 10 or more payment HCCs	4.976	5.806	6.546	7.415	7.608
	Transplant severe illness, 4 payment HCCs	3.531	3.394	3.262	3.071	3.034
	Transplant severe illness, 5 payment HCCs	6.812	6.664	6.540	6.354	6.326
	Transplant severe illness, 6 payment HCCs	10.112	9.960	9.839	9.656	9.631
	Transplant severe illness, 7 payment HCCs	15.321	15.165	15.051	14.879	14.859
	Transplant severe illness, 8 or more payment HCCs	29.664	29.601	29.511	29.375	29.357
<i>Enrollment Duration Factors</i>						
	Enrolled for 1 month, at least one payment HCC	11.074	9.697	8.663	7.661	7.414
	Enrolled for 2 months, at least one payment HCC	4.976	4.271	3.729	3.226	3.102
	Enrolled for 3 months, at least one payment HCC	3.206	2.743	2.369	2.026	1.944
	Enrolled for 4 months, at least one payment HCC	1.883	1.566	1.297	1.054	0.995
	Enrolled for 5 months, at least one payment HCC	1.400	1.164	0.955	0.763	0.714

	Enrolled for 6 months, at least one payment HCC	0.936	0.762	0.599	0.448	0.407
<i>Affiliated Cost Factors</i>						
ACF01	HIV Pre-Exposure Prophylaxis (PrEP)	3.620	3.551	3.472	3.304	3.258
<i>Prescription Drug Factors</i>						
RXC01	Anti-HIV Agents	4.595	4.125	3.714	3.356	3.280
RXC02	Anti-Hepatitis C (HCV) Agents, Direct Acting Agents	9.107	8.614	8.476	8.335	8.361
RXC03 ^b	Antiarrhythmics	0.058	0.052	0.046	0.039	0.046
RXC04	Phosphate Binders	0.868	0.993	0.785	0.988	0.917
RXC05	Inflammatory Bowel Disease Agents	1.133	1.100	1.040	0.981	0.962
RXC06	Insulin	1.313	1.147	0.991	0.843	0.805
RXC07	Anti-Diabetic Agents, Except Insulin and Metformin Only	0.973	0.862	0.698	0.485	0.419
RXC08	Multiple Sclerosis Agents	12.472	11.759	11.490	11.110	11.042
RXC09	Immune Suppressants and Immunomodulators	11.545	10.994	10.921	10.759	10.777
RXC10	Cystic Fibrosis Agents	22.801	22.295	22.221	22.083	22.098
RXC01 x HCC001	Additional effect for enrollees with RXC 01 and HCC 001	2.629	2.556	2.848	3.009	3.091
RXC02 x HCC037_1, 036, 035_2, 035_1, 034	Additional effect for enrollees with RXC 02 and (HCC 037_1 or 036 or 035_2 or 035_1 or 034)	-0.516	-0.455	-0.396	-0.336	-0.325
RXC03 x HCC142	Additional effect for enrollees with RXC 03 and HCC 142	0.000	0.000	0.000	0.000	0.000
RXC04 x HCC184, 183, 187, 188	Additional effect for enrollees with RXC 04 and (HCC 184 or 183 or 187 or 188)	0.000	0.000	0.000	0.000	0.000
RXC05 x HCC048, 041	Additional effect for enrollees with RXC 05 and (HCC 048 or 041)	-1.106	-1.087	-1.040	-0.981	-0.962
RXC06 x HCC018, 019, 020, 021	Additional effect for enrollees with RXC 06 and (HCC 018 or 019 or 020 or 021)	0.466	0.511	0.522	0.482	0.474
RXC07 x HCC018, 019, 020, 021	Additional effect for enrollees with RXC 07 and (HCC 018 or 019 or 020 or 021)	-0.187	-0.143	-0.102	-0.060	-0.050
RXC08 x HCC118	Additional effect for enrollees with RXC 08 and HCC 118	-0.156	0.110	0.411	0.745	0.854
RXC09 x HCC056 or 057 and 048 or 041	Additional effect for enrollees with RXC 09 and (HCC 048 or 041) and (HCC 056 or 057)	0.492	0.557	0.646	0.751	0.780
RXC09 x HCC056	Additional effect for enrollees with RXC 09 and HCC 056	-1.363	-1.259	-1.188	-1.104	-1.086
RXC09 x HCC057	Additional effect for enrollees with RXC 09 and HCC 057	-0.355	-0.286	-0.198	-0.098	-0.069
RXC09 x HCC048, 041	Additional effect for enrollees with RXC 09 and (HCC 048 or 041)	-1.901	-1.802	-1.748	-1.670	-1.651

RXC10 x HCC159, 158	Additional effect for enrollees with RXC 10 and (HCC 159 or 158)	36.448	36.460	36.625	36.751	36.785

^a HCC numbers that appear with an underscore in this document will appear without the underscore in the “Do It Yourself (DIY)” software. For example, HCC 35_1 in this table will appear as HCC 351 in the DIY software.

^b We constrain RXC 03 to be equal to average plan liability for RXC 03 drugs, RXC 04 to be equal to the average plan liability for RXC 04 drugs, and we constrain RXC 03 x HCC142 and RXC 04 x HCC184, 183, 187, 188 to be equal to zero. See *March 2016 Risk Adjustment Methodology Discussion Paper* (2016 March, 16), available at: <https://www.cms.gov/ccio/resources/forms-reports-and-other-resources/downloads/ra-march-31-white-paper-032416.pdf> (where we previously discussed the use of constraints in the HHS risk adjustment models).

TABLE 2: Proposed Child Risk Adjustment Model Factors for the 2027 Benefit Year

<i>Demographic Factors</i>					
Age 2-4, Male	0.297	0.217	0.162	0.118	0.106
Age 5-9, Male	0.222	0.154	0.113	0.085	0.077
Age 10-14, Male	0.210	0.146	0.108	0.082	0.076
Age 15-20, Male	0.246	0.179	0.132	0.097	0.088
Age 2-4, Female	0.237	0.166	0.124	0.092	0.084
Age 5-9, Female	0.162	0.102	0.067	0.044	0.039
Age 10-14, Female	0.216	0.153	0.115	0.089	0.082
Age 15-20, Female	0.267	0.187	0.124	0.077	0.063
<i>Diagnosis Factors</i>					
HIV/AIDS	4.494	4.068	3.903	3.679	3.658
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	14.480	14.282	14.169	14.032	14.013
Central Nervous System Infections, Except Viral Meningitis	14.430	14.273	14.207	14.113	14.097
Viral or Unspecified Meningitis	12.991	12.869	12.785	12.679	12.655
Opportunistic Infections	20.233	20.191	20.119	20.039	20.013
Metastatic Cancer	31.479	31.228	31.163	31.056	31.045
Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	9.613	9.381	9.254	9.091	9.059
Non-Hodgkin Lymphomas and Other Cancers and Tumors	8.609	8.408	8.278	8.118	8.083
Colorectal, Breast (Age < 50), Kidney, and Other Cancers	3.753	3.604	3.500	3.366	3.332
Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	3.753	3.604	3.500	3.366	3.332
Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.204	1.092	0.978	0.855	0.818
Pancreas Transplant Status	11.308	11.349	11.403	11.462	11.475
Diabetes with Acute Complications	2.107	1.904	1.613	1.264	1.175
Diabetes with Chronic Complications	2.107	1.904	1.613	1.264	1.175
Diabetes without Complication	2.107	1.904	1.613	1.264	1.175
Protein-Calorie Malnutrition	17.913	17.788	17.745	17.685	17.674
Mucopolysaccharidosis	27.455	27.228	27.158	27.051	27.042
Lipidoses and Glycogenosis	27.455	27.228	27.158	27.051	27.042
Congenital Metabolic Disorders, Not Elsewhere Classified	4.860	4.741	4.671	4.584	4.566
Amyloidosis, Porphyria, and Other Metabolic Disorders	4.860	4.741	4.671	4.584	4.566
Adrenal, Pituitary, and Other Significant Endocrine Disorders	4.585	4.353	4.263	4.148	4.135
Liver Transplant Status/Complications	11.308	11.349	11.403	11.462	11.475
Acute Liver Failure/Disease, Including Neonatal Hepatitis	12.753	12.612	12.564	12.499	12.492
Chronic Liver Failure/End-Stage Liver Disorders	8.744	8.588	8.509	8.401	8.379
Cirrhosis of Liver	2.077	1.972	1.888	1.798	1.778
Chronic Viral Hepatitis C	2.077	1.972	1.888	1.798	1.778
Chronic Hepatitis, Except Chronic Viral Hepatitis C	1.367	1.287	1.195	1.098	1.073
Intestine Transplant Status/Complications	15.155	15.082	15.015	14.930	14.907

Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	17.893	17.607	17.538	17.427	17.422
Intestinal Obstruction	3.920	3.746	3.616	3.458	3.423
Chronic Pancreatitis	9.814	9.635	9.554	9.449	9.434
Acute Pancreatitis	6.643	6.415	6.272	6.089	6.054
Inflammatory Bowel Disease	10.636	10.225	10.089	9.880	9.859
Necrotizing Fasciitis	4.686	4.490	4.367	4.224	4.197
Bone/Joint/Muscle Infections/Necrosis	4.686	4.490	4.367	4.224	4.197
Rheumatoid Arthritis and Specified Autoimmune Disorders	4.802	4.534	4.429	4.288	4.270
Systemic Lupus Erythematosus and Other Autoimmune Disorders	1.211	1.106	1.002	0.884	0.852
Osteogenesis Imperfecta and Other Osteodystrophies	1.112	1.008	0.919	0.822	0.799
Congenital/Developmental Skeletal and Connective Tissue Disorders	1.112	1.008	0.919	0.822	0.799
Cleft Lip/Cleft Palate	0.852	0.729	0.606	0.470	0.433
Hemophilia	59.554	59.072	58.973	58.779	58.763
Myelodysplastic Syndromes and Myelofibrosis	11.606	11.431	11.349	11.244	11.231
Aplastic Anemia	11.606	11.431	11.349	11.244	11.231
Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	11.606	11.431	11.349	11.244	11.231
Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero	3.359	3.193	3.083	2.958	2.929
Sickle-Cell Disorders, Except Sickle-Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia Major	3.359	3.193	3.083	2.958	2.929
Combined and Other Severe Immunodeficiencies	5.693	5.547	5.470	5.368	5.350
Disorders of the Immune Mechanism	5.693	5.547	5.470	5.368	5.350
Coagulation Defects and Other Specified Hematological Disorders	4.135	4.022	3.937	3.839	3.817
Drug Use with Psychotic Complications	2.239	2.101	1.978	1.833	1.799
Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	2.239	2.101	1.978	1.833	1.799
Alcohol Use with Psychotic Complications	0.811	0.683	0.540	0.377	0.338
Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications	0.811	0.683	0.540	0.377	0.338
Schizophrenia	3.875	3.617	3.437	3.224	3.185
Delusional and Other Specified Psychotic Disorders, Unspecified Psychosis	3.273	3.038	2.852	2.625	2.575
Major Depressive Disorder, Severe, and Bipolar Disorders	2.710	2.509	2.352	2.169	2.126
Personality Disorders	0.597	0.513	0.416	0.311	0.277
Anorexia/Bulimia Nervosa	2.132	1.994	1.886	1.751	1.717
Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	12.106	12.042	12.004	11.952	11.938
Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	0.799	0.693	0.601	0.491	0.463
Autistic Disorder	2.710	2.509	2.352	2.169	2.126
Pervasive Developmental Disorders, Except Autistic Disorder	0.597	0.513	0.416	0.321	0.297
Traumatic Complete Lesion Cervical Spinal Cord	10.342	10.139	10.066	9.954	9.944
Quadriplegia	10.342	10.139	10.066	9.954	9.944

Traumatic Complete Lesion Dorsal Spinal Cord	7.706	7.483	7.370	7.223	7.201
Paraplegia	7.706	7.483	7.370	7.223	7.201
Spinal Cord Disorders/Injuries	4.354	4.171	4.045	3.880	3.841
Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	44.922	44.615	44.563	44.454	44.447
Quadriplegic Cerebral Palsy	1.301	1.125	1.017	0.881	0.861
Cerebral Palsy, Except Quadriplegic	0.394	0.278	0.202	0.113	0.091
Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	1.403	1.295	1.208	1.102	1.078
Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	11.196	11.067	11.035	10.986	10.988
Muscular Dystrophy	6.335	6.182	6.087	5.966	5.942
Multiple Sclerosis	7.535	7.183	7.067	6.898	6.885
Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	6.335	6.182	6.087	5.966	5.942
Seizure Disorders and Convulsions	1.519	1.389	1.256	1.104	1.063
Hydrocephalus	11.643	11.592	11.599	11.603	11.602
Nontraumatic Coma, Except Diabetic, Hepatic, or Hypoglycemic; Nontraumatic Brain Compression/Anoxic Damage	11.490	11.480	11.484	11.487	11.485
Narcolepsy and Cataplexy	3.550	3.402	3.296	3.156	3.115
Respirator Dependence/Tracheostomy Status	26.852	26.609	26.531	26.418	26.408
Respiratory Arrest	15.129	14.889	14.754	14.581	14.559
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	15.129	14.889	14.754	14.581	14.559
Heart Assistive Device/Artificial Heart	15.155	15.082	15.015	14.930	14.907
Heart Transplant Status/Complications	15.155	15.082	15.015	14.930	14.907
Heart Failure	3.656	3.549	3.481	3.391	3.370
Acute Myocardial Infarction	0.225	0.196	0.157	0.107	0.088
Unstable Angina and Other Acute Ischemic Heart Disease	0.225	0.196	0.157	0.107	0.088
Heart Infection/Inflammation, Except Rheumatic	15.433	15.322	15.236	15.136	15.111
Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders	3.711	3.564	3.444	3.307	3.273
Major Congenital Heart/Circulatory Disorders	0.962	0.862	0.757	0.652	0.624
Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders	0.525	0.439	0.352	0.268	0.248
Specified Heart Arrhythmias	3.136	2.983	2.882	2.759	2.732
Intracranial Hemorrhage	12.158	12.048	12.010	11.963	11.955
Ischemic or Unspecified Stroke	0.531	0.420	0.353	0.272	0.255
Cerebral Aneurysm and Arteriovenous Malformation	0.813	0.690	0.607	0.502	0.480
Hemiplegia/Hemiparesis	4.230	4.089	3.989	3.861	3.834
Monoplegia, Other Paralytic Syndromes	2.776	2.633	2.537	2.417	2.392
Atherosclerosis of the Extremities with Ulceration or Gangrene	10.094	9.865	9.741	9.588	9.568
Vascular Disease with Complications	12.595	12.449	12.389	12.300	12.286
Pulmonary Embolism and Deep Vein Thrombosis	19.285	19.147	19.070	18.968	18.947
Lung Transplant Status/Complications	15.155	15.082	15.015	14.930	14.907
Cystic Fibrosis	49.902	49.319	49.258	49.095	49.105
Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	1.825	1.669	1.534	1.379	1.342

Severe Asthma	1.253	1.093	0.929	0.748	0.704
Asthma, Except Severe	0.323	0.248	0.165	0.092	0.072
Fibrosis of Lung and Other Lung Disorders	1.444	1.329	1.211	1.083	1.051
Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	11.365	11.349	11.403	11.462	11.475
Kidney Transplant Status/Complications	11.308	11.349	11.403	11.462	11.475
End Stage Renal Disease	23.942	23.682	23.657	23.578	23.576
Chronic Kidney Disease, Stage 5	2.630	2.522	2.430	2.344	2.325
Chronic Kidney Disease, Severe (Stage 4)	2.630	2.522	2.430	2.344	2.325
Ectopic and Molar Pregnancy	0.988	0.833	0.642	0.431	0.386
Miscarriage with Complications	0.526	0.409	0.233	0.036	0.005
Miscarriage with No or Minor Complications	0.526	0.409	0.233	0.036	0.005
Pregnancy with Delivery with Major Complications	3.019	2.757	2.391	1.934	1.805
Pregnancy with Delivery with Complications	3.019	2.757	2.391	1.934	1.805
Pregnancy with Delivery with No or Minor Complications	2.183	1.972	1.629	1.180	1.023
(Ongoing) Pregnancy without Delivery with Major Complications	0.513	0.378	0.189	0.011	0.000
(Ongoing) Pregnancy without Delivery with Complications	0.513	0.378	0.189	0.011	0.000
(Ongoing) Pregnancy without Delivery with No or Minor Complications	0.284	0.182	0.068	0.000	0.000
Chronic Ulcer of Skin, Except Pressure	2.113	2.020	1.939	1.855	1.833
Extensive Third Degree Burns	22.256	22.021	21.922	21.792	21.772
Major Skin Burn or Condition	2.590	2.420	2.281	2.120	2.083
Severe Head Injury	22.256	22.021	21.922	21.792	21.772
Hip and Pelvic Fractures	4.114	3.906	3.772	3.623	3.596
Vertebral Fractures without Spinal Cord Injury	4.144	3.952	3.811	3.639	3.600
Traumatic Amputations and Amputation Complications	3.694	3.520	3.372	3.192	3.147
Stem Cell, Including Bone Marrow, Transplant Status/Complications	15.155	15.082	15.015	14.930	14.907
Artificial Openings for Feeding or Elimination	4.495	4.323	4.257	4.161	4.151
Amputation Status, Upper Limb or Lower Limb	3.694	3.520	3.372	3.192	3.147
<i>Interacted HCC Counts Factors</i>					
Severe illness, 1 payment HCC	-11.308	-11.349	-11.403	-11.462	-11.475
Severe illness, 2 payment HCCs	-11.308	-11.349	-11.403	-11.462	-11.475
Severe illness, 3 payment HCCs	-10.149	-10.211	-10.174	-10.162	-10.141
Severe illness, 4 payment HCCs	-9.055	-9.082	-8.919	-8.762	-8.697
Severe illness, 5 payment HCCs	-8.454	-8.416	-8.172	-7.938	-7.853
Severe illness, 6 or 7 payment HCCs	-4.190	-3.978	-3.561	-3.133	-3.003
Severe illness, 8 or more payment HCCs	18.133	18.860	19.604	20.422	20.625
Transplant severe illness, 4 or more payment HCCs	15.299	15.306	15.287	15.271	15.267
<i>Affiliated Cost Factors</i>					
HIV Pre-Exposure Prophylaxis (PrEP)	2.089	2.042	1.984	1.923	1.905

TABLE 3: HHS HCCs Selected for the HCC Interacted Counts Variables for the Adult and Child Models for the 2027 Benefit Year

HCC 2 Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	X	
HCC 3 Central Nervous System Infections, Except Viral Meningitis	X	
HCC 4 Viral or Unspecified Meningitis	X	
HCC 6 Opportunistic Infections	X	
HCC 23 Protein-Calorie Malnutrition	X	
HCC 34 Liver Transplant Status/Complications	X	X
HCC 41 Intestine Transplant Status/Complications	X	X
HCC 42 Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	X	
HCC 96 Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	X	
HCC 121 Hydrocephalus	X	
HCC 122 Nontraumatic Coma, Except Diabetic, Hepatic, or Hypoglycemic; Nontraumatic Brain Compression/Anoxic Damage	X	
HCC 125 Respirator Dependence/Tracheostomy Status	X	
HCC 135 Heart Infection/Inflammation, Except Rheumatic	X	
HCC 145 Intracranial Hemorrhage	X	
HCC 156 Pulmonary Embolism and Deep Vein Thrombosis	X	
HCC 158 Lung Transplant Status/Complications	X	X
HCC 163 Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	X	
HCC 218 Extensive Third Degree Burns	X	
HCC 223 Severe Head Injury	X	
HCC 251 Stem Cell, Including Bone Marrow, Transplant Status/Complications	X	X
G13 (Includes HCC 126 Respiratory Arrest and HCC 127 Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes)	X	
G14 (Includes HCC 128 Heart Assistive Device/Artificial Heart and HCC 129 Heart Transplant Status/Complications)	X	X
G24 (Includes HCC 18 Pancreas Transplant Status and HCC 183 Kidney Transplant Status/Complications)	X	X

TABLE 4: Proposed Infant Risk Adjustment Model Factors for the 2027 Benefit Year

Extremely Immature * Severity Level 5 (Highest)	197.671	196.159	195.801	195.221	195.198
Extremely Immature * Severity Level 4	129.748	128.048	127.479	126.693	126.619
Extremely Immature * Severity Level 3	29.087	27.703	27.191	26.528	26.453
Extremely Immature * Severity Level 2	29.087	27.703	27.191	26.528	26.453
Extremely Immature * Severity Level 1 (Lowest)	29.087	27.703	27.191	26.528	26.453
Immature * Severity Level 5 (Highest)	123.452	121.973	121.649	121.124	121.107
Immature * Severity Level 4	67.497	65.845	65.420	64.760	64.712
Immature * Severity Level 3	29.087	27.703	27.191	26.528	26.453
Immature * Severity Level 2	22.383	21.155	20.619	19.967	19.876
Immature * Severity Level 1 (Lowest)	21.881	20.636	20.094	19.436	19.346
Premature/Multiples * Severity Level 5 (Highest)	107.440	105.978	105.584	105.002	104.960
Premature/Multiples * Severity Level 4	27.962	26.600	26.069	25.389	25.317
Premature/Multiples * Severity Level 3	12.192	11.287	10.647	9.906	9.741
Premature/Multiples * Severity Level 2	7.667	6.967	6.351	5.654	5.480
Premature/Multiples * Severity Level 1 (Lowest)	5.481	4.884	4.306	3.679	3.503
Term * Severity Level 5 (Highest)	80.094	78.884	78.453	77.860	77.791
Term * Severity Level 4	16.487	15.512	14.880	14.150	14.017
Term * Severity Level 3	5.490	4.920	4.339	3.704	3.528
Term * Severity Level 2	3.764	3.279	2.717	2.108	1.931
Term * Severity Level 1 (Lowest)	2.081	1.689	1.247	0.869	0.778
Age1 * Severity Level 5 (Highest)	69.546	68.851	68.623	68.313	68.286
Age1 * Severity Level 4	12.005	11.504	11.187	10.827	10.759
Age1 * Severity Level 3	2.842	2.580	2.365	2.151	2.097
Age1 * Severity Level 2	1.802	1.576	1.352	1.132	1.070
Age1 * Severity Level 1 (Lowest)	0.569	0.478	0.421	0.380	0.368
Age 0 Male	0.498	0.460	0.421	0.360	0.340
Age 1 Male	0.067	0.052	0.032	0.011	0.007

TABLE 5: HHS HCCs Included in Infant Model Maturity Categories

Extremely Immature	Extremely Immature Newborns, Birth weight < 500 Grams
Extremely Immature	Extremely Immature Newborns, Including Birth weight 500-749 Grams
Extremely Immature	Extremely Immature Newborns, Including Birth weight 750-999 Grams
Immature	Premature Newborns, Including Birth weight 1000-1499 Grams
Immature	Premature Newborns, Including Birth weight 1500-1999 Grams
Premature/Multiples	Premature Newborns, Including Birth weight 2000-2499 Grams
Premature/Multiples	Other Premature, Low Birth weight, Malnourished, or Multiple Birth Newborns
Term	Term or Post-Term Singleton Newborn, Normal or High Birth weight
Age 1	All age 1 infants

TABLE 6: HHS HCCs Included in Infant Model Severity Categories

Severity Level 5 (Highest)	Metastatic Cancer
Severity Level 5	Pancreas Transplant Status
Severity Level 5	Liver Transplant Status/Complications
Severity Level 5	Intestine Transplant Status/Complications
Severity Level 5	Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis
Severity Level 5	Respirator Dependence/Tracheostomy Status
Severity Level 5	Heart Assistive Device/Artificial Heart
Severity Level 5	Heart Transplant Status/Complications
Severity Level 5	Heart Failure
Severity Level 5	Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders
Severity Level 5	Lung Transplant Status/Complications
Severity Level 5	Kidney Transplant Status/Complications
Severity Level 5	End Stage Renal Disease
Severity Level 5	Stem Cell, Including Bone Marrow, Transplant Status/Complications
Severity Level 4	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
Severity Level 4	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
Severity Level 4	Mucopolysaccharidosis
Severity Level 4	Adrenal, Pituitary, and Other Significant Endocrine Disorders
Severity Level 4	Acute Liver Failure/Disease, Including Neonatal Hepatitis
Severity Level 4	Chronic Liver Failure/End-Stage Liver Disorders
Severity Level 4	Major Congenital Anomalies of Diaphragm, Abdominal Wall, and Esophagus, Age < 2
Severity Level 4	Myelodysplastic Syndromes and Myelofibrosis
Severity Level 4	Aplastic Anemia
Severity Level 4	Combined and Other Severe Immunodeficiencies
Severity Level 4	Traumatic Complete Lesion Cervical Spinal Cord
Severity Level 4	Quadriplegia
Severity Level 4	Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease
Severity Level 4	Quadriplegic Cerebral Palsy
Severity Level 4	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
Severity Level 4	Nontraumatic Coma, Except Diabetic, Hepatic, or Hypoglycemic; Nontraumatic Brain Compression/Anoxic Damage
Severity Level 4	Respiratory Arrest
Severity Level 4	Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes
Severity Level 4	Acute Myocardial Infarction
Severity Level 4	Heart Infection/Inflammation, Except Rheumatic
Severity Level 4	Major Congenital Heart/Circulatory Disorders
Severity Level 4	Intracranial Hemorrhage
Severity Level 4	Ischemic or Unspecified Stroke
Severity Level 4	Vascular Disease with Complications
Severity Level 4	Pulmonary Embolism and Deep Vein Thrombosis
Severity Level 4	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections
Severity Level 4	Chronic Kidney Disease, Stage 5
Severity Level 4	Artificial Openings for Feeding or Elimination
Severity Level 3	HIV/AIDS
Severity Level 3	Central Nervous System Infections, Except Viral Meningitis
Severity Level 3	Opportunistic Infections
Severity Level 3	Non-Hodgkin Lymphomas and Other Cancers and Tumors
Severity Level 3	Colorectal, Breast (Age < 50), Kidney, and Other Cancers
Severity Level 3	Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors
Severity Level 3	Lipidoses and Glycogenosis
Severity Level 3	Intestinal Obstruction

Severity Level 3	Necrotizing Fasciitis
Severity Level 3	Bone/Joint/Muscle Infections/Necrosis
Severity Level 3	Osteogenesis Imperfecta and Other Osteodystrophies
Severity Level 3	Cleft Lip/Cleft Palate
Severity Level 3	Hemophilia
Severity Level 3	Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero
Severity Level 3	Disorders of the Immune Mechanism
Severity Level 3	Coagulation Defects and Other Specified Hematological Disorders
Severity Level 3	Drug Use with Psychotic Complications
Severity Level 3	Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications
Severity Level 3	Alcohol Use with Psychotic Complications
Severity Level 3	Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications
Severity Level 3	Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes
Severity Level 3	Traumatic Complete Lesion Dorsal Spinal Cord
Severity Level 3	Paraplegia
Severity Level 3	Spinal Cord Disorders/Injuries
Severity Level 3	Cerebral Palsy, Except Quadriplegic
Severity Level 3	Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies
Severity Level 3	Muscular Dystrophy
Severity Level 3	Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders
Severity Level 3	Hydrocephalus
Severity Level 3	Unstable Angina and Other Acute Ischemic Heart Disease
Severity Level 3	Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders
Severity Level 3	Specified Heart Arrhythmias
Severity Level 3	Cerebral Aneurysm and Arteriovenous Malformation
Severity Level 3	Hemiplegia/Hemiparesis
Severity Level 3	Cystic Fibrosis
Severity Level 3	Extensive Third Degree Burns
Severity Level 3	Severe Head Injury
Severity Level 3	Hip and Pelvic Fractures
Severity Level 3	Vertebral Fractures without Spinal Cord Injury
Severity Level 2	Viral or Unspecified Meningitis
Severity Level 2	Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors
Severity Level 2	Diabetes with Acute Complications
Severity Level 2	Diabetes with Chronic Complications
Severity Level 2	Diabetes without Complication
Severity Level 2	Protein-Calorie Malnutrition
Severity Level 2	Congenital Metabolic Disorders, Not Elsewhere Classified
Severity Level 2	Amyloidosis, Porphyria, and Other Metabolic Disorders
Severity Level 2	Cirrhosis of Liver
Severity Level 2	Chronic Pancreatitis
Severity Level 2	Acute Pancreatitis
Severity Level 2	Inflammatory Bowel Disease
Severity Level 2	Rheumatoid Arthritis and Specified Autoimmune Disorders
Severity Level 2	Systemic Lupus Erythematosus and Other Autoimmune Disorders
Severity Level 2	Congenital/Developmental Skeletal and Connective Tissue Disorders
Severity Level 2	Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn
Severity Level 2	Sickle-Cell Disorders, Except Sickle-Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia Major
Severity Level 2	Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes
Severity Level 2	Seizure Disorders and Convulsions
Severity Level 2	Monoplegia, Other Paralytic Syndromes
Severity Level 2	Atherosclerosis of the Extremities with Ulceration or Gangrene

Severity Level 2	Chronic Obstructive Pulmonary Disease, Including Bronchiectasis
Severity Level 2	Severe Asthma
Severity Level 2	Fibrosis of Lung and Other Lung Disorders
Severity Level 2	Chronic Kidney Disease, Severe (Stage 4)
Severity Level 2	Chronic Ulcer of Skin, Except Pressure
Severity Level 2	Major Skin Burn or Condition
Severity Level 1 (Lowest)	Chronic Viral Hepatitis C
Severity Level 1	Chronic Hepatitis, Except Chronic Viral Hepatitis C
Severity Level 1	Autistic Disorder
Severity Level 1	Pervasive Developmental Disorders, Except Autistic Disorder
Severity Level 1	Multiple Sclerosis
Severity Level 1	Asthma, Except Severe
Severity Level 1	Traumatic Amputations and Amputation Complications
Severity Level 1	Amputation Status, Upper Limb or Lower Limb

BILLING CODE 4120-01-C**c. Model Performance Statistics**

Each benefit year, to evaluate the HHS risk adjustment model performance, we examine each model's R-squared statistic and predictive ratios (PRs). The R-squared statistic, which calculates the percentage of individual variation explained by a model, measures the predictive accuracy of the model overall. The PR for each of the HHS risk adjustment models is the ratio of the

weighted mean predicted plan liability for the model sample population to the weighted mean actual plan liability for the model sample population. The PR represents how well the model does on average at predicting plan liability for that subpopulation.

A subpopulation that is predicted perfectly would have a PR of 1.0. For each of the current and proposed HHS risk adjustment models, the R-squared statistic and the PRs are in the range of

published estimates for concurrent HHS risk adjustment models.³⁶ Because we propose to blend the coefficients from separately solved models based on the 2021, 2022, and 2023 benefit years' enrollee-level EDGE data, we are publishing the R-squared statistic for each model separately to assess model performance. The R-squared statistics for the proposed 2027 benefit HHS risk adjustment models are shown in Table 7.

TABLE 7: R-Squared Statistics for Proposed 2027 Benefit Year HHS Risk Adjustment Models

Platinum Adult	0.4213	0.4094	0.4152
Gold Adult	0.4154	0.4032	0.4089
Silver Adult	0.4122	0.3996	0.4048
Bronze Adult	0.4077	0.3948	0.3996
Catastrophic Adult	0.4068	0.3937	0.3982
Platinum Child	0.3569	0.3639	0.3412
Gold Child	0.3540	0.3612	0.3381
Silver Child	0.3516	0.3588	0.3357
Bronze Child	0.3484	0.3555	0.3324
Catastrophic Child	0.3474	0.3545	0.3314
Platinum Infant	0.3099	0.2883	0.2727
Gold Infant	0.3062	0.2847	0.2687
Silver Infant	0.3044	0.2827	0.2667
Bronze Infant	0.3019	0.2802	0.2640
Catastrophic Infant	0.3014	0.2797	0.2635

³⁶ Hileman, G., & Steele, S. (2016). *Accuracy of Claims-Based Risk Scoring Models*. Society of

Actuaries. <https://www.soa.org/4937b5/>

[globalassets/assets/files/research/research-2016-accuracy-claims-based-risk-scoring-models.pdf](https://www.hhs.gov/globalassets/assets/files/research/research-2016-accuracy-claims-based-risk-scoring-models.pdf).

3. Overview of the HHS Risk Adjustment Methodology (§ 153.320)

In part 2 of the 2022 Payment Notice (86 FR 24183 through 24186), we finalized the proposal to continue to use the State payment transfer formula finalized in the 2021 Payment Notice for the 2022 benefit year and beyond, unless changed through notice-and-comment rulemaking. We are not proposing changes to the formula in this rule. We therefore would continue to apply the formula as finalized in the 2021 Payment Notice (86 FR 24183 through 24186) in the States where HHS operates the risk adjustment program in the 2027 benefit year.

Additionally, as finalized in the 2020 Payment Notice (84 FR 17466 through 17468), we will maintain the high-cost risk pool parameters for the 2020 benefit year and beyond, unless amended through notice-and-comment rulemaking. We are not proposing changes to the high-cost risk pool parameters for the 2027 benefit year; therefore, we would maintain the \$1 million threshold and 60 percent coinsurance rate.³⁷

a. Comment Solicitation on Retaining Separate Risk Adjustment Transfer Calculations for Individual Catastrophic Plans and Individual Non-Catastrophic Plans Under the State Payment Transfer Formula

We are soliciting comment on whether we should retain separate risk adjustment transfer calculations under the State payment transfer formula for individual catastrophic plans and individual non-catastrophic plans or whether we should calculate State transfers for these plans together.

On September 4, 2025, CMS released guidance entitled “*Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-sharing Reductions Due to Income, and Streamlining Exemption Pathways to Coverage*,”³⁸ which expands upon prior FFE hardship exemption policy by expanding eligibility for catastrophic plans starting with PY 2026.³⁹

³⁷ See for example, the 2018 Payment Notice (81 FR 94081) and 2020 Payment Notice (84 FR 17467).

³⁸ See CMS. (2025). *Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-sharing Reductions Due to Income, and Streamlining Exemption Pathways to Coverage*. <https://www.cms.gov/files/document/guidance-hardship-exemptions.pdf>.

³⁹ This guidance applies to consumers in FFE States and in SBE States that choose to have exemptions processed through the FFE, which currently include all SBEs except California, Connecticut, Maryland, and the District of Columbia. We note that there is a proposal

Specifically, this guidance allows consumers in applicable States to qualify for an exemption to purchase a catastrophic plan on or off an Exchange in accordance with § 155.605(d)(1)(iii) if they are determined or expect to be ineligible for APTC or CSRs based on their projected annual household income.

In light of this guidance and feedback from interested parties concerning this guidance and the potential for increased enrollment in catastrophic coverage starting with PY 2026, we seek comment on the impact of this policy on the HHS-operated risk adjustment program. Currently, risk adjustment transfers under the State payment transfer formula are calculated separately for individual catastrophic plans and individual non-catastrophic plans.^{40 41} By adding this additional hardship exemption that allows individuals ineligible for APTC or CSRs due to projected household income to enroll in a catastrophic plan, a broader population will be permitted to enroll in catastrophic plans starting with PY 2026, which has the potential to impact the individual catastrophic and

elsewhere at III.D.17. of this proposed rule to expand § 155.605(d)(1) to codify the expansion of hardship exemption eligibility to consumers ineligible for APTC or CSRs due to projected household income below 100 percent or above 250 percent FPL in all States.

⁴⁰ Risk adjustment State transfers are calculated separately for individual catastrophic plans, individual non-catastrophic plans and small group market plans for non-merged market States. In merged market States, while individual catastrophic plans' risk adjustment State transfers are still calculated separately, individual non-catastrophic plans and small group market plans are treated as part of the same market risk pool and risk adjustment transfers under the State payment transfer formula are calculated jointly across all of these plans. See the 2014 Payment Notice (77 FR 73118). See, also, Pope et al. (2014). Risk Transfer Formula for Individual and Small Group Markets Under the Affordable Care Act. *Medicare & Medicaid Research Review*, 4(3). Available at: https://www.cms.gov/mmrr/downloads/mmrr2014_004_03_a04.pdf.

⁴¹ We note that for the adjustment to the State payment transfer formula made by the high-cost risk pool (HCRP) is made for all issuers of risk adjustment covered plans in the HCRP national individual (including catastrophic and non-catastrophic plans and merged market plans), or small group market, across all States and the District of Columbia where HHS is responsible for operating the program, based on total premiums in the respective market. As such we adjust risk adjustment State transfers for two high-cost risk pools across all States: one for the individual market (including catastrophic, non-catastrophic, and merged market plans), and one for the small group market. This differs from our implementation of the risk adjustment State payment transfer formula for general risk adjustment transfers, which calculates transfers separately for the individual catastrophic, individual non-catastrophic, and merged markets. See the 2018 Payment Notice (81 FR 61471 through 94082).

individual non-catastrophic market risk pools.

Thus, although we are not proposing to make changes to the State payment transfer formula in light of this guidance for the 2026 benefit year or 2027 benefit year, HHS seeks comments on the potential impact of retaining the separate calculation of risk adjustment transfers under the State payment transfer formula for individual catastrophic plans and individual non-catastrophic plans or whether the calculation of State transfers for individual catastrophic plans should be combined with the calculation of State transfers for individual non-catastrophic plans in non-merged market States or combined with the calculation of State transfers for individual non-catastrophic and small group market plans in merged market States. We are particularly interested in comments on maintaining the separate calculation of risk adjustment transfers under the State payment transfer formula for individual catastrophic plans and individual non-catastrophic plans (or combining them) for risk adjustment purposes in non-merged market States⁴² and the impact on risk adjustment and the resulting impact on the risk pool market composition, premiums, and risk adjustment State transfers under both scenarios, in light of the potential for increased catastrophic plan enrollment as a result of the aforementioned guidance on hardship exemptions.

4. Risk Adjustment Data Validation Requirements When HHS Operates Risk Adjustment (HHS–RADV) (§§ 153.350 and 153.630)

HHS will conduct HHS–RADV under §§ 153.350 and 153.630 in any State where HHS is operating risk adjustment on the State's behalf.⁴³ The purpose of HHS–RADV is to ensure issuers are providing accurate high-quality information to HHS, which is crucial for the proper functioning of the HHS-operated risk adjustment program. HHS–RADV also ensures that risk adjustment transfers reflect verifiable actuarial risk differences among issuers, rather than risk score calculations that are based on poor quality data, thereby helping to ensure that the HHS-operated risk adjustment program assesses charges to issuers with plans with

⁴² We are similarly interested in comments on maintaining the calculation of risk adjustment State transfers for individual catastrophic plans separate from the calculation of individual non-catastrophic and small group market plans (or combining them) in merged market states.

⁴³ Since the 2017 benefit year, HHS has operated the risk adjustment program in all 50 States and the District of Columbia.

lower-than-average actuarial risk while making payments to issuers with plans with higher-than-average actuarial risk. HHS–RADV consists of an initial validation audit (IVA) and a second validation audit (SVA). Under § 153.630, each issuer of a risk adjustment covered plan must engage an independent IVA entity. The issuer provides demographic, enrollment, and medical record documentation for a sample of enrollees selected by HHS to its IVA entity for data validation. Each issuer's IVA is followed by an SVA, which is conducted by an entity HHS retains to verify the accuracy of the findings of the IVA. Based on the findings from the IVA, or SVA (as applicable), HHS conducts error estimation to calculate an HHS–RADV error rate. The HHS–RADV error rate is then applied to adjust the plan liability risk scores (PLRSs) of outlier issuers, as well as the risk adjustment transfers calculated under the State payment transfer formula for the applicable State market risk pools, for the benefit year being audited.

a. HHS–RADV Error Estimation Modification To Incorporate IVA Sampling Changes

We propose to modify one intermediate step of the HHS–RADV

error estimation methodology starting with 2025 benefit year HHS–RADV. In the 2026 Payment Notice (90 FR 4449 through 4452), we finalized excluding enrollees without HCCs from IVA sampling beginning with 2025 benefit year HHS–RADV. We noted that this policy will impact the steps in the error estimation methodology during which HCC-associated error rates are applied to adjust issuers' PLRSs, and stated our intent to seek comments on potential modifications to the intermediate steps in the error estimation methodology to ensure that HCC-associated error rates continue to apply to only the proportion of total PLRSs that are associated with HCC-components of EDGE risk scores. As such, we now propose to add an additional scaling factor, α_i , to the error estimation methodology to address this and capture the proportion of an issuer's total risk for the entire population that is associated with enrollees with HCCs. This scaling factor would be added to the final steps of error estimation in which HCC-associated error rates are applied to adjust issuers' PLRSs, and therefore, its addition would not impact the majority of the error estimation methodology, including the calculation of group failure rates, enrollee-level adjustments or HCC-associated error rates.

The formula for the existing scaling factor $HccPLRSWeight_i$ is the sum of sampled enrollee's stratum-weighted adjusted HCC-associated portion of EDGE risk scores divided by the sum of sampled enrollees' stratum-weighted total EDGE risk score. Because this formula is based on the issuer's sample, it depends on having enrollees with and without HCCs in the audit sample to appropriately estimate the proportion of the issuer's total PLRS that is HCC-related. However, as explained in the 2026 Payment Notice (90 FR 4452), when enrollees without HCCs are excluded from issuers' audit samples beginning with 2025 benefit year HHS–RADV, this formula will only estimate the proportion of enrollees' total EDGE risk scores that is HCC-related for enrollees with HCCs.⁴⁴ Therefore, we are proposing to create another scaling factor beginning with benefit year 2025 HHS–RADV that estimates the proportion of the issuer's total PLRS that is associated with enrollees with HCCs using the issuer's EDGE data. Together, these two scaling factors would capture the proportion of the issuer's total PLRS that is HCC-related.

Therefore, we propose to introduce an additional scaling factor, α_i , as follows:

$$\alpha_i = \frac{\sum_{h=1}^9 meanRiskScore_{i,h} * StrBMM_{i,h}}{\sum_{h=1}^{10} meanRiskScore_{i,h} * StrBMM_{i,h}}$$

Where:

$meanRiskScore_{i,h}$ is the average risk score for all enrollees in stratum h in issuer i 's EDGE population

$strBMM_{i,h}$ is the total stratum billable member months (BMM) for all enrollees in stratum h in issuer i 's EDGE population

Applying the scaling factor α_i to the intermediate steps in the error estimation methodology as follows:

$$TotalER_i = HccER_i * HccPLRSWeight_i * \alpha_i$$

The numerator in the formula for the scaling factor sums the product of each stratum's mean risk score and total BMM for strata 1 through 9, thereby creating an aggregate risk score for all enrollees with EDGE HCCs in an issuer's EDGE population.⁴⁵ The denominator

sums the product of each stratum's mean risk score and total BMM for strata 1 through 10. This includes all enrollees in the issuer's EDGE population including enrollees without HCCs, and thereby creates an aggregate risk score for the issuer.⁴⁶ Overall, the scaling factor α_i estimates the proportion of the issuer's total PLRS that is associated with enrollees with HCCs and, by combining it with the HCC PLRS weighting factor, we could continue to estimate the proportion of the issuer's total PLRS that is HCC-related after the removal of no HCC enrollees from the IVA sample beginning with 2025 benefit year HHS–RADV. After leveraging EDGE data from the relevant benefit year to calculate the scaling factor and the total

error rate, we would continue to adjust issuers' PLRSs using the following formula:

$$AdjPLRS_i = (1 - TotalER_i) * PLRS_i$$

Without adding this additional scaling factor to the error estimation methodology beginning with 2025 benefit year HHS–RADV, the error rate would adjust elements of issuers' total PLRSs that are associated with enrollees' without HCCs and are not intended to be adjusted during error estimation.⁴⁷ We believe these adjustments would be inappropriate, and moreover, could result in double adjustments for any identified data errors of non-HCC components, such as demographic and enrollment factors, that are adjusted through separate

⁴⁴ In other words, this will factor out the contribution of demographic factors, enrollee RXCs, HCC–RXC interaction factors, CSR adjustment factors, HCC-contingent enrollment duration factors, and interacted HCC counts factors towards the EDGE risk scores of enrollees with HCCs. As previously explained, these factors are not included in the calculation of the HCC-associated error rate during HHS–RADV error estimation. See Section

13.3.1.3.3 Calculate Error Rates of the BY24 HHS–RADV Protocols available at https://regtap.cms.gov/uploads/library/HHS-RADV_2024_Benefit_Year_Protocols_v1_5CR_060625.pdf.

⁴⁵ An issuer's EDGE population only consists of enrollees in their risk adjustment covered plans. See §§ 153.610(a) and 153.700(a).

⁴⁶ Although enrollees without HCCs will be excluded from IVA sampling beginning with 2025

benefit year HHS–RADV, enrollees without HCCs on EDGE will be categorized into stratum 10 for these operational purposes.

⁴⁷ Enrollees without HCCs may contribute to the PLRS through demographic factors, enrollee RXCs, and CSR risk adjustment factors. As previously explained, these enrollees are not included in the calculation of the HCC-associated error rate during HHS–RADV error estimation.

processes.⁴⁸ Therefore, starting with the 2025 benefit year of HHS–RADV, we propose to add an additional scaling factor, α_i , to the error estimation methodology to ensure that HCC-associated error rates continue to apply to only the proportion of total PLRSs that are associated with HCC-components of EDGE risk scores.

We seek comments on this proposal.

5. HHS Risk Adjustment User Fee for the 2027 Benefit Year (§ 153.610(f))

We propose an HHS risk adjustment user fee for the 2027 benefit year of \$0.20 PMPM. Under § 153.310, if a State is not approved to operate, or chooses to forgo operating, its own risk adjustment program, HHS will operate risk adjustment on its behalf. For the 2027 benefit year, HHS will operate risk adjustment in every State and the District of Columbia. As described in the 2014 Payment Notice (78 FR 15416 through 15417), HHS' operation of the risk adjustment program on behalf of States is funded through a risk adjustment user fee. Section 153.610(f)(2) provides that, where HHS operates a risk adjustment program on behalf of a State, an issuer of a risk adjustment covered plan must remit a user fee to HHS equal to the product of its monthly billable member enrollment in the plan and the PMPM risk adjustment user fee specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year.

OMB Circular No. A–25 established Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public.⁴⁹ The HHS-operated risk adjustment program provides special benefits as defined in section 6(a)(1)(B) of OMB Circular No. A–25 to issuers of risk adjustment covered plans because it mitigates the financial instability associate with potential adverse risk selection.⁵⁰ The HHS-operated risk adjustment program also contributes to consumer confidence in the health insurance industry by helping to stabilize premiums across the individual, merged, and small group markets.

In the 2026 Payment Notice (89 FR 26218), we calculated the Federal administrative expenses of operating the HHS risk adjustment program for the 2026 benefit year to result in a risk adjustment user fee rate of \$0.20 PMPM based on our estimated costs for HHS risk adjustment operations and estimated BMM for individuals enrolled in risk adjustment covered plans. For the 2027 benefit year, HHS proposes to use the same methodology to estimate our administrative expenses to operate the program. These costs cover development of the models and methodology, collections, payments, account management, data collection, data validation, program integrity and audit functions, operational analytics, interested parties training, operational support, and administrative and personnel costs dedicated to HHS-operated risk adjustment program activities. To calculate the risk adjustment user fee, we divided HHS' projected total costs for administering the program on behalf of States by the expected number of BMM in risk adjustment covered plans in States where the HHS-operated risk adjustment program will apply in the 2027 benefit year.

We estimate that the total cost for HHS to operate the risk adjustment program on behalf of all States and the District of Columbia for the 2027 benefit year will be slightly more than \$65 million, which is similar to the 2026 benefit year budget.⁵¹

Similar to prior benefit years, we projected risk adjustment enrollment scenarios for the 2027 benefit year. Based on our estimates, for the 2027 benefit year, we do not expect enrollment changes to significantly impact collections under this user fee rate.

Our intention is to reconsider the enrollment estimates for the final rule. If these newer enrollment estimates are too low in comparison to our proposed user fee estimates, the final user fee may be higher. If these enrollment estimates are higher in comparison to our proposed user fee estimates, the final user fee may be lower. We also note that if any events result in a deviation from our expectations of current conditions that would significantly change our estimates around costs, enrollment projections, or the finalization of proposed risk adjustment policies between this proposed rule and the final rule, we may modify the HHS risk

adjustment user fee rate proposed in this rule in the final rule. Because we project a similar budget to operate the HHS-operated risk adjustment program for the 2027 benefit year as for the 2026 benefit year, we propose an HHS risk adjustment user fee of \$0.20 PMPM for the 2027 benefit year.

We seek comment on the proposed HHS risk adjustment user fee for the 2027 benefit year.

C. Part 154—Health Insurance Issuer Rate Increases: Disclosure and Review Requirements

1. Submission of Rate Filing Justification (§ 154.215)

a. CSR Reimbursement

Section 1402 of the Affordable Care Act requires issuers to provide cost-sharing reductions (CSRs) to increase the actuarial value for consumers with incomes between 100 and 250 percent of Federal poverty level (FPL) who enroll in silver level QHPs in the individual market, as well as eligible AI/AN consumers who enroll in QHPs at any metal level. Section 1402 of the Affordable Care Act also states that HHS will reimburse issuers for the cost of providing CSRs to eligible enrollees but does not include a valid appropriation to make such payments.⁵²

On October 11, 2017, the Attorney General of the United States provided a legal opinion stating that HHS and the Department of the Treasury could no longer use the permanent appropriation at 31 U.S.C. 1324 to fund CSR reimbursements to issuers.⁵³ In accordance with that opinion, HHS directed CMS to discontinue CSR reimbursements to issuers until Congress provides an appropriation. In response to the termination of CSR reimbursement, State Departments of Insurance either allowed or instructed issuers to increase (or “load”) premiums either primarily, or only, on silver-level QHPs to offset the issuers' cost of providing CSRs.⁵⁴

There are several ways that issuers have determined the CSR load factor.

⁵² Until October 2017, HHS relied on the permanent appropriation at 31 U.S.C. 1324 as the source of funds for Federal CSR reimbursement to issuers.

⁵³ See Verma, Seema. (2017, October 12). Letter to Acting Secretary Eric Hagan Regarding Payments to Issuers for Cost-Sharing Reductions (CSRs), <https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf>, relying on *US. House of Reps. v. Burwell*, 185 F. Supp. 3d 165 (D.D.C. 2016). Available at <https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf>.

⁵⁴ For purposes of this preamble, we use the term “CSR loading” to refer to any rating practices to increase premiums to offset amounts of unreimbursed CSRs whether that is “silver loading” or “broad loading.”

⁴⁸ While HHS–RADV also includes processes for validating RXCs and demographic and enrollment factors, any errors regarding these factors are treated as materially incorrect EDGE server data submissions. See 83 FR 16970 through 16971. Also see 84 FR 17501 and 85 FR 77002 through 77005.

⁴⁹ See Circular No. A–25 Revised. <https://www.whitehouse.gov/wp-content/uploads/2017/11/Circular-025.pdf>.

⁵⁰ *Id.*

⁵¹ We estimated that the total costs for HHS to operate the risk adjustment program on behalf of States for the 2026 calendar year would be approximately \$65 million. See, 2026 Payment Notice (90 FR 4424 at 4448).

For example, issuers have loaded silver plans offered on-Exchange to recover expected lost CSRs based on experience, they have loaded silver plans on-Exchange based on an assumed distribution of enrollment and enrollee utilization (sometimes a set amount mandated by the State), or they have loaded all plans at all metal levels by the same amount to spread lost CSRs across the entire individual market. These differing approaches may result in loads that exceed the expected amount of unreimbursed CSRs by assuming an enrollment and claims distribution that significantly diverges from what actually occurs. Based on our review of actuarial memoranda submitted by issuers for PY 2026, HHS believes these excessive loads on silver plans in particular (and in some cases as mandated by State law) lead to inflated premiums for silver plans, further distort pricing for bronze and gold plans relative to silver plans, limit consumer choice, and significantly increase the cost of the second lowest-cost silver plan available to a consumer, which in turn increases PTC amounts and Federal expenditures.

b. Rate Filing Justifications Regarding CSRs

Section 2794 of the PHS Act directs the Secretary, in conjunction with the States, to establish a process for the annual review of premium increases for health coverage prior to the implementation of the increase. HHS has historically interpreted this requirement with respect to premiums as referring to the underlying rates that are used to develop premiums. Section 154.215 requires issuers to submit rate filing justifications to CMS and the applicable State.⁵⁵

Pursuant to § 154.215(b)(1) through (3), the rate filing justification has three parts. The Unified Rate Review Template (URRT) (Part I of the rate filing justification) is required for all single risk pool products, including new products and products with plans that experience rate increases, rate decreases, or no rate change. It is intended to capture information needed to monitor premium increases of health insurance coverage offered through and outside the Exchanges and ensure compliance with the single risk pool methodology, including allowable market level index rate adjustments to reflect risk adjustment payments and

charges, and other Federal rating requirements.⁵⁶

Part II of the rate filing justification is the Written Description Justifying the Rate Increase (Consumer Justification Narrative). Part II is required only for rate increases in single risk pool products that are subject to review (that is, a plan within the product that has a rate increase of 15 percent or greater). Part II is a consumer-friendly narrative that provides the justification for the rate increase, describes the relevant Part I data, the assumptions used to develop the rate increase, and an explanation of the most significant factors causing the rate increase.⁵⁷

An actuarial memorandum (Part III of the rate filing justification) is required for any rate increase in a single risk pool plan. It is also required for any rate filing containing QHPs or whenever a State requires it to be submitted. Further, an actuarial memorandum is required for all plans in States that do not have an Effective Rate Review Program and for which CMS is responsible for reviewing the rate filing.⁵⁸ The Part III actuarial memorandum includes the actuarial reasoning and assumptions, justifications, and methodologies that support the entries in the URRT.⁵⁹ The actuarial memorandum must also capture appropriate actuarial certifications related to the development of the index rate in accordance with Federal regulations, and the development of plan specific premium rates using allowable modifiers to the index rate.⁶⁰ The issuer is required to provide an explanation of how these modifiers are developed and applied to the market-wide adjusted index rate to derive the plan-adjusted index rate.

In a Bulletin issued on May 2, 2025 (PY26 Rate Filing Guidance),⁶¹ we instructed issuers that make permitted plan-level adjustments to account for CSR amounts provided to eligible enrollees for which the issuer does not otherwise receive reimbursement⁶² (that is, that load premiums) to specify

the amount of unreimbursed CSRs in the actuarial memorandum of their PY 2026 rate filing. Issuers report plan-level adjustments when they submit a rate filing justification to the State or CMS for review. States or CMS review those rate filing justifications to ensure compliance with the Federal rating rules, including 45 CFR 156.80.⁶³

Specifically, through the PY 26 Rate Filing Guidance, and pursuant to our authority under § 154.215(a)(2) and (3), we directed issuers that loaded for unreimbursed CSRs to: (1) specify the actual CSRs the issuer paid on behalf of enrollees for PY 2024 (in dollars); (2) specify the CSR load factor for PY 2026 and explain how it was determined; and (3) explain how the additional revenue to be collected from the applied CSR load compares to the expected amount of CSRs that will be provided to enrollees in PY 2026.

Following issuance of the PY26 Rate Filing Guidance, CMS issued additional guidance entitled, “Frequently Asked Questions on Plan Year 2026 Individual Market Rate Filing Instructions,” on May 27, 2025.⁶⁴ We noted that if an issuer was not able to calculate the precise amount of actual CSRs paid for enrollees for PY 2024 by the applicable rate filing deadline, CMS would accept an estimate developed using a reasonable methodology that enables it to estimate the value of CSRs provided for PY 2024 as accurately as possible, detailed in the actuarial memorandum.⁶⁵

⁶³ If the rate filing contains a proposed increase that meets or exceeds the threshold at § 154.200(a)(1) (currently 15 percent), then the State or CMS also reviews the proposed increase to determine if it is an unreasonable rate increase. Also see 45 CFR 154.205(a). When CMS reviews a rate increase subject to review under § 154.210(a), CMS will determine that the rate increase is an unreasonable rate increase if the increase is an excessive rate increase, an unjustified rate increase, or an unfairly discriminatory rate increase.

⁶⁴ CMS. (2025, May 7). Frequently Asked Questions on Plan Year 2026 Individual Market Rate Filing Instructions. https://regtap.cms.gov/reg_library.php?i=5894.

⁶⁵ Under § 156.80(d)(2)(i), an issuer may vary premium rates for a particular plan from its market-wide index rate for a relevant State market based on the actuarial value and cost-sharing design of the plan, including accounting for, if permitted by the applicable State authority, CSR amounts provided to eligible enrollees under § 156.410, provided the issuer does not otherwise receive reimbursement for such amounts. Therefore, if there is a valid appropriation such that HHS and the Department of the Treasury resume making advance payments of CSRs, issuers may not apply any CSR load to QHPs receiving advance CSR payments. In addition, in the event that advance payments of CSRs are made to issuers to reimburse them for CSRs provided, HHS will calculate these monthly advance payments using the formula finalized in the 2015 Payment Notice and using the standard methodology as set forth in 45 CFR 156.430(c)(2) for

⁵⁶ See *Unified Rate Review Instructions* at: <https://www.cms.gov/files/document/unified-rate-review-instructions.pdf>.

⁵⁷ *Id.*

⁵⁸ CMS reviews rate filing justifications from issuers in States without an Effective Rate Review Program—currently Oklahoma, Tennessee, and Wyoming.

⁵⁹ See *Unified Rate Review Instructions* at: <https://www.cms.gov/files/document/unified-rate-review-instructions.pdf>.

⁶⁰ *Id.*

⁶¹ CMS. (2025, May 2). Plan Year 2026 Individual Market Rate Filing Instructions. <https://www.cms.gov/files/document/py-26-individual-market-rate-filing-instructions.pdf>.

⁶² See 45 CFR 156.80(d)(2)(i).

⁵⁵ See 76 FR 29964, 29969 (May 23, 2011).

Starting with rate filings for the 2027 plan year, we are proposing to continue to require issuers that make a plan-level adjustment to account for unreimbursed CSRs to submit certain information specified in the PY26 Rate Filing Guidance in their URRTs and actuarial memoranda for each plan year in which CSRs are not funded. Specifically, in the URRT for the upcoming plan year, issuers would report CSR amounts paid on behalf of enrollees and the additional revenue collected from the previously applied CSR load using the most recent annual data that is available prior to the applicable filing year, using the standard methodology set forth in § 156.430(c)(2). In most cases, the most recent annual CSR data would reflect the plan year that is two years before the upcoming plan year (for example, CSRs paid for eligible enrollees and the additional revenue collected from the CSR load applied in PY 2025 would be reported during the 2026 filing year on rate filings for PY 2027).

As described by the Secretary in applicable guidance,⁶⁶ under the CMS standard methodology, issuers re-adjudicate the actual complete set of claims incurred by an enrollee in the cost-sharing reduction plan variation as if they had been enrolled in the associated standard plan to determine the difference the enrollee would have paid in deductibles, copayments, coinsurance, and other out-of-pocket expenses for EHBs (other than premiums and balance billing). The difference equals the amount of CSRs provided by the issuer.⁶⁷ As stated in the 2016 Payment Notice, we believe that the standard methodology is the most accurate method for calculating the actual value of CSRs that the issuer has provided on behalf of enrollees in a plan year.⁶⁸ Additionally, we believe that most issuers are familiar with that methodology, which was required to calculate CSRs paid on behalf of enrollees for the 2017 plan year, the most recent year in which CMS

provided advance CSR payments to issuers.

We note that although CMS is proposing that issuers use the standard methodology to calculate CSR amounts paid on behalf of enrollees and to submit an aggregate amount of CSRs provided at the plan level on the URRT, this proposed data submission would not require issuers to use the CSR reconciliation process implemented by CMS, as described in § 156.430(c)(2). We believe this proposal would result in lower burden on issuers as compared to the burden that would be associated with submitting policy-level CSR data to CMS through the CSR reconciliation process. Submission of policy-level CSR data would require direct electronic submissions of data that must conform with our business rules, data element validations, and required file formats. When HHS previously collected such data, it resulted in issuers attempting submissions multiple times before the submission could be accepted by the system. The proposed process would leverage the existing URRT submission process and be much less burdensome.

We also propose that issuers would include in the URRT the applicable CSR load factor for each plan that would be applied to the market adjusted index rate to calculate the calibrated plan adjusted index rate for the upcoming plan year. We are proposing to collect the CSR load factor, if any, to fulfill our responsibility to ensure compliance with § 156.80(d), which requires all permitted plan-level adjustments to be “actuarially justified.” In addition, we propose that issuers would include in the actuarial memorandum an explanation of the methodology used to determine the load factor. We propose that issuers would also include in the URRT the additional revenue expected to be collected from the applied CSR load factor and the expected amount of CSRs that will be paid for enrollees for the upcoming plan year. We also propose that issuers would include in the actuarial memorandum an explanation comparing these amounts. This explanation would allow the State or CMS, as applicable, to determine whether the load factor is actuarially justified and not excessive in relation to the amount expected to be paid for unreimbursed CSRs.

In the 2026 Payment Notice, we stated our expectation that CSR loading practices, to the extent permitted by State regulators, are intended to account for unpaid CSRs. We also noted that, while there is no requirement that a State permit CSR loading, in States that have an Effective Rate Review Program, the State has the responsibility to

determine whether an issuer’s adjustments to the market-wide index rate for plan-specific factors (including accounting for CSR amounts) are actuarially justified.⁶⁹ We further propose that an actuarially justified CSR load factor is one that is calibrated on actual experience and that only accounts for the projected revenue loss of unreimbursed CSR payments without materially exceeding that amount. As such, we believe that this proposal to collect through the URRT and actuarial memoranda information on paid CSRs, additional revenue collected from the previously applied CSR load, CSRs expected to be paid, the CSR load factor and expected resultant additional revenue for the upcoming plan year, the underlying methodology for determining the CSR load factor that would be applied for the upcoming plan year, and an explanation of how the expected additional revenue compares to the amount of CSRs expected to be paid, will benefit State regulators (and CMS in States where CMS functions as the primary reviewer of rates) by providing regulators the data necessary to determine whether CSR load amounts are actuarially justified plan-level adjustments to the index rate under § 156.80.

While we recognize the additional burden on issuers to provide this information, given the significant impact of CSR loading on Federal expenditures through additional premium tax credit (PTC) spending, we believe collection of this information is an important program integrity measure that will help ensure that CSR loads are appropriate to recover lost CSR payments and are not inappropriately inflating Federal expenditures or undermining Federal rating rules.

Therefore, starting with rate filings for the 2027 plan year, we are proposing to collect as part of the rate filing justification information on adjustments to the index rate to account for unreimbursed CSRs. Specifically, we propose to collect data regarding the amount of CSRs previously paid on behalf of eligible enrollees using the most recent annual data that is available prior to the applicable filing year (generally data from the plan year that is two years before the upcoming plan year), the amount previously generated by any load factors from the most recent annual data available, the amount of CSRs expected to be paid on behalf of enrollees in the upcoming plan year, the

reconciliation of cost sharing reduction amounts. See 79 FR 13804–13808. Also see 90 FR 4424, 4488.

⁶⁶ See Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Year 2017 (March 29, 2018) at <https://www.cms.gov/ccio/resources/forms-reports-and-other-resources/downloads/final-csr-reconciliation-guidance-by2017.pdf>.

⁶⁷ CMS. (2018, March 29). Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Year 2017. <https://www.cms.gov/ccio/resources/forms-reports-and-other-resources/downloads/final-csr-reconciliation-guidance-by2017.pdf>.

⁶⁸ HHS Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 FR 10750, 10842 (February 27, 2015), available at: <https://www.govinfo.gov/content/pkg/FR-2015-02-27/pdf/2015-03751.pdf>.

⁶⁹ HHS Notice of Benefit and Payment Parameters for 2026 Final Rule, 90 FR 4424, 4489 (January 15, 2025) available at: <https://www.govinfo.gov/content/pkg/FR-2025-01-15/pdf/2025-00640.pdf>.

underlying methodology for determining the CSR load factor that would be applied for the upcoming plan year, the load factor itself (the expected amount generated by the load factor for the upcoming plan year, and an explanation of how the expected amount generated by the load factor compares to the amount of CSRs expected to be paid on behalf of enrollees for the same period. If this proposal is finalized as proposed, we intend to release guidance on the submission of this information as part of revised Unified Rate Review Instructions, as we have historically provided detailed guidance to issuers on how to complete each field of the URRT and satisfy the criteria for the actuarial memorandum in the Unified Rate Review Instructions.⁷⁰ We are not proposing changes to any regulation text as the collection of these data is already captured under § 154.215(d)(1), which states that historical and projected claims experience must be included in the URRT. Additionally, § 156.80(d)(2)(i) states that plan-level adjustments to account for unreimbursed CSR payments provided to eligible enrollees are permissible only if actuarially justified and permitted by the applicable state authority. We request comment on all aspects of our proposal to require issuers that intend to load premium rates to account for unpaid CSRs for the upcoming plan year to submit this information in their URRTs and the actuarial memoranda for each plan year in which CSRs are not funded, beginning with PY 2027 rate filings.

D. Part 155—Exchange Establishment Standards and Other Related Standards

1. Standardized Plan Options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv))

We propose to exercise our authority under sections 1311(c)(1) and 1321(a)(1)(B) of the Affordable Care Act to discontinue the full suite of standardized plan option policies effective beginning in PY 2027. As discussed in greater detail in the preamble section of this proposed rule addressing § 156.201, we propose to remove the following from our regulations: the definition of “standardized option” at § 155.20; all requirements pertaining to standardized plan options at § 156.201 (the

requirements for FFE and SBE–FP QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one another at paragraph (c)); the differential display of standardized plan options on *HealthCare.gov* at § 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv). We also propose to redesignate paragraphs (c)(3)(i)(I) through (M) of § 155.220 as paragraphs (c)(3)(i)(H) through (L), respectively. Finally, we propose to cease the annual design and publication of these standardized plan options in the applicable Payment Notice rulemaking for each plan year.

2. Approval of a State Exchange (§ 155.105)

We propose to remove § 155.105(b)(4) to rescind a requirement made in the 2025 Payment Notice (89 FR 26259 through 26261), that a State seeking to operate a State Exchange must first operate, for at least 1 plan year, a State-based Exchange on the Federal platform (SBE–FP). The original amendment was intended to give States sufficient time to create, staff, and structure a State Exchange. However, we recognize that requiring States to first operate as an SBE–FP for at least 1 plan year could potentially create unnecessary barriers for States that are well-prepared to implement a State Exchange more immediately.

Sections 1311(b) and 1321(b) of the Affordable Care Act allow States to elect to operate their own health insurance Exchanges to provide individuals and employers with health insurance coverage. Every State that has implemented a State Exchange after 2014—the year the initial 13 State Exchanges began operation—first operated an SBE–FP for at least 1 plan year. This history shows how first operating an SBE–FP has been the preferred approach. However, we recognize that States may have existing infrastructure, relationships, and expertise that could support a State’s successful operation of a State Exchange, without first operating an SBE–FP. For example, FFE States are permitted to elect to perform plan management functions similar to the plan management functionality required

of all SBE–FPs.⁷¹ The infrastructure and the associated stakeholder relationships and State expertise to support such functionality could be leveraged from a direct FFE to State Exchange implementation. Additionally, the technology infrastructure available today to States for implementation of State Exchanges has become more compatible, such that the technology used to support one State Exchange implementation could be leveraged by another State Exchange. A State must demonstrate its ability to operationalize State Exchange functional requirements through a well-established and robust review process with HHS. Whether a State first operates an SBE–FP does not change our review process for determining whether a State is ultimately prepared to implement a State Exchange. For the reasons provided above, we propose to remove § 155.105(b)(4), such that a State seeking to operate a State Exchange is not required to first operate an SBE–FP for at least 1 plan year, including its first open enrollment period.

We seek comment on this proposal.

3. Approval of a State Exchange (§ 155.106)

In an effort to support the overall goals of Executive Order 14192, “Unleashing Prosperity through Deregulation,”⁷² we propose to amend § 155.106(a)(2) to rescind a requirement we made in the 2025 Payment Notice (89 FR 26261 through 26263) that, as part of a State’s activities for its establishment of a State Exchange, the State must provide, upon request, supporting documentation demonstrating progress toward meeting or implementing State Exchange Blueprint requirements. Section 155.106(a)(2) requires that States electing to operate a State Exchange submit a State Exchange Blueprint Application to HHS for approval. The current State Exchange Blueprint application provides that we may require live demonstrations of Exchange functionality on the State Exchange’s platform, as well as supporting documentation, as evidence of the State’s progress toward meeting State Exchange Blueprint application requirements. For clarity, we had

⁷¹ A state may choose to operate plan management functions within the FFE. CMS. (2012, May). Plan Management Partnership in the Federally Facilitated Exchange (FFE). Available at: <https://www.cms.gov/CCIIO/Resources/Presentations/Downloads/hie-plan-management-partnership-in-the-ffe.pdf>.

⁷² E.O. 14192, January 31, 2025 (90 FR 9065), available at <https://www.federalregister.gov/documents/2025/02/06/2025-02345/unleashing-prosperity-through-deregulation>.

⁷⁰ The information collection described in this section will be submitted as a revision to the currently approved PRA package CMS–10379 (OMB Control Number 0938–1141) for OMB review under the Paperwork Reduction Act.

finalized in the 2025 Payment Notice to codify that as part of the State's submission of a State Exchange Blueprint application, CMS has the authority to request supplemental documents it determines necessary for the State to detail its implementation of the required State Exchange functionality. To support deregulation where possible, we are now proposing to remove what we codified.

The State Exchange Blueprint continues to serve as a vehicle for a State to document its progress toward implementing its intended Exchange operational model. HHS approves a State's Exchange Blueprint Application and subsequently provides approval for a State to operate a State Exchange, based upon a State meeting State Exchange implementation requirements noted in the Blueprint Application. The current Blueprint Application requires a State to sign and agree that HHS may require supporting documentation from a State as evidence of its progress toward meeting State Exchange Blueprint Application requirements, which is part of the overall process for providing a State with approval to operate a State Exchange. Notably, in our experience, States recognize the need for HHS to request supplemental documentation in order for HHS to assess a State's readiness to operate a State Exchange, which supports a State's successful State Exchange operation. States have provided such supplemental documentation upon HHS request both before and after this requirement was originally codified. Given this preexisting process, we do not believe deregulation in this instance is harmful, nor would it lead to burden on States. Therefore, we propose to rescind the requirement that a State provide, upon request, supporting documentation demonstrating progress toward meeting or implementing State Exchange Blueprint requirements from § 155.106(a)(2).

We seek comment on this proposal.

4. Amending Requirements for State Exchanges To Operate a Centralized Eligibility and Enrollment Infrastructure (§§ 155.205(b) and 155.221(k))

a. Amending Requirements for State Exchanges To Operate a Centralized Eligibility and Enrollment Platform on the State Exchange's Website (§ 155.205(b))

We are proposing to revise § 155.205(b)(4) and (5) to remove the requirement that all State Exchanges operate a consumer-facing centralized eligibility and enrollment platform on the State Exchange's website such that

a State Exchange could choose to rely entirely on web-brokers (a type of non-Exchange entity) for implementing and operating consumer-facing websites that facilitate the eligibility and enrollment process in a State Exchange, pursuant to the proposal in section III.D.4.b. of this preamble. These consumer-facing websites operated by web-brokers would facilitate the online submission of eligibility applications by individuals seeking coverage through a State Exchange and facilitate the selection and enrollment into QHPs on a State Exchange for qualified individuals. These consumer-facing websites operated by web-brokers would also interface with the State Exchange website, which the State would still be required to operate broadly under § 155.205(b), in such a manner as to transmit information from the non-Exchange website to the State Exchange website. This would facilitate the State Exchange meeting the requirements at §§ 155.205(b)(4) and (5) which requires an Exchange to maintain a website that allows an individual to submit a single streamlined eligibility application to the State Exchange and enroll in coverage through the State Exchange. Operationally, such consumer-facing websites operated by web-brokers would be required to interface with the information technology platform that the State Exchange would still need to operate to appropriately process applicant eligibility determinations and process enrollment transactions with QHP issuers (that is, the State Exchange's 'back-end' eligibility and enrollment system). Using State Exchange-approved technical specifications and/or standards for those interfaces (for example, web services) would allow the exchange of data between the consumer-facing websites operated by web-brokers and the State Exchange in a manner that is seamless to consumers. Such an interface would allow for the transmission of consumer eligibility application information and/or QHP selection and enrollment information necessary for the State Exchange to meet key Exchange functional requirements. These requirements include collecting information from applicants through an HHS-approved single, streamlined eligibility application for insurance affordability programs per §§ 155.310 and 155.405; performing eligibility verifications required at §§ 155.315 and 155.320; performing assessments or determinations of Medicaid/CHIP eligibility required at § 155.302; and performing determinations of eligibility for QHP enrollment and APTC/CSRs at

§§ 155.305 and 155.310. This also includes key enrollment functions such as collecting and maintaining records of QHP enrollment for all consumers of the State Exchange as required under § 155.400 and transmitting such enrollment information to CMS and IRS. Such consumer-facing websites operated by web-brokers would also need to allow for consumers to select and enroll into a QHP (that is, through direct enrollment) in order to submit QHP selection and enrollment to the State Exchange. This model, referred to as the State Based Exchange Enhanced Direct Enrollment (SBE-EDE) model, is proposed and discussed in further detail in section III.D.4.b of this proposed rule. State Exchanges that opt to take this approach would be required to establish standards and a process for selecting the web-brokers who they may interface with in this manner, similar to the standards and criteria that we have established for direct enrollment entities at §§ 155.221(j) and 155.220(n), including a requirement that a non-Exchange web-broker entity satisfy all requirements under § 155.110(a).

When HHS finalized the requirement at § 155.205(b) that Exchanges operate a centralized eligibility and enrollment platform on the Exchange's website in the 2025 Payment Notice (89 FR 26271), HHS' intent was to tie together regulatory requirements throughout part 155 regarding the integrated nature of online, real-time automated eligibility functions that Exchanges were intended to perform. This included the intent to clearly affirm the close integration that exists and is necessary between Exchange-operated websites, the online consumer-facing single streamlined eligibility application, and the back-end eligibility system that performs automated eligibility verifications and eligibility determination functions that return real-time, online results to the consumer.

While we continue to affirm that State Exchanges are responsible for making all eligibility determinations for QHP coverage and related insurance affordability programs through a centralized eligibility processing system and enrollment records system, we have determined that requiring State Exchanges to operate a consumer-facing, centralized eligibility and enrollment consumer website that interfaces with the State Exchange's back-end eligibility processing and enrollment records system may prohibitively restrict Exchange flexibility and innovation. While all State Exchanges that do not use the Federal platform currently operate their own eligibility and enrollment consumer interface on the

State Exchange's website, we believe that maintaining this requirement in regulation could discourage State Exchanges from pursuing innovative approaches that might better serve their specific populations and enhance the consumer experience, including private sector-focused consumer engagement and enrollment strategies. We believe that providing State Exchanges with flexibility in how they offer their online eligibility and enrollment consumer interface may allow State Exchanges to develop solutions that address the unique needs of their residents and markets. Removing the requirement for an Exchange to operate an eligibility and enrollment consumer interface on its website is a necessary step in order to codify the SBE-EDE option we are proposing at § 155.221(k), as described in section III.D.4.b. and previously in this section. Under this option, the ability for State Exchanges to exclusively utilize web-brokers to operate consumer-facing websites that facilitate eligibility and enrollment is the key component.

We note that section 1311(c)(5) and (d)(4)(C) of Affordable Care Act, do not require Exchanges to operate a centralized consumer-facing eligibility and enrollment website that supports both eligibility determinations for, and enrollments in, QHPs.⁷³ Rather, section 1311(d)(4)(C) of the Affordable Care Act provides that an Exchange must maintain an internet website through which enrollees and prospective enrollees of QHPs may obtain standardized comparative information on QHPs available in the State. Exchanges must also undertake certain minimum functions to facilitate the purchase of QHPs under section 1311(b)(1)(A) of Affordable Care Act and make available QHPs to qualified individuals and employers under section 1311(d)(2)(A) of Affordable Care Act. These minimum functions facilitate the purchase of QHPs by helping to make the purchase of QHPs easier and also by administering elements of the structure necessary to make QHPs available. This approach of relying on private sector EDE entities aligns with the general Affordable Care Act framework that relies on and benefits from the government working within the existing health insurance coverage

infrastructure rather than taking a purely governmental or public approach to advancing coverage for the individually insured population. The Affordable Care Act does not establish new government-provided health plans but instead creates Exchanges to facilitate the purchase of government-subsidized QHPs through the individual health insurance market. Exchanges support specific statutory functions that make QHPs available to purchase. These functions include certifying that QHPs conform to certain Federal standards in addition to State and Federal standards that govern the individual health insurance market. Exchanges must also provide certain tools to help consumers shop for QHPs, as well as support eligibility determinations and enrollment in other public health care programs such as Medicaid Affordable Care Act and CHIP. Importantly, these additional standards do not dictate any specific changes to the existing enrollment pathways on the individual market.

In the context of operating an internet website, we interpret the statutory language at section 1311(c)(5) and (d)(4)(C) of Affordable Care Act to require that Exchanges minimally operate an informational website that provides consumers with the ability to view comparative information on QHP options, but that the Exchange may direct consumers to other entities or resources for purposes of facilitating the submission of applications for eligibility and enrolling enrollment in QHPs, with APTC and CSRs, if otherwise eligible. Accordingly, a State Exchange that elects the new SBE-EDE option would continue to be responsible for determining eligibility for, and granting exemption certifications under, section 1311(d)(4)(H) of Affordable Care Act, as applicable; making available an electronic calculator consistent with section 1311(d)(4)(G) of Affordable Care Act; establishing a Navigator program as required under section 1311(d)(4)(K) of Affordable Care Act; and providing for the operation of a toll-free telephone hotline under section 1311(d)(4)(B) of Affordable Care Act. As mentioned earlier and consistent with section 1311(d)(4)(F) of the Affordable Care Act, a State Exchange that elects to pursue this new SBE-EDE option would continue to be responsible for conducting assessments or determinations of eligibility for Medicaid and CHIP. They would use the information provided by consumers on the consumer-facing website operated by a web-broker State Exchange's approved single, streamlined eligibility

application that is made available on the consumer websites operated by the web-brokers selected by the State Exchange as part of the SBE-EDE option, and for referring individuals who are assessed or determined eligible for Medicaid or CHIP to the appropriate State Medicaid agency for enrollment in those programs.

The State Exchanges that are currently operating have had to engage with private entities in a manner that would similarly translate to what a State Exchange would be doing under the SBE-EDE model, in terms of relying on the services of private entities to develop and operate a consumer-facing website (that is, online eligibility and enrollment portal) that facilitates consumers applying for and enrolling in QHPs through the State Exchange. Most State Exchanges currently in operation have competitively-procured services from a private entity to develop and operate an online eligibility and enrollment portal (including through which an applicant can submit a single, streamlined application for insurance subsidy programs) and consumer-facing QHP enrollment portal on their respective State Exchange website. These online, consumer-facing eligibility and enrollment portals on State Exchange websites facilitate the online submission of consumer eligibility applications and QHP selection and enrollments, and through web interfaces that are seamless to consumers, transmit that information to the State Exchange's back-end eligibility and enrollment processing information system. We believe that in the absence of a centralized consumer facing website for eligibility and enrollment operating on a State Exchange's website under the proposed SBE-EDE approach, web-brokers may provide that service to a State Exchange in a manner that is similar to that which currently exists between State Exchanges and the private entities they have contracted with to operate their centralized consumer-facing online eligibility and enrollment portal on the State Exchange's website. In both approaches, whether a web-broker provides the online eligibility and enrollment portal to consumers outside of the State Exchange's website, as would be the case under this proposal, or a private entity has developed and operates the consumer-facing online eligibility and enrollment portal on the State Exchange's website in a centralized fashion, the State Exchange maintains responsibility for meeting all other Federal requirements for their online consumer assistance functions. As such,

⁷³ Section 1311(c)(5) of the Affordable Care Act instead requires the Secretary to make available to all Exchanges a model Exchange website template developed by the Secretary. Section 1311(d)(4)(C) of the Affordable Care Act requires the Exchanges to maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans.

the State Exchange would still need to maintain a website that meets all other website requirements for State Exchanges under § 155.205(b), in the same manner that SBE-FPs are currently required to maintain an informational website for consumers while relying on the Federal eligibility and enrollment platform for eligibility and enrollment functions. In particular, State Exchanges that elect the SBE-EDE option would be required to meet the minimum Exchange function requirement under section 1311(d)(4)(C) of the Affordable Care Act to maintain a website providing standardized comparative information on such plans to enrollees and prospective enrollees of QHPs.

In the 2025 Payment Notice (89 FR 26271), we amended § 155.302(a) to codify the Exchange's responsibility for conducting eligibility determinations and maintaining records of all QHP enrollments on the Exchange. State Exchanges would still maintain this responsibility if it elects to pursue the new SBE-EDE option and exclusively utilize web-brokers for operating consumer websites that facilitate the eligibility and enrollment process in a State Exchange. Additionally, enrollment through such a consumer website would still be considered enrolling in a QHP through the State Exchange per § 155.220(c)(3) and proposed § 155.221(k)(2).

We note that this proposed amendment would not affect other regulatory requirements throughout 45 CFR part 155 that govern State Exchange eligibility and enrollment functions. For instance, per § 155.405, State Exchanges would still be required to obtain HHS approval for the eligibility application used on the consumer websites. HHS' review of the State Exchange's eligibility application would follow the currently established processes, including requiring that the State Exchange demonstrate appropriate functionality to make accurate determination. As such, State Exchange that does not rely on the Federal eligibility and enrollment platform can continue to meet these obligations without operating a singular, centralized consumer-facing eligibility and enrollment website.

We recognize that allowing State Exchanges to take this approach would create different consumer experiences in applying for and enrolling in coverage through State Exchanges as compared to an approach where a State Exchange implements and operates a centralized eligibility and enrollment infrastructure. We seek comment on how State Exchanges that implement such an approach can create comparable

consumer experience, in addition to comments on HHS oversight and the approval requirements proposed in section III.D.4.b. of this proposed rule. We seek comment on this proposal.

b. SBE-Enhanced Direct Enrollment Option (§ 155.221(k))

To build on the success of the EDE pathways and enhance the consumer enrollment experience, we are proposing to offer additional flexibility to State Exchanges to leverage the benefits of EDE through a private sector-supported consumer engagement and enrollment strategy that is tailored to the needs of local markets. Accordingly, we propose to add a new paragraph (k) to § 155.221 to establish a process for State Exchanges that do not rely on the Federal eligibility and enrollment platform to elect a new SBE-EDE option, in which the applicable State Exchange could seek HHS approval for web brokers to serve as the exclusive enrollment pathways for operating consumer-facing websites that facilitate the eligibility and enrollment process in a State Exchange. These consumer-facing websites operated by web-brokers would facilitate the online submission of eligibility applications by individuals seeking an eligibility determination for, and enrollment in, a QHP offered through the Exchange with APTC and CSRs, if otherwise eligible. Previously, the Exchange DE option was finalized in part 1 of the 2022 Payment Notice Final Rule (86 FR 6151) and later repealed in part 3 of the 2022 Payment Notice (86 FR 53429). We propose to codify this policy again and to also allow Exchanges to offer their consumers a form of EDE in which the Exchanges rely exclusively on web-brokers to implement and operate the consumer-facing websites through which consumers select and enroll in a QHP without requiring that the Exchanges also operate a centralized consumer-facing eligibility and enrollment website. We are proposing this for State Exchanges exclusively to gather their insight into, and leverage any operational experience they gain in, implementing this model. This would help inform operational considerations were we to expand this model to the FFEs and State Exchanges that use the Federal eligibility and enrollment platform, both of which were included in the previous policy. Since the repeal of the Exchange DE option, many of the policy and operational priorities, as well as then-new Federal laws cited at that time to justify the repeal, are no longer competing for agency resources, and

this has created bandwidth to codify a version of the DE option once again.⁷⁴

A State Exchange electing to implement the SBE-EDE option would continue to be responsible for meeting, and ensuring that all approved EDE partners meet all applicable statutory and regulatory requirements governing application for and enrollment in QHPs. The State Exchange would also continue to be responsible for sharing eligibility determination and enrollment information in coordination with issuers and HHS in accordance with §§ 155.340, 155.400, and 155.430. The State Exchange would continue to provide HHS enrollment data to ensure accurate APTC payments are made to issuers on behalf of qualified individuals and in support of reconciliation of APTC on individual income tax returns.

In connection with the SBE-EDE option, the State Exchange would still be required to make available a website listing basic QHP information for comparison,⁷⁵ and a listing with links to approved partner websites for consumer shopping, plan selection, and enrollment activities. Consistent with section 1311(d)(4)(E) of Affordable Care Act, the comparative plan information presented on the State Exchange's website would need to continue to utilize a standardized format, including the use of the uniform summary of benefits and coverage established under section 2715 of the PHS Act.⁷⁶ The standardized comparative information displayed on the Exchange website would also be required to continue to include the quality ratings assigned to each QHP offered through the Exchange.⁷⁷ In addition, the State

⁷⁴ Policy and operational priorities and then-new Federal laws included implementation of E.O. 13985 and E.O. 14009; Affordable Care Act-related programs under the American Rescue Plan Act of 2021 (ARP) (namely, the State Exchange Modernization Grant Program) and the No Surprises Act; and activities undertaken by HHS to implement the COVID-19 SEP. While activities undertaken pursuant to the No Surprises Act continue, E.O. 13985 and 14009 have been rescinded. Additionally, many resources needed to implement and oversee administration of the enhanced subsidies codified under the ARP, and later extended under the Inflation Reduction Act of 2022, are no longer needed since they expired at the end of 2025. The State Exchange Modernization Grant program also has concluded and States closed out their grants between January and August of 2023. Additionally, activities related to implementing the COVID-19 SEP, including coordination with and oversight of State Exchanges with respect to similar SEPs they implemented in response to the COVID-19 public health emergency (PHE), concluded before the PHE ended in 2023.

⁷⁵ 45 CFR 155.205(b)(1) outlines the QHP comparative information which must be displayed.

⁷⁶ See § 155.205(b).

⁷⁷ See section 1311(d)(4)(D) of Affordable Care Act and 45 CFR 155.205(b). Also see sections 1311(c)(3) and (c)(4) of Affordable Care Act and §§ 155.1400 and 155.1405.

Exchange, along with its EDE partners, would continue to be responsible for meeting Federal accessibility standards under § 155.205(c) for individuals living with disabilities and for individuals who have limited English proficiency.⁷⁸ Finally, all consumer data collected, stored, or transmitted through web-broker platforms operating under the SBE-EDE option would remain subject to the privacy and security standards established at § 155.260 and web-brokers participating in the SBE-EDE option would be subject to HHS oversight and monitoring pursuant to § 155.280 as a non-Exchange entity. State Exchanges implementing the SBE-EDE option would be required to ensure that web-brokers comply with these protections, including, but not limited to, encryption, access controls, and audit logging requirements.

HHS would maintain oversight authority over State Exchanges under § 155.1200, which would enable enforcement of Federal requirements associated with the SBE-EDE option and would allow HHS to take necessary actions to mitigate program integrity risks inherent in this model. To ensure ongoing compliance and reduce program integrity risks under the SBE-EDE option, HHS would rely on the State-based Marketplace Annual Reporting Tool (SMART), as a key oversight mechanism. Under § 155.1200(b), State Exchanges would be required to complete SMART submissions annually, attesting to their compliance with relevant Exchange operational requirements under part 155. Additionally, under § 155.1200(c), State Exchanges would need to engage independent qualified auditing entities to perform annual external financial and programmatic audits, which would be included with SMART submissions. HHS would review all SMART submissions and would issue formal letters to State Exchanges summarizing observations on areas of noncompliance and identifying any required corrective actions. This SMART-based compliance monitoring process would serve as a critical safeguard against program

integrity risks by providing HHS with regular, audited documentation of State Exchange operations and would be relied on under the SBE-EDE model.

Beyond the SMART process, HHS would employ additional oversight mechanisms to mitigate program integrity risks. These include formal technical assistance opportunities tailored to SBE-EDE implementation efforts and challenges, as well as ongoing informal communications with State Exchange leadership and staff for proactive, real-time issue identification and resolution. Together, these oversight tools—anchored by the SMART compliance monitoring process—would enable HHS to exercise its enforcement authority and ensure that State Exchanges implementing the SBE-EDE option maintain program integrity and meet all Federal requirements.

In this proposed rule, we propose to modify § 155.221(k) such that, subject to HHS approval, a State Exchange that does not rely on the Federal eligibility and enrollment platform may elect to engage one or more web-brokers described in paragraph § 155.221(a) to facilitate QHP enrollments through its Exchange. Such approved entities would enroll qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange⁷⁹ and would also facilitate consumer submission of eligibility applications through the entity's consumer website to the State Exchange to receive eligibility determinations from the State Exchange for APTCs and CSRs.

At § 155.221(k), we propose requirements for a State Exchange to become an SBE-EDE. We propose that a newly-transitioning or approved State Exchange must submit an Exchange Blueprint application, or Blueprint revision, to HHS for review at least 15 months prior to the targeted open enrollment launch date as an SBE-

EDE.⁸⁰ For an approved State Exchange, this would be considered a significant change to its Blueprint.⁸¹ We also propose that the State Exchange must meet all other applicable Federal statutory and regulatory requirements for the operation of an Exchange, including for approved State Exchanges to request and obtain HHS approval for any significant changes to its single, streamlined eligibility application under § 155.405. Following submission of an approved State Exchange's submission of a revised Exchange Blueprint application, in accordance with § 155.105(e), HHS would have up to 90 days⁸² to review the revision and approve or deny the change.

Additionally, in accordance with § 155.105(c)(2), we propose at § 155.221(k)(1) that a State Exchange that wants to implement the SBE-EDE option would be required to demonstrate to HHS operational readiness for the State Exchange to enroll qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange and to enable individuals to apply for APTC and cost sharing for QHPs, as well as receive assessments or determinations of Medicaid and CHIP eligibility from the Exchange as described in § 155.302, using the eligibility application described in § 155.405. We propose a new requirement at § 155.221(k)(2) that the State also would receive approval only if it provides HHS with an implementation plan and timeline that details the key activities, milestones, and its communications and outreach strategy to support the transition of enrollment operations to EDE entities. This is to ensure that HHS and the State

⁸⁰ This approach is consistent with the 15-month State Exchange approval timeline requirements under § 155.106(a)(2) for States seeking to newly establish and operate a State Exchange to submit its State Exchange Blueprint for review and approval. While the SBE-EDE model is distinct from the State Exchange model, we would consider a transition to the SBE-EDE model to require a significant operational effort to implement such that a consistent timeframe would have many benefits to the State and HHS, particularly while the SBE-EDE model remains a new Exchange model.

⁸¹ This approach is consistent with the requirement that a State notify HHS and receive written approval from HHS before significant changes are made to the Exchange Blueprint. See, for example, 77 FR 18316. Significant changes could include altering a key function of Exchange operations or other changes to the Exchange Blueprint that would have an impact on the operation of the Exchange. This includes, but is not limited to, the process for enrollment in a QHP. See, for example, 76 FR 41871.

⁸² As detailed in § 155.105(e), HHS generally has 60 days after receipt of a completed request to complete its review of a significant change to an Exchange Blueprint and, for good cause, may extend the review period by an additional 30 days up to a total of 90 days.

⁷⁸ Covered entities such as States, recipients of Federal financial assistance from HHS, programs or activities administered by HHS under title I of Affordable Care Act (such as the FFE), and programs or activities administered by any entity established under Title I (such as State Exchanges), must comply with applicable Federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, sex, age, and disability. These laws include section 1557 of Affordable Care Act (42 U.S.C. 18116) (Section 1557), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d *et seq.*) (Title VI), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) (Section 504), and the Americans with Disabilities Act of 1990 (29 U.S.C. 12101 *et seq.*) (ADA).

⁷⁹ Section 1401(a) of Affordable Care Act added new section 36B to the Code, which provides for PTCs for eligible individuals, while section 1402 of Affordable Care Act provides for CSRs for eligible individuals. For individuals to be eligible to receive PTCs, among other requirements, the Affordable Care Act requires that individuals be enrolled in a QHP through an Exchange. We have interpreted this statutory language to allow a QHP issuer to enroll an applicant who initiates enrollment directly with the QHP issuer. See § 156.1230, whereby individuals enrolling directly on the website of a QHP issuer are considered enrolled "through an Exchange" so long as the issuer meets applicable requirements. We adopted a similar approach to allow a web-broker to enroll an applicant who seeks to enroll through the web-broker's website. See § 155.220(a)(2) and (c), whereby individuals enrolling directly through the site of a web-broker are considered enrolled "through an Exchange" so long as the web-broker meets applicable requirements.

have an opportunity to coordinate these details to maximize the chances of a successful transition. State Exchanges that elect to implement the SBE-EDE option would retain the flexibility to determine their own business controls while complying with § 155.220(n) and § 155.221(j), which outline the applicability of Federal web-broker and EDE requirements to State Exchanges, including requirements related to standardized website disclaimers, web-broker operational readiness, business audit and security and privacy documentation, and display of website changes. We propose at § 155.221(k)(3) that HHS would not approve a State Exchange to implement the SBE-EDE option unless the State Exchange demonstrates to HHS that at least one EDE entity selected by the State is capable of enrolling all consumers in the State. In particular, we believe it is critical that State Exchanges that elect to implement the SBE-EDE option establish that at least one EDE entity meets the minimum Federal requirements to participate in the Federally-facilitated Exchange enhanced direct enrollment program, including requirements at §§ 155.220 and 155.221, particularly § 155.220(c)(3)(i)(A) and (D),⁸³ to ensure consumers have at least one option through which to view detailed QHP information for all available QHPs in the State, and meets accessibility requirements under § 155.205(c). Therefore, we propose that if no EDE partner meets these requirements, the State Exchange would be required to continue operation of its own consumer-facing State Exchange website for purposes of eligibility and enrollment. To assist State Exchanges in meeting requirements to become an SBE-EDE, State Exchanges could partner with an existing, HHS-approved web-broker EDE partner⁸⁴ as a starting

point to develop their own EDE programs, as these entities have already met requirements for HHS approval to participate in the FFE's EDE program.

In summary, we propose in this rule to allow newly-transitioning or approved State Exchanges to make web-brokers the exclusive enrollment pathways to facilitate the online submission of eligibility applications by individuals seeking coverage through the State Exchange, including by adding the following new provisions: § 155.221(k), which describes the proposed SBE-EDE option and approval process; § 155.221(k)(1), which lays out the proposed requirement for a State Exchange to demonstrate operational readiness to enroll qualified individuals in a QHP through approved EDE entities to be considered a SBE-EDE; § 155.221(k)(2), which details the proposed requirement to provide an implementation plan and timeline; and § 155.221(k)(3), proposing to require that a minimum of one EDE entity selected by the State meets minimum Federal requirements to participate in the FFE's EDE program and is capable of enrolling all consumers in the State in all available plan offerings, as well as meeting certain other requirements. We solicit comment on all aspects of this proposal, including any comments related to interest in pursuing this model among State Exchanges or other interested parties, expanding the option to other Exchange models, anticipated impacts to Exchange operating costs, and any other considerations or recommendations to effectively operationalize the SBE-EDE option. We also seek comment on the appropriate timing for making this option available to State Exchanges, specifically whether HHS should make this option available to State Exchanges for the PY 2028 annual open enrollment period (consistent with the 15-month Blueprint timeline referenced in this section) or delay implementation to PY 2029 (or later) to allow additional transition time for early adopters of the model.

5. Additional Required Benefits (§ 155.170)

We propose to revise § 155.170(a) to provide that any State-required benefits would be considered “in addition to EHB” (and thus not an EHB) if they are: required by a State action taking place after December 31, 2011; applicable to the small group and/or individual markets; specific to required care, treatment, or services; and not required by State action for purposes of

compliance with Federal requirements. Under this proposal, such State-required benefits would be considered in addition to EHB regardless of whether the mandated benefits are embedded in the State's EHB-benchmark plan. We propose that this change would be effective beginning with PY 2027. We also propose revisions to the regulatory text at §§ 155.170(a)(2) and 156.115(a) to align with this proposal and to have State and issuer responsibilities with respect to State-required benefits appear in a more logical reading order in the CFR.

Section 1311(d)(3)(B) of the Affordable Care Act permits a State to require QHPs offered in the State to offer benefits in addition to the EHB, but requires the State to make payments, either to the individual enrollee or to the QHP issuer on behalf of the enrollee, to defray the cost of these additional State-required benefits.

In the EHB final rule (78 FR 12838), we finalized a standard at § 155.170(a)(2) that specified that State-required benefits enacted on or before December 31, 2011, even if not effective until a later date, are considered EHBs and therefore the costs of these benefits are not required to be defrayed by the State. The 2017 Payment Notice (81 FR 12242 through 12244) revised § 155.170(a)(2) to make clear that benefits required by State action taking place on or before December 31, 2011 are considered EHB, regardless of whether required benefits were established through legislative action, regulation, guidance, or other State action. We also amended § 155.170(a)(2) to provide that benefits required by State action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, are considered in addition to EHB.

Most recently in the 2025 Payment Notice (81 FR 26264 through 26268), we finalized that, beginning in PY 2025, covered benefits in a State's EHB-benchmark plan are considered an EHB under § 155.170(a)(2) and thus, do not require defrayal by the State. However, we noted that 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. Additionally, we noted that beginning in PY 2025, a State that is defraying the costs of a benefit required by a mandate that is in addition to the EHB under § 155.170 will be permitted to cease defraying the

⁸³ In addition to ensuring there is at least one website available in the State that satisfies all accessibility requirements under § 155.205(c), we proposed that there must also be at least one website available in the State through which consumers can view and enroll in all available QHPs in the State.

⁸⁴ In coordination with third-party auditors, HHS vets prospective Classic DE and EDE partners that want to operate on the FFE's DE or EDE pathway to ensure compliance with §§ 155.220 and 155.221, and meet other operational requirements further detailed in sub-regulatory guidance (available at: <https://www.cms.gov/files/document/guidelinesfor-enhanceddirectenrollmentauditsforyear8final.pdf> and <https://www.cms.gov/files/document/fq-regarding-decommissioning-classic-direct-enrollment-de-pathway091125.pdf>). HHS also maintains an updated list of approved DE and EDE partners, which it posts publicly on the website for the Centers for Medicare & Medicaid Services (available at: <https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/downloads/classic-de-webbrokers.pdf> and <https://www.cms.gov/files/document/ede-approved-partners.pdf>).

costs of that benefit if the benefit was included in its EHB-benchmark plan or upon updating its EHB-benchmark plan to include such benefit coverage. We further clarified that because any covered benefits in a State's EHB-benchmark plan are considered to be an EHB, such benefits are subject to the various rules applicable to EHB, including the prohibition on discrimination in accordance with § 156.125, the annual limitation on cost sharing in accordance with § 156.130, and restrictions on annual or lifetime dollar limits in accordance with § 147.126. We supported the revision to § 155.170(a)(2) finalized in the 2025 Payment Notice in part based on our understanding of States' struggle to understand and operationalize the policy that previously required States to defray the cost of State-required benefits, even if such benefits were included in the State's EHB-benchmark plan. We stated that finalization of this policy would promote consumer protections and facilitate compliance with the defrayal requirement by making the identification of benefits in addition to the EHB more intuitive.⁸⁵

We have since reevaluated this position and believe we should not jeopardize the affordability of premiums, particularly for unsubsidized enrollees, for an intangible improvement to States' understanding of Federal defrayal requirements. When States enact benefit mandates, plan premiums must generally increase to account for the additional coverage. In the individual market (in which QHPs are sold), if State-required benefits are EHB, the associated premium increases will be entirely offset for consumers receiving APTC by higher APTC expenditures because the amount of APTC is tied directly to the premium amount. Over time, the accumulation of new State-required benefits that are EHB could substantially increase Federal APTC costs, undermining the purpose of the statutory defrayal policy. While premium increases associated with the accumulation of State-required benefits that are EHB would be offset for subsidized consumers, they are not offset for unsubsidized enrollees because they do not receive APTC. As a result, we are concerned that the

policy finalized in the 2025 Payment Notice that any covered benefits in a State's EHB-benchmark plan are considered EHB has an outsized impact on unsubsidized enrollees who do not receive APTC, which threatens to disincentivize enrollment amongst this population.

We believe that our current policy incentivizes States to enact additional State-required benefits and then to select an EHB-benchmark plan under § 156.111 that includes such State-required benefits such that these benefits are considered to be EHB. We believe this approach drives up premiums, which, in turn, increases Federal APTC expenditures, negatively impacts unsubsidized enrollees, and exacerbates low enrollment amongst this population.

Therefore, we propose to revise § 155.170(a)(2) to revert to the standard that was in place prior to the 2025 Payment Notice, which required States to defray the cost of applicable State-required benefits at § 155.170(a)(1) taken by State action after December 31, 2011, even if such benefits are included in the State's EHB-benchmark plan beginning with PY 2027. Specifically, we propose to revise § 155.170(a)(1) to provide that a State mandated benefit would be considered "in addition to EHB" (and thus not EHB) if it is: (i) required by a State action taking place after December 31, 2011; (ii) applicable to the small group and/or individual markets; (iii) specific to required care, treatment, or services; and (iv) not required by State action for purposes of compliance with Federal requirements.

We note that the proposed revisions at § 155.170(a)(1)(i) through (iv) would explicitly add into the regulatory text four conjunctive elements that determine when State-required benefits require defrayal. These four elements have long been included as part of a State's defrayal analysis, but have not all been included in the regulatory text at § 155.170.⁸⁶ We now propose to add them to § 155.170 in order to make explicit the specific circumstances that require State defrayal of benefits in addition to EHB. We propose to revise

§ 155.170(a)(2) to state: "A State must make payments in accordance with paragraph (b) of this section to defray the cost of any State-required benefits in addition to the EHB." We also propose to revise and reorder the requirements for health plans to provide EHB at § 156.115(a) by adding at § 156.115(a)(2) the longstanding requirement that benefits required by State action taking place on or before December 31, 2011 are EHB that must be provided by health plans, and redesignating current paragraphs (a)(2) through (a)(6) as paragraphs (a)(3) through (a)(7). We emphasize that, other than the proposed change to remove consideration of whether the benefits are included in the State's EHB-benchmark plan from the defrayal analysis, these proposed revisions are not intended to substantively change existing State and issuer responsibility with respect to State-required benefits. These revisions are only intended to codify longstanding elements of the defrayal analysis, make conforming changes to the regulatory text, and to reorder these responsibilities so they would appear in a more logical reading order in the CFR. In particular, we propose revisions to § 156.115(a) that would ensure the regulatory text captures all the instances in which a benefit provided in a health plan is an EHB, as this regulation does not reference § 155.170(a)(2).

If finalized as proposed, a State would be required to defray the costs of any benefit that does not satisfy the proposed standard at § 155.170(a)(1) by making payments to individual enrollees or to the QHP issuer on behalf of enrollees. We expect this would better mitigate premium increases and better support unsubsidized enrollees because States would be required to defray the cost of a wider array of State-required benefits than under the existing policy, such that both subsidized and unsubsidized enrollees alike would be shielded from the increase to premiums resulting from State-required benefits.

Starting in PY 2027, a State that is not defraying the costs of a State-required benefit because of the policy finalized in the 2025 Payment Notice that designated any benefit covered in the State's EHB-benchmark plan as EHB would be required to begin defraying the costs of that benefit regardless of whether the benefit is included in its EHB-benchmark plan. If this proposal is finalized and a State begins defraying costs associated with a State-required benefit and making payments to QHP issuers because it is no longer considered EHB, QHP issuers would be required to update their plan filings

⁸⁵ On November 12, 2025, the Government Accountability Office (GAO) released a report "Health Insurance Marketplaces: CMS Has Limited Assurance That Premium Tax Credits Exclude Certain State Benefit Costs." GAO-25-107220, available at <https://files.gao.gov/reports/GAO-25-107220/index.html>. We concurred with the GAO's recommendation to review CMS' current oversight approach for defrayal of State mandated benefits and determine whether additional oversight is needed, and that work is ongoing.

⁸⁶ These elements appear in the EHB Final Rule (78 FR 12838) and the 2017 Payment Notice (81 FR 12242). We acknowledge that the element that the State requirement must be "specific to required care, treatment, or services" has not previously been included in § 155.170. However, in the EHB Final Rule (78 FR 12838), we stated that "[W]e interpret 'State-required benefits' to include the care, treatment and services that an issuer must provide to its enrollees. Other State laws that do not relate to specific benefits, including those relating to providers and benefit delivery method, are not addressed in § 155.170." See also the 2025 Payment Notice (81 FR 26264).

accordingly beginning in PY 2027 to reflect that the benefit is no longer covered as an EHB and should not be included in the percentage of premium attributable to coverage of EHB for the purpose of calculating APTC. We clarify, however, that we would not require States with any such benefits in their EHB-benchmark plans to update their EHB-benchmark plan under § 156.111 to remove the benefit; the proposed revision to § 155.170 would simply render the benefit's inclusion in the EHB-benchmark plan null and void for purposes of defining the EHB in the State. We also clarify that a State that wants to avoid defrayal obligations for State-required benefits that are already in the State's EHB-benchmark would be able to do so by repealing the applicable State requirement as being applicable to QHPs. If the State does not repeal or otherwise limit market applicability for the applicable State requirement, the State would be financially responsible for defraying the costs associated with the State benefit mandate. Given variation in State legislative calendars and session timing, and the need for issuers to update their plan filings and rates to account for benefits that would be defrayed by the State, we solicit comment on finalizing an effective date of PY 2028 instead of PY 2027.

We acknowledge that this proposal, a reversion to the standard that was in place prior to the 2025 Payment Notice, constitutes a change in policy with respect to the treatment of State-required benefits under the Affordable Care Act. We understand that a small number of States and issuers have taken significant action based on current § 155.170, including that some States have sought or are seeking EHB-benchmark plan changes under § 156.111 to add certain State-required benefits as EHB based on the understanding that such EHB additions would be effective indefinitely absent any further EHB-benchmark plan changes under § 156.111 and that the cost of these additions would not require defrayal by the State. If finalized, any State-required benefit that fulfills the four proposed conjunctive elements at proposed § 155.170(a)(1)(i) through (iv) would require defrayal, regardless of whether the benefit is included in the State's EHB-benchmark plan.⁸⁷

⁸⁷ If this proposal is finalized as proposed, the policy finalized in the 2025 Payment Notice would remain applicable for PYs 2025–2026. States would not be required to defray the costs of any State-mandated benefits that are included in the State's EHB-benchmark plan as EHB during PYs 2025–2026 but would be required to defray such costs beginning in PY 2027.

In turn, this would mean that State-required benefits that are in addition to EHB under this proposed policy would not be subject to the rules applicable to EHB, including the prohibition on discrimination in accordance with § 156.125, limitations on cost sharing in accordance with § 156.130, and restrictions on annual or lifetime dollar limits in accordance with § 147.126. Although we do not take these impacts lightly, these changes are necessary to return to the longstanding read of section 1311(d)(3)(B) of the Affordable Care Act and better balance the cost of the EHB for unsubsidized enrollees. We established our longstanding read of section 1311(d)(3)(B) of the Affordable Care Act in the EHB Rule (78 FR 12838) when we finalized that State-required benefits enacted after December 31, 2011, are not considered EHBs and therefore the costs of these benefits are required to be defrayed by the State. We believe reverting to this foundational read is warranted to remove the incentive from States to enact more benefit mandates that could in turn increase premiums and negatively impact unsubsidized enrollees to the detriment of overall enrollment by this population. The defrayal requirement in section 1311(d)(3)(B) of the Affordable Care Act prevents States from shifting costs to the Federal government through Federal expenditures. Over time, the accumulation of new State-required benefits being treated as EHB (without corresponding defrayal by States) could increase Federal outlays and undermine the purpose of section 1311(d)(3)(B) of the Affordable Care Act. While the availability of such benefits as EHB (with the associated protections) is a consideration, so is the overall affordability of coverage and the impact on overall enrollment. If such coverage is so expensive that it is unaffordable, particularly for unsubsidized enrollees, then the entire market suffers and those that cannot afford to enroll do not enjoy any benefits of coverage whatsoever. Our proposal seeks to mitigate that risk.

We are aware that this proposed policy reversal, if finalized, could also impact health plans that are not directly impacted by EHB requirements. This includes self-insured group health plans and large-group market fully insured plans that must follow the annual and lifetime dollar-limit restrictions on EHB and annual cost-sharing limitation requirements under §§ 147.126 and 156.130.⁸⁸ This proposal, if finalized,

⁸⁸ See parallel requirements to § 147.126 at 26 CFR 54.9815–2711 (<https://www.ecfr.gov/current/title-26/chapter-I/subchapter-D/part-54/section-54.9815-2711>), and 29 CFR 2590.715–2711 (<https://www.ecfr.gov/current/title-29/chapter-I/subchapter-B/part-2590/section-2590.715-2711>).

would affect plan sponsors to the extent that a plan sponsor selects a certain State's EHB-benchmark plan for purposes of complying with sections 2707 and 2711 of the PHS Act and that State changes benefits in its EHB-benchmark plan.⁸⁹ The proposal's impact would also extend beyond these plan sponsors to include BHPs established under Affordable Care Act section 1331 and Medicaid Alternative Benefit Plans (ABPs) implemented under section 1937.

Finally, we note that we are aware of State legislation that includes clauses stating that the requirement to defray the costs associated with State-required benefits is precluded if HHS fails to respond to the State's request for confirmation of whether new mandates require defrayal within a certain time. Such provisions are inconsistent with § 155.170, as they inappropriately put the onus on HHS to decide whether the State-required benefit is in addition to EHB. Failure by HHS to respond to a State's request for a determination of whether new mandates require defrayal by the State does not relieve a State from its defrayal obligation. Under § 155.170, it is the State's responsibility to identify which State-required benefits require defrayal. While States are encouraged to reach out to us concerning State defrayal questions in advance of passing and implementing benefit mandates, HHS does not provide determinations of whether the cost of a State-required benefit requires defrayal by the States.

In summary, we propose to revise § 155.170(a) to provide that any State-required benefits would be considered “in addition to EHB” (and thus not EHB) if they are: required by a State action taking place after December 31, 2011; applicable to the small group and/or individual markets; specific to required care, treatment, or services; and not required by State action for purposes of compliance with Federal requirements. We also propose revisions to the regulatory text at §§ 155.170(a)(2) and 156.115(a) to align with this proposal and to have State and issuer responsibilities with respect to State-required benefits appear in a more logical reading order in the CFR.

We seek comment on these proposals.

www.ecfr.gov/current/title-29/subchapter-B/chapter-XXV/subchapter-L/part-2590/subpart-C/section-2590.715-2711). Additionally, section 2707(b) of the PHS Act, as added by the Affordable Care Act, was adopted by reference into section 9815 of the Code and section 715 of the Employee Retirement Income Security Act (ERISA).

⁸⁹ See at Q2 of Affordable Care Act Implementation FAQs—Set 18 at https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/aca_implementation_faqs18.

6. Ability of States To Permit Agents and Brokers and Web-Brokers To Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220(j))

Section 1312(e) of the Affordable Care Act directs the Secretary to establish procedures under which a State may permit agents and brokers to enroll individuals and employers in QHPs through an Exchange and to assist individuals in applying for financial assistance for QHPs sold through an Exchange. We are proposing new standards of conduct and additional consumer protection standards related to agents, brokers, and web-brokers who assist consumers with enrollments through FFEs and SBE-FPs. These proposals focus on requirements related to consumer consent documentation (§ 155.220(j)(2)) and requirements related to marketing activities (proposed redesignation at § 155.220(j)(3)).

In addition, section 1313(a)(5)(A) of the Affordable Care Act 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 155.220 specifies procedures to support the State's ability to permit agents, brokers, and web-brokers to assist individuals, employers, or employees with enrollment in QHPs offered through an Exchange, subject to applicable Federal and State requirements. This includes processes under § 155.220(g) and (h) under which HHS may suspend or terminate an agent's, broker's, or web-broker's Exchange agreement(s) in circumstances that involve fraud or abusive conduct or where there are sufficiently severe findings of noncompliance. This also includes the FFE standards of conduct for agents, brokers, and web-brokers who assist consumers in enrolling in coverage through the FFEs that we established under § 155.220(j) to protect consumers and ensure the proper administration of the FFEs. Consistent with § 155.220(l), agents, brokers and web-brokers who assist with or facilitate enrollment in States with SBE-FPs must comply with all applicable FFE standards, including the requirements in § 155.220. Similarly, consistent with § 155.220(n), web-brokers who assist with or facilitate enrollment in States with State Exchanges must comply with all applicable FFE standards, including the requirements in § 155.220(c)(3)(i)(A), (G), (I), and (j)(2)(i).

We have observed numerous abusive, misleading, and coercive practices that

harm consumers both financially and medically, necessitating these proposed amendments.⁹⁰ For example, some agents, brokers, and web-brokers have been incorrectly attesting to, or failing to ascertain, whether consumers are enrolled in other minimum essential health coverage. We have also observed manipulation of income projections and tax household composition to qualify consumers for QHPs in the FFE. Further observations include agents, brokers, and web-brokers enrolling consumers with inaccurate residence addresses to conceal unauthorized enrollments and enrolling deceased consumers. Given these observations and their potential for consumer harm, we propose the following amendments to § 155.220(j): separating conduct related to consumer enrollment from conduct related to consumer marketing at § 155.220(j)(2)(i); establishing new standards of conduct and additional consumer protection standards for agents, brokers, and web-brokers at § 155.220(j)(2); and introducing new marketing requirements in redesignated § 155.220(j)(3).

a. Proposals Related to FFE Standards of Conduct and Mandating a Standard Eligibility Application Review Form and Consumer Consent Form (§ 155.220(j)(2))

Section 155.220(j)(2) sets forth the standards of conduct for agents, brokers, and web-brokers that assist with or facilitate enrollment of qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through an FFE or SBE-FP, or that assist individuals in applying for APTC and CSRs for QHPs sold through an FFE or SBE-FP.

Section 155.220(j)(2)(i) requires agents, brokers, and web-brokers to provide consumers with correct information and refrain from marketing or conduct that is misleading. Section 155.220(j)(2)(ii) requires agents, brokers, and web-brokers to document that the consumer (or the consumer's authorized representative) has reviewed and confirmed his or her eligibility application information is accurate. Under § 155.220(j)(2)(ii), agents, brokers, or web-brokers must also provide the FFEs and SBE-FPs with correct

information under section 1411(b) of the Affordable Care Act. Section 155.220(j)(2)(iii) also requires agents, brokers, web-brokers to document the consumer's consent prior to facilitating enrollments through the FFEs. As explained in the 2017 Payment Notice proposed rule (81 FR 12258 through 12264), these standards are designed to protect against agent, broker, and web-broker conduct that is harmful towards consumers or prevents the efficient operation of the FFEs and SBE-FPs.

We have been conducting documentation reviews to determine compliance with eligibility application review documentation requirements and consent documentation requirements. During these reviews, we have found numerous instances of noncompliance, such as documentation not containing the name of the assisting agent, broker, or web-broker, a missing date, and more. While we have engaged in Technical Assistance (TA) or enforcement, when appropriate, given these findings, we have determined that HHS would likely reduce consumer harm by revising the current requirements in § 155.220(j)(2)(ii) and (iii).

We propose to amend existing regulatory authority under § 155.220(j)(2)(ii)(A) and (j)(2)(iii)(A) to require agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review documentation requirements and consent documentation requirements. Our proposal would eliminate the currently broad allowances on the format for meeting these requirements by mandating that agents, brokers, and web-brokers use only the HHS-approved and -created form. The regulation would also be changed to clarify what types of actions constitute a consumer "taking an action" within the meaning of the regulation.

Currently, agents, brokers, and web-brokers are required to document that a consumer, or the consumer's authorized representative, reviewed their eligibility application information prior to the submission of the information. In the 2024 Payment Notice (87 FR 78206), we established documentation requirements to help ensure a consumer, or their authorized representative, has reviewed and confirmed their eligibility application information to be accurate prior to enrollment submission. This language was added to the regulations to help combat fraud and reduce consumer harm caused by application submissions containing inaccurate information. Currently, however, there are no specific requirements regarding the

⁹⁰ See for example, the GAO report published on December 3, 2025, in which the GAO developed and submitted fictitious applications via brokers and subsequently gained fully-subsidized health insurance coverage through the Federal Exchanges. GAO (2025, Dec. 3). *Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist*. <https://www.gao.gov/products/gao-26-108742>.

format of this documentation, so long as it meets the minimum regulatory requirements under

§ 155.220(j)(2)(ii)(A). As a result, we have reviewed documentation submitted in response to enforcement activity in both paper and audio recording formats. During these reviews, we have found that a substantial amount of this documentation lacked regulatorily required information.⁹¹ These documentation reviews determine next steps, such as engaging in TA or enforcement activity.

Additionally, paper documentation often contains language and formatting that are generally unique to the specific agent, broker, or web-broker. This language can sometimes be complicated or difficult to follow for consumers, leading to potential consumer harm, as explained below. Based on our experience, the documentation submitted by a significant number of agents, brokers, and web-brokers frequently failed to meet the required eligibility application review documentation criteria. These criteria may include but are not limited to: an explanation of attestations; required dates; the name of the agent, broker, or web-broker; an affirmative response from the consumer; a review of all application information; and the name of the consumer or authorized representative. Missing or incorrect information on eligibility applications can harm consumers. Inaccurate application information may lead to incorrect eligibility determinations, affect a consumer's tax liability, or result in other negative consequences. For example, if a consumer receives an incorrect APTC determination or is unaware they are enrolled, they may owe money to the Internal Revenue Service (IRS) when reconciling their Federal income taxes. Ensuring that a consumer's income determination has been reviewed and confirmed as accurate can help prevent these issues.

Incorrect consumer information on eligibility applications may also affect Exchange operations or HHS' analysis of Exchange trends. For example, a high volume of applications containing erroneous information, such as U.S. citizens attesting to not having an SSN, could hinder the efficient and effective operation of the Exchanges on the Federal platform by requiring HHS to divert time and resources to address these discrepancies. While we have processes in place to investigate and adjudicate complaints, these types of complaints can present challenges when the only available evidence consists of

conflicting accounts from the parties involved. We generally do not have access to additional contextual information that could help clarify the circumstances. To help address this, the 2024 Payment Notice (88 FR 25740) revised the standards of conduct at § 155.220(j)(2)(ii) to require agents, brokers, and web-brokers to document prior to the submission of information that the eligibility application information under section 1411(b) of the Affordable Care Act was reviewed and confirmed to be accurate by the consumer or their authorized representative, who has been designated in compliance with § 155.227.

Additionally, under § 155.220(j)(2)(iii), as finalized in the 2024 Payment Notice (88 FR 25740), agents, brokers, and web-brokers are required to document consumer consent on the FFEs and SBE-FPs prior to providing enrollment assistance. This documentation must comply with specific regulatory requirements and show that the consumer took an action that created a record that the agent, broker, or web-broker can maintain and produce to confirm that consent was provided by the consumer or their authorized representative.

Presently, there are no specific format requirements for consumer consent documentation, as long as it meets the minimum regulatory requirements under existing § 155.220(j)(2)(iii)(A) which requires a consumer, or their authorized representative, to "take an action" that produces a record that can be maintained and produced by an agent, broker, or web-broker to confirm that the consumer's consent was documented and confirmed to be accurate. While consent must also be documented, this regulation does not explicitly require an agent, broker, or web-broker to obtain it through the same action. During HHS' investigations, we have found that a substantial amount of the submitted consumer consent documentation either lacked the required information, or presented it unclearly, potentially resulting in consumer harm. HHS has consistently received documentation from agents, broker, and web-brokers that failed to include required information, including, but not limited to: the name of the agent, broker, web-broker, or agency receiving consent; the name of the consumer or their authorized representative; the dates of consent; the scope, duration, and purpose of the consent; and the process through which a consumer or their authorized representative may rescind the consent. There have also been instances where

documentation of consumer consent was not provided upon request.

Documentation that omits these regulatory requirements does not adequately demonstrate that the consumer, or their authorized representative, provided consent prior to the agent, broker, or web-broker's facilitation of enrollment or provision of enrollment assistance. Submitting consumers' eligibility applications without compliant documented consumer consent is harmful to consumers because the consumers or their representatives may be unaware of their enrollments and the submitted enrollment application may contain incorrect information. This could lead to consumers receiving inaccurate eligibility determinations; not receiving plan correspondence; not being able to access more suitable health coverage for which they may qualify; and unexpected tax liabilities.

Given these findings, we propose amendments to § 155.220(j) to improve the accuracy of application information and better ensure compliance with consumer consent documentation requirements. First, we propose amending § 155.220(j)(2)(ii)(A) to further clarify expectations for agent, broker, and web-broker compliance and to make clear that the requirements in this provision are not intended to allow for a broad range of interpretations. Specifically, we propose to revise § 155.220(j)(2)(ii)(A) to state that documentation by agents, brokers, and web-brokers showing that eligibility application information has been reviewed and confirmed to be accurate by the consumer (or the consumer's authorized representative) must be effectuated by having the consumer or the consumer's authorized representative take an action to execute the HHS-approved and created consumer consent form.⁹²

We also propose redesignating § 155.220(j)(2)(ii)(A)(2) as 155.220(j)(2)(ii)(A)(3) and amending newly revised § 155.220(j)(2)(ii)(A)(2) to describe acceptable and unacceptable actions that either a consumer (or consumer's authorized representative) can take that would allow the agent, broker, or web-broker to demonstrate their confirmation of the review of eligibility application information. Specifically, we propose that these actions may include: a hand-written or electronic written signature or initials,

⁹² Please find the HHS-approved and created CMS Model Consent Form for Marketplace Agents, Brokers, Web-brokers, and Agencies here: <https://www.cms.gov/marketplace/agents-brokers/files/cms-model-consent-form-marketplace-agents-brokers.pdf>.

⁹¹ CMS-10840/OMB Control Number: 0938-1438.

made directly on a document indicating a person's consent, approval, or agreement; an email from the consumer or the consumer's authorized representative; a recorded verbal conversation; or other clear and verifiable means. A signature that is simply typed on the documentation or a filled-in check-box would not clearly indicate the eligibility application information was reviewed and confirmed to be accurate by the consumer or the consumer's authorized representative, as HHS is unable to verify whether the consumer or their authorized representative personally reviewed and confirmed the accuracy of their information based on such a signature or checked box. A handwritten signature or handwritten initials made directly on the document indicates a consumer's or a consumer's representative's consent because it would more clearly illustrate that the consumer or the consumer's representative indeed gave his/her consent as it can be compared against another handwritten signature or handwritten initials. The proposed amendments aim to reduce confusion among agents, brokers, and web-brokers on what constitutes compliant documentation, reduce consumer harm from noncompliant documentation, and enhance HHS' investigative efficiency.

We propose revising § 155.220(j)(2)(iii)(A) to require agents, brokers, or web-brokers to demonstrate that the consumer or their authorized representative has obtained and reviewed consent documentation by executing an HHS-approved and created consumer consent form. This form would fulfill regulatory documentation requirements related to eligibility application review and consumer consent, ensuring all regulatory requirements are in the documentation provided to and reviewed by the consumer or their authorized representative. It would also streamline the review of potentially noncompliant agents, brokers, and web-brokers, facilitate the removal of noncompliant agents, brokers, and web-brokers from assisting consumers on the Exchange, and protect consumers from potential harm while safeguarding the integrity of the Exchange. Finally, it would enable more timely resolution of investigations, benefiting agents, brokers, and web-brokers by generally providing faster final determinations from HHS.

We further propose redesignating current § 155.220(j)(2)(iii)(C) as § 155.220(j)(2)(iii)(D) and revising § 155.220(j)(2)(iii)(C). Newly proposed § 155.220(j)(2)(iii)(C) would require that the action taken by the consumer or

their authorized representative to provide consent to definitively prove to HHS that consent was indeed given by the consumer or the consumer's representative. Section 155.220(j)(2)(iii)(C) would provide examples of acceptable actions, which mirror those proposed at § 155.220(j)(2)(ii)(A)(2). We also propose that a signature that is simply typed on the documentation or a filled-in check-box would not clearly indicate consent was provided, as, based on this information, HHS is unable to verify whether the consumer or their authorized representative personally typed the name and completed the checkboxes, or if the agent, broker, or web-broker did so without obtaining actual consent from the consumer or their authorized representative. As mentioned previously in this section, a handwritten signature or handwritten initials made directly on the document indicates a consumer's or a consumer's representative's consent because it would more clearly illustrate that the consumer or the consumer's representative indeed gave his/her consent as it can be compared against another handwritten signature or handwritten initials. Although we released an FAQ⁹³ in 2024 clarifying the "take an action" requirement, we are formalizing these expectations in regulation to provide greater transparency.

In summary, we are proposing to revise § 155.220(j)(2)(ii)(A) to state that the consumer or their authorized representative must take an action to execute the HHS-approved and created form, indicating that the eligibility application information has been reviewed and confirmed to be accurate by the consumer (or the consumer's authorized representative). We are also proposing redesignating § 155.220(j)(2)(ii)(A)(2) as § 155.220(j)(2)(ii)(A)(3) and amending newly revised § 155.220(j)(2)(ii)(A)(2) to describe the acceptable and unacceptable actions that a consumer (or their authorized representative) can take that would allow the agent, broker, or web-broker to demonstrate the consumer's or the consumer's authorized representative's confirmation of the review of eligibility application information. We are also proposing to revise § 155.220(j)(2)(iii)(A) to require agents, brokers, or web-brokers to demonstrate that the consumer or their

authorized representative has obtained and reviewed consent documentation by executing an HHS-approved and created form. Finally, we are proposing redesignating current

§ 155.220(j)(2)(iii)(C) and revising § 155.220(j)(2)(iii)(D). Newly proposed § 155.220(j)(2)(iii)(C) would require that the action taken by the consumer or their authorized representative to provide consent must be clear to HHS on the face of the documentation and would describe acceptable actions.

We seek comment on these proposals.

b. Proposals Related To Creating Standards of Conduct Related To Marketing (§ 155.220(j)(3))

We propose to redesignate current § 155.220(j)(3) to § 155.220(j)(4) and add language at § 155.220(j)(3) to create standards of conduct by which agents, brokers, and web-brokers must adhere when engaging in marketing practices related to assisting or facilitating enrollment of qualified individuals, qualified employers, or qualified employees in FFE coverage, or applying for APTC or CSRs for QHPs sold through an FFE or SBE-FP. This proposal would establish marketing requirements and list certain prohibited marketing practices. The marketing practices we would prohibit are the most common misleading advertisement types we have discovered on social media websites to date.

In the Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals final rule (78 FR 54076 through 54081), we established a framework for terminating an agent's, broker's, or web-broker's Exchange agreement(s) for cause in situations in which, in HHS' determination, a specific finding of noncompliance or pattern of noncompliance is sufficiently severe.⁹⁴ Section 155.220(g)(2)(i) states that agents, brokers, or web-brokers may be determined noncompliant for violations of "[a]ny standard specified under this section," which would include marketing violations under § 155.220(j)(2)(i). Under this existing framework, HHS can terminate an agent's, broker's, or web-broker's Exchange agreement(s) for cause to protect consumers and the efficient and effective operation of Exchanges in cases of sufficiently severe violations or patterns of violations. In such situations, under § 155.220(g)(3), HHS provides the agent, broker, or web-broker with 30 calendar days' notice

⁹³ CMS. (2024, June 12). *Frequently Asked Questions: Consumer Consent & Application Review Requirements*. <https://www.cms.gov/files/document/frequently-asked-questions-consumer-consent-application-review-requirements.pdf>.

⁹⁴ See 45 CFR 155.220(g)(1)–(4). Also see, for example, 78 FR 37047 through 37048 and 78 FR 54076 through 54081.

and an opportunity to resolve and address the finding(s) of noncompliance during that 30 day notice period.⁹⁵ If after 30 calendar days the noncompliance is not addressed to HHS' satisfaction, HHS may terminate the Exchange agreement(s) for cause. Once their Exchange agreement(s) are terminated for cause under § 155.220(g)(1), the agent, broker, or web-broker is no longer registered with the FFE, is not permitted to assist with or facilitate enrollment of a qualified individual, qualified employer, or qualified employee in coverage in a manner that constitutes enrollment through the Exchange, and is not permitted to assist individuals in applying for APTC and CSRs for QHPs.⁹⁶ Consistent with § 155.220(h)(1), an agent, broker, or web-broker whose Exchange agreement(s) are terminated can request reconsideration of such action. Reconsideration requests submitted to HHS are handled by a division separate and independent from the one that imposed termination. Section 155.220(h)(2) provides the agent, broker, or web-broker with 30 calendar days to submit their request (including any rebuttal evidence or information) and § 155.220(h)(3) requires HHS to provide agents, brokers, or web-brokers with written notice of HHS' reconsideration decision within 60 calendar days of receipt of the request for reconsideration.

In the 2017 Payment Notice (81 FR 12204), we added section § 155.220(j)(2) to require agents, brokers, and web-brokers to provide consumers with correct information, without omission of material fact, regarding FFEs, QHPs offered through the FFEs, and insurance affordability programs, as well as refrain from marketing or conduct that is misleading, coercive, or discriminatory.

We have found many instances of advertisements that mislead consumers during our reviews of existing advertisements. We intend to prioritize taking enforcement actions against agents, brokers, and web-brokers who engage in misleading marketing.

Complaints regarding misleading marketing can be sent to the Agent Broker (AB) Helpdesk⁹⁸ and we also intend to increase our monitoring of social media sites and other sources to root out misleading marketing. If we discover what we believe is misleading marketing, we may begin enforcement by engaging in TA or directly move to following the termination process established in § 155.220(g)(1). We currently use a misleading marketing-specific evaluation method we created to help us determine whether it is appropriate to engage in TA or take an enforcement action in response to an agent's broker's, or web-broker's marketing practices. This evaluation method utilizes a scoring system, based on the number of ads used in public marketing and number of violations within each ad, to determine which response path to take, with higher scores generally indicating more egregiously noncompliant behavior that would lead to enforcement action. More egregious noncompliant behavior could be related to a large volume of ads being posted or ads containing multiple regulatory violations. Applying such a universal standard would help ensure all agents, brokers, and web-brokers are treated equitably.

Furthermore, there are instances when it can be difficult or impossible for HHS to determine who is responsible for posting the misleading marketing, hindering HHS' ability to take enforcement actions in those instances. In order to take an enforcement action, our investigation would need to find a definitive connection between the misleading marketing and an individual agent, broker, or web-broker. We could make this connection by receiving contractual information regarding the posting of the marketing, finding agent, broker, or web-broker contact information in the metadata of the posted marketing, or by finding other reliable means that provide a connection between the misleading marketing and an individual agent, broker, or web-broker. We plan to engage in TA to explain our approach when determining misleading marketing, and we would provide guidance to agents, brokers, and web-brokers to bring their materials into compliance with HHS' marketing requirements. While we anticipate each investigation would be different depending on the facts of the case, we propose to utilize two mechanisms for agents, brokers, and web-brokers who

have engaged in misleading marketing to become compliant. First, the agent, broker, or web-broker would need to remove the misleading marketing in a timely fashion. This would help ensure no additional consumers would see the advertisement and be misled. Additionally, we would ask that agents, brokers, and web-brokers review CMS-provided materials on what constitutes compliant marketing practices. This would help educate agents, brokers, and web-brokers to prevent future incidents of noncompliance.

We have found emerging patterns of misleading marketing and have been engaging in TA and enforcement actions when appropriate. We have found numerous examples of misleading marketing, with common issues ranging from guaranteeing zero-dollar enrollment to misrepresenting enrollment timelines. We believe these misleading marketing practices warrant additional HHS oversight and believe more robust marketing standards of conduct under § 155.220(j) are needed. Although our current regulations provide ample authority to begin our new TA program as described above and take enforcement action against misleading marketing, we propose to amend our regulations to add more specific language on marketing prohibitions so that agents, brokers, and web-brokers know what is and is not permitted in their marketing.

Therefore, we propose to amend § 155.220(j)(2) to remove "marketing or" from § 155.220(j)(2)(i); separate conduct related to enrollment from conduct related to marketing in newly redesignated paragraph § 155.220(j)(3); expand marketing requirements for agents, brokers, and web-brokers; and codify a list of prohibited practices, requirements for responding to HHS requests related to marketing, and responsibilities related to marketing conducted by third parties with whom an agent, broker, or web-broker contracts. We also propose to remove language from § 155.220(j)(2)(i) that defines the term "sex" to include sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes. This proposed change would recognize a person's sex as referring to an individual's immutable biological classification as either male or female, consistent with Executive Order 14168 (90 FR 8615) that reflects the current policy of the United States. HHS is of the view that because the sexes are not changeable and one's sex is grounded in fundamental and incontrovertible reality, it is not necessary to address ancillary issues of

⁹⁵ See 45 CFR 155.220(g)(3)(i). The one exception is for situations where the agent, broker, or web-broker fails to maintain the appropriate license under applicable State law(s). See 45 CFR 155.220(g)(3)(ii). In these limited situations, HHS may immediately terminate the agent, broker, or web-broker's Exchange agreement(s) for cause without any further opportunity to resolve the matter upon providing notice to the agent, broker, or web-broker. *Ibid*.

⁹⁶ 45 CFR 155.220(g)(4).

⁹⁷ The agent, broker, or web-broker must continue to protect any PII accessed during the term of their Exchange agreements. See, for example, 45 CFR 155.220(g)(4) and 45 CFR 155.260.

⁹⁸ The Agent Broker (AB) Helpdesk can be contacted at FFMProducer-AssisterHelpDesk@cms.hhs.gov.

gender ideology in a regulation governing the activities of State-licensed agents, brokers, and web-brokers. Based on our experience overseeing agents, brokers, and web-brokers as they assist consumers with enrollment through the FFE, we do not believe this change would result in or facilitate any discrimination against consumers.⁹⁹

At § 155.220(j)(3), we propose that an individual or entity described in paragraph (j)(1) is required to comply with the standards set forth at § 155.220(j)(3).

We propose at new paragraph § 155.220(j)(3)(i) to require that all conduct involving marketing must comply with the standards of conduct described within § 155.220(j)(2).

We also propose, at § 155.220(j)(3)(ii), that all agents, brokers, and web-brokers must provide consumers with correct information about FFEs, QHPs offered through the FFE, and insurance affordability programs, that does not omit any material facts. We propose that agents, brokers, and web-brokers must refrain from marketing that is misleading, materially inaccurate, coercive, or discriminates based on race, color, national origin, disability, age, or sex. For purposes of this proposal, and consistent with the proposed revisions to § 155.220(j)(2)(i), the term “sex” refers to an individual’s immutable biological classification as either male or female consistent with Executive Order 14168 (90 FR 8615).

At § 155.220(j)(3)(iii), we propose seven examples of prohibited marketing practices. We propose at § 155.220(j)(3)(iii)(A) that agents, brokers, and web-brokers may not provide cash, monetary rebates, gift cards, travel vouchers, or cash equivalents to induce consumers to enroll or for other purposes.

At § 155.220(j)(3)(iii)(B), we propose that agents, brokers, and web-brokers may not offer gifts to consumers unless such gifts are: of nominal value; offered to similarly-situated consumers without regard to whether the consumer enrolls; and are not in the form of cash or cash equivalents.¹⁰⁰ Nominal value would have the meaning provided by the HHS Office of Inspector General¹⁰¹ and our review of nominal gifts would utilize the same prohibitions and allowances currently used in the Medicare Advantage (MA) Program.¹⁰² Many of these prohibitions on gifts associated with enrollments, excluding permissible nominal gifts, are also prohibited under State law and our proposals would not attempt to supersede State laws on these topics. Any termination stemming from a violation of one of these proposals would be shared with the State(s) where the agent, broker, or web-broker is licensed, as required under § 155.220(g)(6).

We propose at § 155.220(j)(3)(iii)(C) to prohibit agents, brokers, and web-brokers from falsely asserting or suggesting that consumers will always qualify for zero-dollar insurance or zero-dollar premiums. This type of advertisement may confuse or mislead consumers into providing an agent, broker, or web-broker their PII based on a false assumption of what they would qualify for. This PII may then be used by the agent, broker, or web-broker to enroll the consumer in a plan without authorization or for other unauthorized purposes. This proposed language would therefore aim to prevent consumers from providing their PII to agents, brokers, or web-brokers based on a false assumption.

At § 155.220(j)(3)(iii)(D), we propose to prohibit agents, brokers, and web-brokers from falsely using identical or facsimiles of government or other official logos and notations. This proposal is related to providing consumers with correct information and builds off existing language in § 155.220(j)(2)(i) that prohibits having a

“. . . direct enrollment website that HHS determines could mislead a consumer into believing they are visiting *HealthCare.gov*. . .” Our proposal would extend this requirement to advertisements and be broader in scope, extending to government websites beyond *HealthCare.gov*. We wish to prevent consumers from visiting a website they believe is an official government website or is approved by the government but that, in reality, is not. Such false assumptions may lead to consumers who otherwise would not give their PII to a private entity into believing they are providing their PII to a government entity.

At § 155.220(j)(3)(iii)(E), we propose to prohibit agents, brokers, and web-brokers from miscommunicating enrollment timelines and deadlines. This proposal would include actions such as providing false information related to SEP deadlines. Inaccurate timelines or misreporting of SEP deadlines may coerce consumers to enroll prematurely, believing they are about to miss a deadline to enroll in coverage or miss an SEP deadline. This may cause consumers to enroll in a plan they may not have chosen otherwise if they realized they had more time to consider their options.

At § 155.220(j)(3)(iii)(F), we propose to prohibit the misconstruing of legislation, regulations, or Executive Orders, including listing references or citations to fake or incorrect legislation, regulations, or Executive Orders. This proposal would encompass advertisements using fictional citations, using misleading characterizations when describing specific citations, or other deceptive practices related to legislation, regulations, or Executive Orders. This proposal would help reduce misinformation and disinformation in advertisements, helping ensure consumers are not misled before providing their PII to an agent, broker, or web-broker.

We also propose at § 155.220(j)(3)(iii)(G) to prohibit the use of an image, likeness, or quote from a notable figure, such as a celebrity or politician, in an advertisement claiming that the figure has endorsed the agent, broker, web-broker, or their agency when that endorsement is not truthful. This would include using artificial intelligence-generated videos, such as, but not limited to, deep fakes, or falsely attributing a quote to the public figure. This behavior may lure consumers into clicking on an advertisement or providing their PII based on a false assumption a public figure has endorsed the product or the person promoting the product. An endorsement would not be

⁹⁹In the May 6, 2024 *Federal Register*, we finalized the Nondiscrimination in Health Programs and Activities final rule (89 FR 37522) (hereinafter referred to as the 2024 Section 1557 final rule), 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.

¹⁰⁰The OIG definition of “cash equivalents” will be used, which can be found here: <https://oig.hhs.gov/faqs/general-questions-regarding-certain-fraud-and-abuse-authorities/>.

¹⁰¹OIG. (2016, December 7). *Office of Inspector General Policy Statement Regarding Gifts of Nominal Value To Medicare and Medicaid Beneficiaries*. <https://oig.hhs.gov/documents/special-advisory-bulletins/887/OIG-Policy-Statement-Gifts-of-Nominal-Value.pdf>. We recommend visiting the OIG’s website to determine whether this policy statement is still in effect or has been updated.

¹⁰²CMS. (2022, February 9). *Medicare Communications and Marketing Guidelines (MCMG)*. Pp. 9–10. <https://www.cms.gov/files/document/medicare-communications-and-marketing-guidelines-3-16-2022.pdf>.

truthful if the figure in the advertisement did not actually endorse the product, did not actually speak the words the advertisement says they stated, or other similar behaviors. Furthermore, this behavior may violate State or Federal law on using someone's name, image, or likeness without permission.

The language we would use in proposed § 155.220(j)(3)(ii), and the behaviors we propose to list in new § 155.220(j)(3)(iii), would better align Exchange requirements with MA requirements and help protect consumers. Aligning marketing rules for agents, brokers, and web-brokers across the Exchanges would ensure uniformity in enforcement and enhance regulatory compliance, thus creating consistent consumer information. We also believe these proposals would help ensure advertisements about the Exchanges are accurately providing consumers information about the Exchanges prior to providing their PII and enrolling in a health plan. Accurate advertisements help ensure more consumers enroll on time and provide required supporting documentation in a timely manner, leading to more consumers being enrolled in coverage. The integrity of the Exchange would be improved by reducing the amount of misleading information being provided to consumers, helping foster an environment where enrollees trust the agents, brokers, and web-brokers providing Exchange enrollment support, as they play an integral role in facilitating enrollments and providing consumers information about the Exchange.

Current §§ 155.220(j)(2)(ii)(A)(2) and 155.220(j)(2)(iii)(C) state HHS or our designee may periodically monitor and audit an agent, broker, or web-broker to assess their compliance with applicable requirements. These requirements allow HHS to request and review eligibility application information and consent documentation to determine compliance with applicable regulations. Therefore, consistent with these other standards of conduct and documentation requirements, we propose to include the same language in new proposed § 155.220(j)(3)(iv) that agents, brokers, and web-brokers must produce any marketing material upon request in response to monitoring, audit, and enforcement activities conducted consistent with paragraphs (c)(5), (g), (h), and (k) of this section. We do not believe a record retention requirement, similar to what is in place in §§ 155.220(j)(2)(ii)(A)(2) and 155.220(j)(2)(iii)(C), is necessary

because we would already have access to the marketing materials.

We believe it is the responsibility of all agents, brokers, and web-brokers to ensure advertisements bearing their name or directing consumers to them for Exchange enrollment assistance do not contain misleading information and follow all regulatory requirements. Accordingly, at § 155.220(j)(3)(v), we propose that an individual or entity described in paragraph (j)(1) of this section would be responsible for ensuring that all marketing-related materials created, written, released, or otherwise produced by the individual or an entity or on their behalf adhere to the requirements of § 155.220(j)(3)(ii)–(iii) and to make all such marketing-related materials available to HHS upon request in accordance with § 155.220(j)(3)(iv). An entity working on an agent, broker, web-broker's behalf under § 155.220(j)(3)(v) could be an agent or broker working for another agent or broker that has been tasked with creating marketing materials, a third-party marketing organization with whom an agent or broker has contracted to create marketing materials on the agent or broker's behalf, or other similar parties. This proposal would support HHS compliance actions against agents, brokers, and web-brokers whose marketing materials do not comply with § 155.220(j)(3)(ii)–(iii) when necessary.

In summary, we are proposing to redesignate § 155.220(j)(3) as § 155.220(j)(4) and at new § 155.220(j)(3), to clarify standards of conduct for marketing. We are also proposing at § 155.220(j)(3)(iv) to require that an individual or entity described in § 155.220(j)(1) must produce marketing materials to HHS upon request in response to monitoring, auditing, or enforcement activities. Finally, we are proposing at § 155.220(j)(3)(v) to establish that an individual or entity described in paragraph (j)(1) of this section is responsible for ensuring that all marketing-related materials created, written, released, or otherwise produced by the individual or entity or on their behalf adhere to the requirements of § 155.220(j)(3)(ii)–(iii) and, at § 155.220(j)(3)(iv), to produce to the HHS any marketing-related materials upon request in response to monitoring, audit, and enforcement activities.

We seek comment on all aspects of these proposals. Specifically, we seek comment on additional marketing standards of conduct we should consider for agents, brokers, web-brokers, and third-party marketing organizations to address deceptive

marketing practices while minimizing administrative burden.

7. Removal of the Vendor Program (§ 155.222)

We propose to remove § 155.222, which currently governs the vendor program to provide agent and broker training on an annual basis for a given plan year. Removal of this regulation would effectively sunset the vendor program.

The vendor program was established through § 155.222 to be implemented in PY 2016 and beyond to allow the possibility for certain training and information verification functions to be provided by HHS-approved vendors. In the 2016 Payment Notice (80 FR 10749), we outlined in § 155.222(a) the application and approval process for vendors seeking recognition as HHS-approved vendors for FFE training and information verification for agents and brokers. Section 155.222(b) outlines the standards that an entity must meet to be approved by HHS as a vendor and to maintain their status as an approved vendor, and § 155.222(c) provides that the approved list of vendors will be published on an HHS website. Section 155.222(d) describes how vendors will be monitored for ongoing compliance with the standards outlined in § 155.222(b). Section 155.222(e) describes the appeals process available to vendors whose applications are denied, or whose approvals to offer training and information verification are revoked.

The vendor program is an underutilized program with static growth. Since the program's inception in PY 2016, only six entities have participated as vendors, with only two or three participating in any given plan year. Additionally, agents and brokers who utilize the program only account for 9.3 percent (9,138) of registered agents and brokers in PY 2025. Moreover, since 2015, training completions by agents and brokers through vendors have never surpassed 10 percent. Importantly, eliminating the vendor program would save the Federal Government approximately \$300,000 each plan year.

If this proposal to discontinue the vendor agent/broker training program is finalized, it would affect neither the quality of nor access to agent/broker annual training. Agents and brokers would continue to have the ability to access training through CMS' existing Marketplace Learning Management System (MLMS) platform. The proposal to discontinue the vendor agent/broker training program only proposes to remove the option of this alternate

training platform—one that, as noted, has been historically underutilized.

In summary, we propose to terminate the vendor program, which allows approved third-party entities to facilitate the annual agent and broker training and registration process for the Exchange, through removal of § 155.222.

We request comment on the proposal to remove § 155.222 and eliminate the vendor program.

8. Limit APTC Eligibility to “Eligible Noncitizens” (45 CFR 155.20; 45 CFR 155.305(f)(1); 45 CFR 155.320(c)(3) and 42 CFR 600.5)

Section 71301 of the WFTC legislation established new eligibility requirements for the PTC. Specifically, section 71301 of the WFTC legislation amends 26 U.S.C. 36B(e) to provide that a PTC is allowed for the coverage of a lawfully present noncitizen only if he or she is an “eligible alien.” Section 71301 of the WFTC legislation defines “eligible alien” as an individual who is either lawfully admitted for permanent residence (sometimes referred to as a “lawful permanent resident” or “green card holder”); an individual who has been granted the status of Cuban-Haitian Entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980; or an individual who is lawfully residing in the United States in accordance with the Compacts of Free Association (COFA) as defined at 8 U.S.C. 1612(b)(2)(G) (sometimes referred to as a “COFA migrant”). Section 71301 of the WFTC legislation also makes conforming amendments to sections 1411(a)(1), 1411(a)(2), 1411(b)(3), 1411(c)(2)(B)(ii), and 1412(d) of the Affordable Care Act. These amendments require Exchanges to collect attestations regarding “eligible alien” status for applicants applying for APTC, to verify such attestations with the Secretary for the Department of Homeland Security, and to determine eligibility for APTC under section 36B of the Code based on whether an applicant is an “eligible alien.” Section 1402(g)(2) of the Affordable Care Act specifies that CSRs are only allowed for applicants who are also eligible for PTC. While section 71301 of the WFTC legislation does not amend section 1402(g)(2) of the Affordable Care Act, because section 71301 limits PTC eligibility for applicants who are “eligible aliens,” section 1402(g)(2) requires that CSR eligibility also be limited to only those who are “eligible aliens.”

To align Exchange eligibility and verification rules with section 71301 of the WFTC legislation’s amendments to sections 1411 and 1412 of the Affordable Care Act, we propose to add

a new definition of “eligible noncitizen” at § 155.20, providing that the term “eligible noncitizen” would have the same meaning as the term “eligible alien,” as defined in 26 U.S.C. 36B(e)(2)(B), which was newly defined in section 71301 of the WFTC legislation.

We further propose a technical update to § 155.305(f)(1)(ii) to cross-reference 26 CFR 1.36B–1(d). Currently, § 155.305(f)(1)(ii) States that a tax filer may be eligible for APTC if the Exchange determines that one or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse, meets QHP enrollment eligibility requirements and is not eligible for MEC during the coverage month. Our proposed edits amend this section to State that a tax filer is eligible for APTC if the Exchange determines that one or more applicants who is a member of the tax filer’s family, as defined at 26 CFR 1.36B–1(d), meets QHP enrollment eligibility requirements and is not eligible for MEC during the coverage month. This proposed change better aligns with existing Treasury regulations regarding PTC eligibility, and provides a clearer description of the individuals on whose behalf a tax filer may be allowed APTC, given that taxpayers can no longer claim personal exemptions on their Federal income tax returns.¹⁰³

Additionally, we propose to add § 155.305(f)(1)(ii)(C) to provide that an Exchange must grant eligibility for APTC to individuals who are U.S. citizens, U.S. nationals, or eligible noncitizens. To align with the new eligibility requirements for APTC for “eligible noncitizens” established by section 71301 of the WFTC legislation, we propose to add verification regulations at § 155.320(c)(3)(ix). This proposal would establish Exchange verification requirements for applicants who attest to having an eligible noncitizen immigration status as defined at § 155.20. Specifically, it would require Exchanges to attempt to verify eligible noncitizen immigration status using data from the Department of Homeland Security’s Systematic Alien Verification for Entitlements (SAVE) program and proceed with the inconsistency process outlined in § 155.315(f)(1) through (4) when the Exchange cannot verify the information using SAVE data.

¹⁰³ The personal exemption reduction was reduced to zero for tax years 2018 through 2025 by Section 11041 of the Tax Cuts and Jobs Act (Pub. L. 115–97). This reduction was made permanent by Section 70103 of the WFTC legislation.

As a part of this regulatory update, we also propose to remove duplicative language and correct the lack of headings in § 155.320(c)(3) by removing the first occurrence of § 155.320(c)(3)(viii) and adding headings to § 155.320(c)(3)(vii) and (viii). We believe that the redundancy resulted from an oversight in previous rulemaking, as both provisions were intended to define “family size” to align with definitions in the Code and related Treasury Regulations. The first provision referenced 26 CFR 1.36B–1(d), while the second referenced section 36B(d)(1) of the Code. We believe that the regulatory definition in 26 CFR 1.36B–1 is more appropriate for use in our regulations.

Additionally, we note that section 71301 of the WFTC legislation will impact Federal payments to States that operate BHPs for individuals enrolled in the BHP who are lawfully present noncitizens but who are not “eligible aliens,” as defined in 26 U.S.C. 36B(e)(2)(B). To align BHP program regulations with this statutory change, we propose to add a definition of “eligible noncitizen” at 42 CFR 600.5, cross-referencing the definition of the same term at 45 CFR 155.20. The definition’s proposed update, which is relevant for Federal funding to States that operate BHP programs, would not impact underlying eligibility for BHP; rather it would provide clarity in future guidance regarding the payment methodology for the BHP. The underlying statutory provisions at section 71301 of the WFTC legislation apply to plan years beginning on or after January 1, 2027. Accordingly, our proposed regulatory amendment would be effective beginning with plan years starting on or after January 1, 2027.

Under section 1331(d)(3)(A)(i) of the Affordable Care Act and 42 CFR 600.605(a), Federal BHP payments to States include 95 percent of both the PTC under section 36B of the Code and the CSR that would have been provided for the fiscal year to eligible individuals enrolled in BHP standard health plans in the State if such eligible individuals had been enrolled in QHPs through an Exchange. Currently, Congress has not funded CSR payments. Therefore CMS assigns a value of zero to the CSR portion of the BHP payment rate calculation and States receive no BHP funding attributable to that portion.

While section 71301 of the WFTC legislation eliminates eligibility for PTC for lawfully present noncitizens who are not “eligible aliens,” such individuals remain eligible for enrollment in the BHP, provided they meet the eligibility requirements of section 1331(e) of the

Affordable Care Act and 42 CFR 600.305. However, Federal BHP payments to States that operate a BHP attributable to such enrollees will cease beginning with plan years starting on or after January 1, 2027.

We are proposing to update §§ 155.20, 155.305(f)(1), and 155.320(c)(3)(ix) to align Exchange regulations with section 71301 of the WFTC legislation. Section 71301 of the WFTC legislation amended section 36B of the Code to provide that a PTC is allowed for lawfully present noncitizen only if he or she is an “eligible alien” and made conforming amendments to section 1411 of the Affordable Care Act requiring Exchanges to verify applicants’ “eligible alien” status. Accordingly, we propose to add a new definition in § 155.20, update our APTC eligibility regulations at § 155.305(f)(1), and add to our verification regulations in § 155.320(c)(3)(ix) to align Exchange eligibility and verification rules with section 71301 of the WFTC legislation.

We seek comment on these proposals.

9. Disallow APTC for Individuals Who Are Ineligible for Medicaid Due to Their Immigration Status and Have Income Below 100 Percent of the FPL (§ 155.305(f)(2))

Section 71302 of the WFTC legislation amended 26 U.S.C. 36B(c)(1) by striking subparagraph (B) which provided that an individual could be considered an applicable taxpayer, and therefore eligible for PTC, if they had household income under 100 percent of the FPL and were a noncitizen lawfully present in the United States who was ineligible for Medicaid due to their immigration status. Because 26 U.S.C. 36B(c)(1)(B) was repealed, such noncitizens are no longer eligible for PTC. Under section 1402(g) of the Affordable Care Act, which provides that an individual is only eligible for CSRs if they are also eligible for PTC for that month, such noncitizens are also no longer eligible for CSRs. This provision is effective for taxable years beginning after December 31, 2025.

We propose to remove § 155.305(f)(2) to align regulations with section 71302 of the WFTC legislation. Section 155.305(f)(2) currently requires an Exchange to determine a tax filer eligible for APTC if the Exchange determines that the tax filer is expected to have household income of less than 100 percent of the FPL for the benefit year for which coverage is requested, the tax filer or one or more applicants for whom the tax filer expects to be eligible for a personal exemption is lawfully present and ineligible for Medicaid due to their immigration

status, and the tax filer otherwise meets APTC eligibility requirements. Section 71302 of the WFTC legislation amended section 36B of the Code such that PTC is no longer allowed for this population. Removing § 155.305(f)(2) would align Exchange APTC eligibility rules with the Code’s PTC eligibility rules, as required by section 1411(a)(2)(A) of the Affordable Care Act.

We also propose conforming amendments to the verification regulations at § 155.320(c)(3)(iii)(A) and to SEP regulations at § 155.420(d)(13), to remove references to § 155.305(f)(2) and to the population described in that provision.

Additionally, we note that section 71302 of the WFTC legislation will impact Federal payments to States that operate BHPs for individuals enrolled in the BHP who are ineligible for Medicaid due to their immigration status and with incomes below 100 percent of the FPL. As stated above, under section 1331(d)(3)(A)(i) of the Affordable Care Act and 42 CFR 600.605(a), Federal BHP payments to States include 95 percent of the PTC under section 36B of the Code. Following the repeal of 26 U.S.C. 36B(c)(1)(B) by section 71302 of the WFTC legislation, noncitizens who are lawfully present, ineligible for Medicaid due to immigration status, and have household income below 100 percent of the FPL are no longer eligible for PTC. Therefore, States will stop receiving Federal BHP payments attributable to members of this population who are BHP enrollees as of January 1, 2026.¹⁰⁴

Section 71302 of the WFTC legislation is applicable beginning January 1, 2026. Section 71302 is self-effectuating and Exchanges are required to operationalize the changes required to implement these new statutory requirements beginning with eligibility determinations for the PY 2026 even though conforming changes to Exchange regulations will not yet have been finalized.

We are proposing to remove § 155.305(f)(2) and make conforming updates to §§ 155.320(c)(3)(iii)(A) and 155.420(d)(13) to align Exchange regulations with section 71302 of the WFTC legislation. Removing § 155.305(f)(2) and updating § 155.320(c)(3)(iii)(A) would align Exchange APTC eligibility and verification rules with the statutory changes enacted by section 71302 of the WFTC legislation. We further propose conforming amendments to § 155.420(d)(13) to remove the SEP

triggering event for individuals with household income under 100 percent of the FPL who did not enroll in coverage while waiting for HHS to verify their citizenship or immigration status, as the intent of this SEP was to provide an enrollment opportunity for individuals described at § 155.305(f)(2) who were not able to verify their eligibility for APTC within their original enrollment window.

We seek comment on this proposal.

10. Failure To File and Reconcile (FTR) Policy (§ 155.305)

We propose to amend paragraph § 155.305(f)(4) so that in PY 2028 and beyond, all Exchanges 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 1 year for which tax data would be utilized for verification of household income and family size, and (2) the tax filer, or the tax filer’s spouse if the tax filer files jointly, did not comply with the requirement to file a Federal income tax return and reconcile APTC for that year (referred to as the “1-tax year FTR” process). We also propose that, at the option of the Exchange, an Exchange may choose to early adopt the 1-tax year FTR policy in PY 2027 if it has the resources and capability to do so, or it can continue to administer a 2-tax year FTR process until PY 2028. If this proposal is finalized, Exchanges on the Federal platform would adopt the 1-tax year FTR process in PY 2027, as HHS has the resources available to do so.

As background, 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 Affordable Care Act with their PTC allowed under section 36B of the Code. FTR regulations, implemented pursuant to the Secretary of HHS’s general rulemaking authority under section 1321(a) of the Affordable Care Act, facilitate compliance with those requirements and were implemented as part of the 2012 Exchange Establishment Rule (77 FR 18352 through 18353). Exchange enrollees whose tax filer fails to comply with the requirement to file an income tax return and reconcile APTC as described in § 155.305(f)(4) are referred to as having failed to “file and reconcile.” These individuals are referred to as having an FTR status, and the Exchanges conduct the FTR process to identify such individuals.

¹⁰⁴ CMCS Informational Bulletin, December 10, 2025, “Basic Health Program; Federal Funding Methodology for Program Year 2026,” available at <https://www.medicare.gov/federal-policy-guidance/downloads/cib12102025.pdf>.

In the Exchange Establishment Rule, we finalized the FTR policy in part to prevent a primary tax filer or spouse who has failed to comply with tax filing rules from accumulating additional Federal tax liabilities due to overpayment of APTC. FTR was originally finalized and implemented as a 1-tax year FTR policy and HHS began FTR operations in late 2015. FTR continued as a 1-tax year policy until it was paused in 2021 during the COVID-19 public health emergency (PHE). FTR operations were paused due to concerns that consumers who had filed and reconciled would lose APTC due to IRS processing delays resulting from IRS processing facility closures and a corresponding processing backlog of paper filings.¹⁰⁵

During the PHE pause, we amended the FTR process such that an Exchange could not determine a tax filer or their enrollee ineligible for APTC until they have failed to file a Federal income tax return and reconcile APTC for 2-consecutive tax years in the 2024 Payment Notice (88 FR 25814). Specifically, this 2-tax year FTR policy prohibits an Exchange from determining 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 2 consecutive years 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 those 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 who have not filed and reconciled for 1-tax year. We further mitigated this concern when, in the 2026 Payment Notice (90 FR 4424), we also required Exchanges to issue associated warning notices for enrollees in Exchanges who have been identified as not filing and reconciling for 2 consecutive tax years. When we implemented the 2-tax year FTR policy, 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.

In the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074), we finalized a return to the 1-tax year FTR process. Specifically, we finalized at § 155.305(f)(4)(iii) that, through the end of PY 2026, Exchanges would be required to find tax filers (or their enrollees) ineligible for APTC if they had a 1-tax year FTR status for PY 2026 only. The finalized regulation provided that Exchanges would revert to the 2-tax year FTR process beginning in PY 2027. We did so for a number of reasons. First, we stated in the 2025 Marketplace Integrity and Affordability final rule that we believe the prior 2-tax year FTR process places a substantially higher number of tax filers at a greater risk of accumulating increased tax liabilities when filing their Federal income taxes. Second, we stated that we believe that the 2-tax year FTR process could incentivize tax filers to not file and reconcile because they would be allowed to keep APTC eligibility for an additional year without filing their Federal income tax return and reconciling APTC. This policy was stayed by the District Court for the District of Maryland in *City of Columbus et al. v. Kennedy et al.*, on August 22, 2025. The judge stayed this particular provision after concluding the

plaintiffs were likely to succeed in arguing the 1-tax year FTR policy is contrary to law. Due to the Court's decision, the 2-tax year policy remained in place for PY 2026 for all Exchanges.

Under section 36B(b)(1) of the Code, no PTC is allowed for any month that is not a "coverage month." On July 4, 2025, Congress passed and President Trump signed the WFTC legislation which, under section 71303, amended the definition of "coverage month" under section 36B(c) of the Code for taxable years after December 31, 2027, to provide that "coverage month" will not include, with respect to any individual enrolled in a QHP through an Exchange, any month for which the Exchange does not meet the requirements of § 155.305(f)(4)(iii), as added by the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074). Section 155.305(f)(4)(iii) reflects the 1-tax year FTR policy proposed in this rule. Thus, under section 71303 of the WFTC legislation, for taxable years beginning after December 31, 2027, no APTC is payable on behalf of any enrollee in an Exchange for any month in which the Exchange has not implemented a 1-tax year FTR policy.

We propose that for PY 2028, an Exchange must determine a tax filer or their enrollee ineligible for APTC, and that, at an Exchange's option, an Exchange may make such a determination for PY 2027 if: (1) HHS notifies the Exchange that APTC was paid on behalf of the tax filer, or their spouse if the tax filer is married, for a year for which tax data would be utilized for verification of household income and family size; and (2) the tax filer, or their spouse if the tax filer is married, did not comply with the requirement to file a Federal income tax return and reconcile APTC payments with PTC the tax filer is allowed to claim on their tax return for that year. If the Exchange does not choose to adopt the 1-tax year FTR policy for PY 2027, they must determine a tax filer or their enrollee ineligible for APTC if: (1) HHS notifies the Exchange that APTC was paid on behalf of the tax filer, or their spouse, if the tax filer is a married couple, for 2 consecutive tax years for which tax data would be utilized for verification of household income and family size; and (2) the tax filer, or their spouse if the tax filer is a married couple, did not comply with the requirement to file a Federal income tax return and reconcile APTC payments with PTC the tax filer is allowed to claim on their tax return for those 2 consecutive years.

We propose to amend the language at § 155.305(f)(4) to clearly reflect an

¹⁰⁵ Please see, CMS. (2021, July 23). Failure to File and Reconcile (FTR) Operations Flexibilities for Plan Years 2021 and 2022—Frequently Asked Questions (FAQ). Available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/FTR-flexibilities-2021-and-2022.pdf>. See also, CMS. (2022, July 18). Failure to File and Reconcile (FTR) Operations Flexibilities for Plan Year 2023. Available at <https://www.cms.gov/cciio/resources/regulations-and-guidance/ftr-flexibilities-2023.pdf>.

Exchange's option to implement either the 1-tax year FTR policy or 2-tax year FTR policy for PY 2027 and the 1-tax year FTR policy for PY 2028 and beyond. We are proposing to reorganize paragraph (f)(4) to include three sections—Definitions, APTC eligibility, and Notices. We also propose to revise the language to ensure that notices are sent to consumers that reflect whether the Exchange is implementing the 1-tax year or 2-tax year FTR policies for PY 2027 coverage, and that the Exchange will implement the 1-tax year FTR policy for PY 2028 coverage. In addition, we are making non-substantive changes to improve the readability and clarity of the regulatory text. We believe this change is important because it would be imprudent for Exchanges to implement the 2-tax year FTR policy in PY 2028 and thereafter due to the impacts on the definition of coverage month under section 36B(c) of the Code, and allowing Exchanges to voluntarily adopt the 1-tax year policy for PY 2027 gives Exchanges the operational flexibility they need to navigate the vast pre-enrollment verification changes also imposed in section 71303 of the WFTC legislation.

While the revised definition of coverage month that compels Exchanges to implement the 1-tax year FTR policy is scheduled to take effect for PY 2028 under the WFTC legislation, we believe it is important to begin implementing this policy in PY 2027 to protect people from accumulating tax liabilities. Until 2026, the amount of APTC that consumers were required to repay when filing their Federal income tax return and reconciling their APTC was limited by section 36B(f)(2)(B) of the Code based on their income level as a percentage of the FPL. Section 71305 of the WFTC legislation eliminated those excess APTC recapture limits for consumers who have received APTC in the prior year for tax years beginning after December 31, 2025. As a result, consumers with excess APTC will have their tax liability increased by the entire amount of the excess APTC. Given this, we are even more concerned about the potential for high tax liabilities that could accumulate if consumers do not file their Federal income tax returns and reconcile APTC. The current 2-tax year FTR 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, which would expose the tax filer to up to 18 additional months of excess APTC if the tax filer does not file and reconcile. We previously concluded in the

Marketplace Integrity and Affordability final rule (90 FR 27074) that this does not provide reasonable protection against accumulating tax liabilities.¹⁰⁶ By switching from a 2-tax year FTR process to a 1-tax year FTR process for PY 2027, our hope is that consumers would not inadvertently be responsible for repaying the entirety of 18 months of excess APTC if they do not file and reconcile, which is likely a significant financial hardship for many consumers receiving APTC.

The Marketplace Integrity and Affordability final rule reinstated the 1-tax year FTR policy, but to balance competing concerns, the rule sunsets the policy automatically after the end of PY 2026. At the time, we concluded that the 1-tax year FTR policy was needed immediately to reduce the number of improper APTC payments in Exchanges on the Federal platform. However, we also concluded 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. While we have made progress in reducing improper unauthorized enrollments over the past year, we remain concerned there is substantial number of unauthorized enrollments on the Federal platform and therefore believe there is still an immediate need for the 1-tax year FTR.

When we finalized the sunset of the 1-tax year policy in the finalized 2025 Marketplace Integrity and Affordability rule, commenters also expressed the following concerns: (1) that the 1-tax year FTR process may result in coverage losses because the tax filing process is complex and consumers are not fully aware of the requirements to file and reconcile, (2) that the 1-tax year FTR process could have a negative impact on the risk pool, and (3) that the 1-tax year process negatively impacts low-income consumers who have a more difficult time predicting and verifying income due to the unpredictable nature of their income. While we acknowledge these concerns, we believe that for plan year 2027, the overriding policy need for the Federal Exchange is to be able to remove unauthorized enrollments from the Marketplace, and the 1-tax year FTR policy enables us to do that better than

a 2-tax year FTR policy. As for State-Based Exchanges, which do not all face the same problem in regards to unauthorized enrollments, we believe that the flexibility to be able to nimbly respond to whatever the Court decides in regards to the final decision in *City of Columbus et al. v. Kennedy et al.*, as well as during the implementation of all the other requirements imposed by the WFTC legislation, is the utmost policy goal for PY 2027. However, for PY 2028, due to the requirement of Exchanges to operate the 1-tax year FTR policy in order for a month to be considered a "coverage month," thereby ensuring that consumers are eligible for APTC, all of our previously stated concerns, which are still valid, become secondary to the goal of ensuring that consumers are eligible for APTC, because APTC is essential for the Exchanges to function as designed in the Affordable Care Act.

HHS also understands that State Exchanges and other stakeholders may have planned their FTR operations based on the sunset of the 1-tax year policy as finalized in the 2025 Marketplace Affordability and Integrity final rule. However, due to the stay imposed by the Court, State-Based Exchanges have not implemented the 1-tax year FTR process for 2026. If the stay continues through PY 2026, they would have nothing to sunset in 2027 (that is, the 2-tax year FTR policy would continue). Alternatively, if HHS prevails in *City of Columbus et al. v. Kennedy et al.* during PY 2026 and the 1-tax year FTR policy is reinstated for the remainder of the plan year, it would be a burden for Exchanges to revert to a 2-tax year FTR policy in PY 2027 and then revert back to a 1-tax year FTR policy again in PY 2028, if that component of this proposal is finalized. Taking both these potential scenarios into account, we believe it would be most prudent to allow State Exchanges the option to choose between a 1- and 2-tax year FTR process for PY 2027. Additionally, as State Exchanges do not report the same problems with unauthorized enrollments as those currently facing the FFEs, there is less reason to require the 1-tax year policy in 2027. Further, it could be overburdensome to require State Exchanges to implement the 1-tax year FTR policy due to limited operational resources while they implement other requirements of the WFTC legislation.

A review of plan selections during the 2026 open enrollment period shows 29 percent of people enrolled in fully subsidized plans through the Federal platform. Thus, there remains an opportunity for unscrupulous agents and brokers to enroll people without

¹⁰⁶ 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>.

their knowledge. In addition, HHS removed APTC from an estimated 430,000 enrollees as of January 1, 2026 for failing to file their Federal tax return and reconcile APTC for 2 consecutive tax years (2023 and 2024 tax years) in accordance with the 2-tax year FTR policy.¹⁰⁷ This population is already larger than the 235,000 enrollees who lost APTC eligibility as part of FTR operations for PY 2025¹⁰⁸ and this is just the first stage in the process for PY 2026. In the Marketplace Integrity and Affordability 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. This is because, for some households, the income requirement to file a tax return is approximately 100 percent FPL which is the minimum household income to qualify for APTC.¹⁰⁹ 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. In addition, someone improperly enrolled entirely without their knowledge would also not know to reconcile. Considering our prior analyses that suggest FTR status is a strong indicator that a current enrollee is ineligible for APTC and the growth in enrollees with a 2-tax year FTR status for PY2026, we remain very concerned about the number of consumers in the Exchange that were potentially improperly enrolled and remain enrolled.

Though the enforcement of the 1-tax year policy for PY 2026 was stayed after a district court concluded it would likely be found contrary to law, we continue to believe we have a strong statutory basis for applying the 1-tax year policy. In the Marketplace Integrity and Affordability proposed rule (90 FR

12961), we stated HHS's belief that the Affordable Care Act does not allow HHS to determine someone eligible for APTC if they failed to meet the requirement to file a tax return. Sections 6011 and 6012 of the Code, as implemented under 26 CFR 1.6011–8, require enrollees who receive APTC to file a tax return and reconcile the APTC. Notwithstanding, the court reasoned that the policy was likely unlawful because nothing in the statute expressly conditions eligibility on reconciling tax credits. However, our analysis of the statute has focused on the importance of filing a tax return, not reconciling APTC. That's because the tax return is a critical element of the income verification process to qualify for APTC under the statute. As such, filing a tax return is a means of verifying a condition of eligibility and not itself a condition of eligibility. As we explained in the Marketplace Integrity and Affordability proposed rule, the statute requires APTC to be set on the basis of the individual's household income for the most recent taxable year for which information is available. Therefore, the income reported on the tax return for the most recent taxable year establishes the starting point for verifying whether an applicant's income meets the requirements to qualify for APTC. As discussed previously, when the IRS does not have tax return information to verify an applicant's income, section 1412 of the Affordable Care Act requires HHS to establish alternative procedures to determine APTC when there is a change in circumstances or “in cases where the taxpayer was not required to file a return . . .”. Because section 1412(b)(2)(B) only references cases where a tax filer was *not required* to file a return, we do not believe an applicant who fails to meet the requirement to file a return qualifies for this alternative process for determining APTC. Therefore, to determine and verify household income, it is imperative that consumers file a Federal income tax return when they are required to do so.

While we had previously intended to sunset the 1-tax year policy in PY 2026, due to both the inability to implement it in PY 2026 due to a judicial stay in *City of Columbus et al. v. Kennedy et al.*, as well as the WFTC legislation preventing consumers from receiving APTC in any Exchanges not implementing the 1-tax year policy beginning in PY 2028, we believe it is best to implement the 1-tax year policy for PY 2028 for all Exchanges, with the option for Exchanges to early adopt for PY 2027 or continue operating the 2-tax year policy for PY 2027. As mentioned

previously, we are giving Exchanges the option to continue operating the 2-tax year policy during PY 2027 because, while the Federal Exchange has the resources to early adopt the 1-tax year FTR policy in 2027, many State-Based Exchanges face different financial constraints. This may be particularly true in 2027 when States will have to also implement the other pre-enrollment verification changes required by the WFTC legislation. Therefore, in light of these considerations, we are proposing to revise § 155.305(f)(4) to require Exchanges to find consumers ineligible for APTC after they or their tax filer have been determined to have failed to file and reconcile for 1 tax year beginning in PY 2028, or in PY 2027 at the option of the Exchange. We are also proposing in § 155.305(f)(4) that an Exchange must operate the 2-tax year FTR process in PY 2027 if they do not elect to operate the 1-tax year FTR process.

We seek comment on this proposal.

11. Comment Solicitation on Eligibility Verification Provisions of the WFTC Legislation, Section 71303

Section 71303(a) and (b) of the WFTC legislation imposes new requirements on Exchanges related to eligibility verification effective with PY 2028.

Section 71303(a) of the WFTC legislation adds a new paragraph (5) to section 36B(c) of the Code, establishing that a month is not a coverage month for an applicant, and therefore no PTC is allowed for the applicant's coverage for that month, if the month begins before the Exchange verifies the applicant's eligibility to enroll in a QHP and for APTC, “using applicable enrollment information that shall be provided or verified by the applicant.” Section 71303(a) of the WFTC legislation also:

- Specifies a minimum set of “applicable enrollment information”;
- Clarifies that a past month may be treated as a coverage month if an Exchange later verifies the applicant's eligibility;
- Specifies that these verification requirements do not impact eligibility to enroll in a QHP;
- Permits the Secretary of the Department of the Treasury to waive these verification requirements when an individual qualifies for an SEP based on a change in family size; and
- States that Exchanges are permitted to use “any data available to the Exchange and any reliable third-party sources in collecting information for verification by the applicant.”

Section 71303(b) of the WFTC legislation amended section 36B(c)(3)(A) of the Code such that any

¹⁰⁷ CMS. (2026, January 28). CMS Actions to Protect Consumers and Strengthen Exchange Program Integrity. Available at <https://www.cms.gov/newsroom/fact-sheets/cms-actions-protect-consumers-strengthen-exchange-program-integrity>.

¹⁰⁸ CMS. Failure to File and Reconcile (FTR) Methodology available at <https://www.cms.gov/files/document/failure-file-and-reconcile-data-plan-year-2025.xlsx>.

¹⁰⁹ Information regarding the income amount that requires one to file is available on the IRS website at <https://www.irs.gov/individuals/check-if-you-need-to-file-a-tax-return#amount-to-file>.

plan enrolled in through an Exchange is not considered a QHP, and therefore no PTC is allowed for enrollment in the plan, unless, no later than August 1 of the preceding year, Exchanges provide “a process for pre-enrollment verification” that permits any applicant to verify their household income and eligibility for enrollment in such plan for the upcoming plan year.

We plan to issue regulations, guidance, technical assistance, and educational materials in the future to facilitate implementation of these provisions of section 71303 of the WFTC legislation. In this proposed rule, we seek comment on considerations for future policy development and implementation of these provisions of section 71303 of the WFTC legislation. We seek comment on topics including but not limited to: operational considerations for State Exchanges, issuers, agents and brokers, navigators and assisters, and consumers; and effective rollout and communications. We seek input from interested parties regarding the required timelines to comply with the law, including the requirement that Exchanges establish a pre-enrollment verification process no later than August 1, 2027. We also seek input on the anticipated complexity, costs, burden, enrollment impacts, and any State-specific considerations.

Section 71303 of the WFTC legislation also adds new paragraph (6) to section 36B(c) of the Code, regarding failure to file and reconcile; please see section III.D.10 of this proposed rule for discussion on our proposals regarding failure to file and reconcile.

12. Income Verification Policy When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))

To support improved payment integrity measures throughout the Exchanges, we finalized a series of income verification provisions in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27121), including revisions to § 155.320(c)(3), to require the submission of documents to verify income when an applicant’s attested projected household income is at or above 100 percent of the FPL and trusted data sources indicate the consumer’s household income is below 100 percent of the FPL. This policy was a resumption of the requirement to verify income for this subset of consumers that was first finalized in the 2019 Payment Notice (83 FR 16985), a regulation that was later vacated by the U.S. District Court for the District of Maryland in *City of Columbus v.*

Cochran.¹¹⁰ Following HHS’s discovery of a massive volume of improper enrollments in 2023 and 2024, HHS re-proposed and finalized this policy in the 2025 Marketplace Integrity and Affordability Rule based on its assessment that additional eligibility verifications were necessary to prevent improper enrollments and payments of APTC, and to guard against improper enrollment behaviors by agents, brokers, and web-brokers. Based on commenters’ concerns, HHS finalized this rule to sunset at the end of PY 2026 to provide further opportunities to monitor the policy’s effects instead of codifying it to be applicable indefinitely. This policy was also sunset with the expectation that the reduction in fully-subsidized plans would reduce the urgency of its program integrity features and in response to commenter feedback that the measure was not necessary in State Exchanges that had not experienced high levels of improper enrollments. HHS believed that implementing this policy through the end of PY 2026, when paired with existing program integrity measures and additional measures finalized in the 2025 Program Integrity Rule, would strike the right balance between urgent program integrity concerns and long-term enrollment efficiencies. In August 2025, the U.S. District Court for the District of Maryland stayed enforcement of the regulation based on its conclusion that HHS did not meaningfully engage with challenges to the data and reports it used to justify the regulation.¹¹¹

Since the finalization of the 2025 Marketplace Integrity and Affordability final rule and the issuance of the August 2025 court stay, HHS has continued to focus on finding and stopping improper enrollments, including those supported by inaccurate income estimations. Without the implementation of the stayed income verification regulation requiring documentation of income when an applicant attests to household income above 100 percent FPL and trusted Federal data sources indicate household income is below 100 percent FPL, the use of inflated incomes could have resulted in consumers being improperly enrolled in Marketplace coverage, oftentimes without their knowledge. Between October 2025 and the time of publication of this proposed rule, the Federal Exchange continued to detect improper enrollments that included suspect attestations of income. For example, the Federal Exchange has

received reports that agents, brokers, and web-brokers may be using artificial intelligence to impersonate consumers and falsely attest to household income that could potentially qualify the consumers for decreased APTC and CSR benefits now that the enhanced subsidies have expired, something that we were not aware of when we finalized the 2025 Marketplace Integrity and Affordability final rule. Inaccurate household attestations 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.

Verifying an applicant’s household income could result in HHS detecting improper enrollments before APTC can be paid. We continue to uncover improper enrollments through reports from consumers, agents and brokers, and, in particular, issuers. As mentioned in the fact sheet on CMS actions to strengthen program integrity and protect consumers,¹¹² in 2025, the Federal Marketplace cancelled 250,000 unauthorized enrollments. Additionally, the Federal Marketplace stopped APTC for 500,000 enrollees who were found to be concurrently enrolled in Exchange coverage with APTC and other coverage. The proposed policy, if finalized, could go far in protecting Federal funds from being paid to support improper enrollments for those who do not qualify for APTC or those who never intended to enroll in Exchange coverage, especially those who are already enrolled in Medicaid coverage and therefore did not need coverage through the Exchange. HHS is of the view that these circumstances present sufficient risk to Exchanges’ ability to accurately verify eligibility determinations for APTC. HHS is of the view that it cannot continue to ignore the obvious risk presented by circumstances under which APTC and CSR eligibility is granted, notwithstanding that trusted data sources indicate that an applicant’s household income is below 100 percent FPL, making them ineligible for receiving APTC or CSRs. We believe it is reasonable, necessary, and not unduly burdensome to require individuals to submit documentation to resolve these inconsistencies.

Moreover, submitting documentation to verify income is now even more important to protect applicants from accumulating tax liabilities due to

¹¹⁰ *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021).

¹¹¹ See *City of Columbus v. Kennedy*, 796 F. Supp. 3d at 168.

¹¹² CMS. (2026, January 28). CMS Actions to Protect Consumers and Strengthen Exchange Program Integrity. Available at <https://www.cms.gov/newsroom/fact-sheets/cms-actions-protect-consumers-strengthen-exchange-program-integrity>.

misestimating or misreporting their income. As we explained in relation to the FTR policy in section III.D.10. of this proposed rule, the WFTC legislation was enacted after the finalization of the 2025 Marketplace Integrity and Affordability rule which removes limitations on repayment of the APTC beginning with plan year 2026. Under section 71305 of the WFTC legislation, repayment caps on excess APTC payments will discontinue starting in PY 2026. Under this proposed policy, households would likely receive an income DMI that would require them to submit documents to verify their annual household income and, if they do not verify with documents, would result in the loss of APTC after the 90-day DMI period and protect them from accumulating substantial tax liabilities.

We note that Congress did not limit HHS's authority under section 1411 of the Affordable Care Act to verify income under the circumstances targeted by the policy, but granted HHS broad authority and discretion to design verification procedures the HHS Secretary determines appropriate. Section 1411(c) of the Affordable Care Act provides that applicant household incomes for taxable year for second calendar year preceding the year the plan year begins upcoming plan year reported on an Exchange application must be submitted to the Secretary of the Treasury for verification. Section 1411(d) of the Affordable Care Act directs HHS or an Exchange to verify the accuracy of information that is not required to be submitted to Treasury, Homeland Security, and Social Security. Income information provided to verify eligibility when there are "changes in circumstances" is not required to be submitted to Treasury. Therefore, under 1411(d), HHS or Exchanges must verify this income information, which includes verifying income through other trusted data sources. If no trusted data source can verify income, section 1411(e)(4) of the Affordable Care Act requires the HHS Secretary to notify the Exchange of the inconsistency and the Exchange to take reasonable steps to resolve the inconsistency, including by contacting the applicant or by taking any additional actions as the HHS Secretary may identify through regulation or other guidance. If the inconsistency remains unresolved, the Exchange must give the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the Secretary of the Treasury. The policy we propose in this rulemaking reflects Congress' directives in section

1411(e)(4) of the Affordable Care Act. Given Congress' directive under section 1411(e) of the Affordable Care Act to collect documentation of applicant income in appropriate circumstances, as well as the discretion it granted to the HHS Secretary under the same section, it is difficult to pinpoint circumstances under which a requirement to verify or reconcile inconsistent data would be deemed unreasonable. Accurate income attestation and verification from households has long-ranging implications for payment integrity in the Exchange, with impacts to consumer protection, appropriate agent/broker compensation, data integrity, and the expenditure of tax dollars. Increased repayment responsibilities now makes these further verifications an essential protection against accumulating tax liabilities. Given HHS's authority, the ongoing need to strengthen program integrity and protect enrollees from accumulating tax liabilities, we propose to require Exchanges to comply with the requirement in 1411(e)(4) of the Affordable Care Act to set a 90-day inconsistency period for instances where the applicant's attested annual household income cannot be verified by data sources for verifications of eligibility for 2027 coverage and beyond. While we acknowledge that such a change may impose burden to State Exchanges and other interested parties, particularly in consideration of work that may have been done to support the 2025 Marketplace Integrity and Affordability final rule, we believe this proposal is a reasonable exercise of the authority and discretion that Congress vested in the HHS Secretary under section 1411 of the Affordable Care Act and is necessary given the payment integrity and tax liability issues noted above. Furthermore, we believe that the long-term program integrity savings of this change outweigh the operational costs to the Exchanges, as outlined in the Collection of Information Requirements in section IV. of this proposed rule.

With this in mind, section 1412 of the Affordable Care Act describes the process for determining eligibility for APTC using the process described section 1411 of the Affordable Care Act. Specifically, section 1412(b)(2) of the Affordable Care Act gives the Secretary authority to define additional verification procedures where a consumer's application reflects a change in the consumer's circumstances when compared to data for the most recent taxable year that is available from the Secretary of the Treasury. In cases, as described previously, where an

applicant attests to annual household income at or above 100 percent of the FPL but the IRS indicates it is below 100 percent of the FPL, the Exchange would use this authority to determine whether they may be eligible for APTC using their attested annual income amount, given the 'changes in circumstances' from their tax data. In cases where trusted data sources cannot verify their income under these circumstances, we propose to specify that Exchanges on the Federal platform would follow the procedures established under 1411(e)(4) and implemented in § 155.315(f)(1) through (4) to create an annual income DMI for these consumers.

Beyond statutory authority, there are concerns regarding program integrity that continue to validate enhanced scrutiny for consumers whose annual household income is indicated by tax data as below 100 percent of the FPL. As we noted in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27121), a GAO study on improper payments determined our control activities, such as income verification policies, related to the accuracy of APTC calculations were not properly designed.¹¹³ While we originally proposed temporarily instituting this policy in part due to lack of new data around this problem, a more recent GAO study published after the 2025 Marketplace Integrity and Affordability final rule (90 FR 27121) illustrates that this continues to be a problem. Specifically, this recent GAO study described issues that persist in the payment integrity protections of the Exchange, including vulnerabilities related to potential SSN misuse as well as negative impacts resulting from unauthorized enrollment changes from agents and brokers.¹¹⁴ The study utilized 20 fictitious applicants to identify program integrity control issues, of which 18 remained improperly enrolled as of September 2025. The GAO argued that these cases highlighted vulnerabilities in verification processes that can contribute to APTC reconciliation issues. We find that continued issues on the Exchange with accurately determining APTC eligibility as highlighted in this study present ongoing risks to the financial integrity

¹¹³ 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>.

¹¹⁴ GAO. (2025 Dec.) Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist, GAO-26-108742. <https://www.gao.gov/products/gao-26-108742>.

for the Exchanges and create opportunities for agent, broker, and web-broker-driven improper conduct. This gives further weight to the necessity of the continuation of this income verification policy beyond 2027.

A notable driver of these continued payment integrity concerns, as evidenced by the 2025 GAO findings, is agent, broker, and web-broker behavior. In the 2025 Marketplace Integrity and Affordability final rule (90 FR 27121), we provided evidence connecting agent, broker, and web-broker actions to consumers misrepresenting or overestimating their income and the rise in unauthorized enrollments. We observed that 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 without their knowledge, even when the consumers are not eligible. The persistence of agent, broker, and web-broker actions to undermine payment integrity highlight the need for continued changes to address improper enrollment and improve the accuracy of income attestations. In recently identified internal data, we found that nearly 80 percent of income DMIs were generated for households who worked with an agent, broker, and/or web-broker in PY 2024. This underscores that there continues to be broad miscalculations in household income attestation and resulting APTC assessment for applications assisted by agents, brokers, and web-brokers across Exchanges on the Federal platform, which the additional income verification outlined within this provision will help address.

We seek comment on this proposal.

13. Removal of the Requirement To Accept Attestations of Household Income When Tax Data is Unavailable (§ 155.320(c)(5))

In the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074), we removed the requirement for all Exchanges to accept an applicant's annual household income attestation when IRS is successfully contacted but the IRS returns no tax data. We finalized the policy to sunset after PY 2026, requiring Exchanges to resume acceptance of applicant attestations of their household income where the IRS, on behalf of the Treasury Secretary, reports that it has no data in response to a verification request under section 1411(c) of the Affordable Care Act. In this rule, we propose to permanently rescind the requirement under § 155.320(c)(5) that Exchanges accept attestations under the current rule, in

favor of requiring Exchanges, beginning with applications for coverage for the 2027 PY, to collect documentation from applicants to verify an applicant's household income when the IRS returns no data.

There were many reasons that we opted to temporarily pause the requirement for Exchanges to accept household income attestation when tax data is unavailable. As outlined in the 2025 Marketplace Integrity and Affordability final rule, we believed that this policy may have helped contribute to the weakening of the Exchange eligibility system, which some agents, brokers, and web-brokers took advantage of enrolling consumers in fully-subsidized plans they may not have been eligible for, oftentimes without those consumers' knowledge. Additionally, after reassessing our reasoning for implementing the original policy, we concluded that no longer agreed that the original income verification process, including time and effort to submit verifying documents, was punitive. Given this, we concluded in the 2025 Marketplace Integrity and Affordability final rule that the administrative burden of the full income verification process was offset by program integrity benefits that reinstating this policy would have.

We finalized this provision in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074) because we recognized that the imminent program integrity concerns were being driven by the existence of fully-subsidized plans. We noted that the expiration of the enhanced subsidies coupled with the temporary program integrity requirements enacted by the rule could alleviate the need for ongoing higher levels of program integrity policies beyond PY 2026. We stated that as the level of improper enrollments decreased in 2026, we expected 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 enacted in that rule. In other words, the burden of continuing the temporary policy would reach a point at which it outweighed any benefits.

After further consideration, we are proposing to remove § 155.320(c)(5), effectively eliminating the requirement to accept an applicant's household income attestation if IRS does not return any tax data so that for PY 2027 and beyond, Exchanges must generally follow the existing income verification process when the IRS returns no data. We are proposing to continue this policy based on our statutory authority

and new consideration of impacts from the WFTC legislation.

Section 1411(b)(3)(A) of the Affordable Care Act requires consumers applying for APTC to provide income information described in the Code for the tax year ending the second year preceding the plan year. However, as APTC is determined based on annual household income for the plan year for which they are applying for coverage, when the consumer applies during the open enrollment period, they provide their projected income for the plan year rather than the income from the second year preceding the plan year. Section 1411(c)(3) of the Affordable Care Act requires HHS to submit this income information provided under section 1411(b)(3)(A) of the Affordable Care Act to the IRS for verification without exception. Section 1411(d) of the Affordable Care Act then requires HHS or the Exchanges to verify information submitted on the application that is not required to be submitted to the IRS. This includes income information on "changes in circumstances" under section 1411(b)(3)(B) of the Affordable Care Act as described in section 1412(b)(2) of the Affordable Care Act. Section 1412 of the Affordable Care Act outlines the process for determining APTC. Section 1412(a) directs the Secretary of HHS in consultation with the Secretary of Treasury to establish a program for determining APTC eligibility, and section 1412(b)(2) allows the Secretary of HHS to provide procedures for determining APTC eligibility when a change in circumstance has occurred, which includes substantial changes in income and when the household was not required previously to file a tax return. Finally, section 1412(c)(2)(1) of the Affordable Care Act requires the Secretary of Treasury to provide APTC to issuers on a monthly basis for the plan year.

Historically, given the inconsistency between the statutory requirement for HHS to develop an APTC eligibility process that generally uses income verified by the IRS from the second tax year preceding the plan year, and the fact that HHS must determine eligibility for APTC for the plan year (which occurs significantly after the tax year for which income is used for verification), we have interpreted section 1412(b)(2) of the Affordable Care Act to require households to provide projected annual household income to allow the Secretary of HHS to determine whether a change in circumstance has occurred since the second tax year preceding the plan. In instances where Exchanges receive IRS data as defined in

1411(b)(3)(A) of the Affordable Care Act, the applicant's projected annual household income is compared to that IRS data to determine if it aligns (within certain thresholds) or if there has been a change in circumstance. The Secretary then determines APTC based on projected income per section 1412(b)(2) of the Affordable Care Act if a change in circumstance has occurred and if a change in circumstance has not occurred, meaning the IRS data is aligned with the projected household income, the Exchange is effectively determining APTC based on IRS data for the second tax year preceding the plan year. Furthermore, section 1412(b)(2)(B) allows for instances in which an applicant was not required to file a tax return for the second preceding year to also be considered a change in circumstance, which is one reason why IRS data may not be returned for an applicant. When the IRS cannot verify income and there is a change in circumstance, HHS or the Exchanges then turn to verify income through additional trusted data sources under section 1411(d) of the Affordable Care Act.

In a situation where neither IRS data under section 1411(c)(3) of the Affordable Care Act nor additional trusted data sources under section 1411(d) of the Affordable Care Act cannot verify income, HHS must then follow the process in 1411(e)(4) of the Affordable Care Act to both require Exchanges to make a reasonable effort to determine the cause of the inconsistency and then allow the applicant the opportunity to correct the inconsistency within a 90-day period. In a situation in which an applicant lacks additional documentation or other supporting evidence of their attested income within the applicable time period, HHS would generally be compelled by statute to deny eligibility for APTC and CSRs based on the inconsistency with IRS data after the 90-day period has ended. In scenarios where IRS does not return income information for a household after the Exchange completes a data request, the statutory framework just outlined establishes additional verifications. When the Exchange's attempt to receive IRS information as stipulated in 1411(b)(3)(A) of the Affordable Care Act is not successful, we believe that simply considering that attested annual household income fully verified is insufficient to the authority in section 1411(d) of the Affordable Care Act to verify change in circumstance information stipulated in section 1411(b)(3)(B) of the Affordable Care Act

and determine the method of verification, as it does state that the Secretary "shall verify" that information. Absent IRS data, CMS believes that it is necessary to proceed with further verification of this information in order to comply with the requirement in section 1411(d) of the Affordable Care Act to verify it, which would be more than simply accepting attestation.

Therefore, upon further review and consistent with our discussion in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12968), we believe the best method of verification to be the current established verification processes for annual income, and that accepting attestation without further verification is not compliant with the requirement to, in some way, verify the information.

Finally, since newly applicable policy from the WFTC legislation provides much stronger motivation to verify consumer income information more stringently than previous practice. Under section 71305 of the WFTC legislation, repayment caps on excess APTC payments will discontinue starting in PY 2026. Absent this proposed policy, households for whom IRS returns no data will have their annual household income verified by their attestation of projected household income and, if eligible based on this income, would receive APTC for the duration of the plan year (unless there is a change in eligibility). In contrast, under this proposed policy such household incomes would likely be verified against additional trusted data sources and, if this verification fails, receive an income DMI that would require them to submit documents to verify their annual household income and, if they do not, would result in the loss of APTC after the 90-day DMI period. Previously, Exchanges instituted a repayment cap on the maximum amount of APTC that a household was responsible for paying back upon Federal income tax filing based on their income. In general, this capped repayments for people with incomes below 400 percent of FPL. Absent the proposed policy and with the removal of the repayment caps, tax filers whose APTC continues uninterrupted and whose actual household income is higher than their projected household income may have excess PTC and, if so, must pay back the full difference between their APTC and PTC, regardless of their income level. Therefore, the proposed policy, which ends APTC for consumers who cannot verify their income with documentation, provides

an important protection for consumers against significant tax liabilities.

This is particularly important for consumers whose income is intentionally or unintentionally misrepresented by agents, brokers, web-brokers, or other intermediaries for enrollment on the Exchange. For example, many of these agents, brokers, and web-brokers intentionally estimate a household's attested income to receive the maximum amount of APTC possible in order to, even with the expiration of the enhanced subsidies, get consumers into low cost plans that they may not otherwise be eligible for at the price point provided. While we previously stated in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074) that we believe that unauthorized enrollments will decrease as a result of \$0 benchmark plans no longer being available due to the expiration of the enhanced subsidies, the removal of the repayment caps necessitates this policy becoming permanent to protect consumers from significant tax liabilities.

For these reasons, we believe that the justifications for sunseting this policy in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074) starting in Plan Year 2027 are now outweighed by the loss of the repayment caps. We had previously stated that the removal of the enhanced subsidies, and likely subsequent decrease in unauthorized enrollments, would mean that the corresponding Exchange costs and consumer burden for additional income verification, potential negative risk pool impact, and potential loss of coverage for low-income consumers would be greater than the positive program integrity benefits of making this policy permanent. However, we now believe that the tax liability changes for these consumers outweigh those concerns, and providing that protection is necessary even with the costs, burdens, and coverage impacts this policy could result in. We reiterate that applicants whose income is not returned by IRS will benefit from other verification procedures, including the Exchange checking other data sources beyond IRS and having 90 days to submit documentation to verify their attested annual household income.

We seek comment on this proposal.

14. Comment Solicitation on Premium Payment Threshold (\$ 155.400)

We are seeking comment on whether HHS should permanently discontinue regulatory options allowing QHP issuers to implement a fixed-dollar and gross percentage-based premium payment threshold for PY 2027 and beyond. In

the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074), we finalized for PY 2026 that issuers are only able to implement a net percentage-based premium threshold for PY 2026 and, effective January 1, 2027, issuers will be permitted to implement the fixed-dollar threshold and either the net or gross premium percentage-based thresholds.

In the 2017 Payment Notice (81 FR 12271 through 12272), in which HHS established the option for issuers to implement a percentage-based premium payment threshold, we received comment requesting that issuers be allowed to establish a fixed-dollar threshold. At that time, we did not consider implementing a fixed-dollar threshold because there can be cases where, due to the payment of APTC on behalf of an enrollee, even a low, flat-dollar amount could represent a large percentage of an enrollee's portion of the premium (81 FR 12272).

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 could consider an enrollee to have paid all amounts due in the following circumstance: the enrollee pays 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 could consider an enrollee 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.

We stated in the 2025 Marketplace Integrity and Affordability final rule, which was published after the 2026 Payment Notice, that, due to program integrity concerns stemming from the enhanced subsidies, offering these optional threshold flexibilities to issuers could enable a consumer to stay enrolled in a plan they are unaware of after payment of binder. At that time, we finalized modifications to § 155.400(g) that paused through the end of PY 2026 QHP issuers' ability to

implement a fixed-dollar or gross percentage-based premium payment threshold. We specified that QHP issuers would regain authority to implement a fixed-dollar or gross-premium threshold after December 31, 2026. We explained that allowing the provision to sunset on December 31, 2026, would address the urgent improper enrollment concerns previously noted without permanently dismantling these premium threshold options.

Overall, HHS observed an increase in the number of unauthorized enrollment (UE) complaints made in 2024 compared to 2025; 229,734 were made in 2024 vs. 341,906 in 2025. However, although HHS continues to see noncompliant behaviors resulting in improper enrollments, we believe that program integrity measures implemented over the past year, in addition to the expiration of enhanced APTCs that took effect on January 1 of this year, are likely to lead to a decrease in the number of UE complaints received. Data from the beginning of this year already demonstrate a substantial decrease, with 46,099 UE cases reported in January 2025 compared to 24,053 for January 2026, and this trend is likely to continue.

We have also continued working to implement policies to quickly resolve cases where a consumer may be dually enrolled in Medicaid and a QHP with financial assistance without their consent (referred to as "Medicaid UEs"). We have also implemented multiple data cleanup efforts and have worked with issuers to identify and resolve UEs. We continue to monitor complaints received and UEs resolved to ensure that program integrity concerns continue to decrease.

However, in addition to erroneous and improper enrollment data, there is evidence that consumers in many instances are unaware that they remain in coverage. For example, in a recent internal analysis of claims data from 2019 through 2024, we found that among silver plans offered on- and off-Exchange, a significantly higher percentage (34 percent from PY 2023 through PY 2024) of on-Exchange silver enrollments were associated with no claims as compared to off-Exchange silver enrollments (18 to 23 percent from PY 2019 through PY 2024) across all years examined, with the greatest difference occurring in PY 2023 and 2024. This trend was reflected in the percentage of zero claim enrollments in each metal level and was even reflected among enrollees in 94 percent of CSR plans, where out-of-pocket costs are mostly covered by insurers, and where

utilization is generally expected to be higher as compared to plans with lower or no cost-sharing assistance available. In addition to this, as we explained in the 2025 Marketplace Affordability and Integrity final rule (90 FR 27140), continued access to zero-dollar bronze plans after the application of APTC increases the risk of fraudulent enrollments and consumers continuing to be enrolled in coverage they do not want. Despite the discontinuation of enhanced APTCs, it is estimated that 27 percent of enrollees can select a PY 2026 QHP with an after-APTC premium of \$0, and 60 percent can select a PY 2026 QHP with an after-APTC premium of less than \$50.

The FFE does not collect data from issuers on whether they have implemented a premium payment threshold policy (nor the threshold type), but we have observed that of all auto re-enrolled consumers who had a \$0 premium in 2024 but who newly had a non-zero premium in 2025 (1,831,739 consumers), 19.2 percent owed \$10 or less for their monthly premium (171,382 consumers owed >\$0–\$5, and \$180,469 consumers owed >\$5–\$10), while 27.6 percent of consumers owed >\$10–\$25.¹¹⁵ This suggests that while these premium thresholds prevent some consumers from being placed in a grace period, they likely also exacerbate the problem of consumers unknowingly remaining in coverage they did not or no longer want, since many consumers have premiums that fall below the threshold and could avoid delinquency without making paying premiums. With the expiration of enhanced subsidies for PY 2026 and the continued availability of zero-dollar and lower cost plans after application of APTC, HHS is of the view that it may be reasonable and necessary to continue to limit the fixed-dollar and gross-premium percentage-based thresholds beyond PY 2026.

Under the 2025 Marketplace Integrity and Affordability final rule, we finalized that issuers would re-gain the authority to implement fixed-dollar and gross-premium percentage-based thresholds after the end of the 2026 PY. This policy responded to commenter concerns that rescinding QHP-issuer flexibility to implement fixed-dollar and gross-premium percentage thresholds could create barriers to coverage for low-income enrollees who struggle to pay

¹¹⁵ Source: Internal CMS enrollment data. CMS reviewed net premium changes for consumers who had a \$0 premium for PY2024 and a subsequent >\$0 premium for PY2025. The analysis shows how many consumers had net premiums of >\$0–\$5, >\$5–\$10, >\$10–\$15, >\$15–\$20, >\$20–\$25, >\$25–\$50, >\$50–\$100, >\$100–\$300, >\$300–\$500, and >\$500.

premiums and that consumers with chronic conditions might be able to utilize either the gross-premium percentage-based or fixed-dollar thresholds to avoid coverage gaps. It also acknowledged comments from State Exchanges and State-specific advocacy organizations that limiting this flexibility was unnecessary in States served by State Exchanges that experienced lower rates of improper enrollments.

While we recognize the additional flexibility these policies might provide to consumers who may struggle in some months to pay their full share of their premium, we still believe it may be necessary to limit flexibilities to ensure that enrollees do not remain in coverage for extended periods of time without paying at least some of the premium owed. We stated at the time that this policy increases the risk that improper enrollments remain undetected, since the enrollee is less likely to receive invoices, and a delinquency 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 gross 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.

As such, we are concerned that allowing the rescission of the fixed-dollar and gross-premium percentage-based threshold flexibilities to sunset for PY 2027 may exacerbate the risks we have outlined. We seek comment from interested parties on whether we should take no regulatory action and allow the policies to sunset at the end of PY 2026, or whether we should amend § 155.400 to rescind these policies for another fixed period of time or permanently in the interest of maintaining program integrity, as the fixed-dollar and gross percentage-based thresholds may hinder efforts at program integrity by allowing consumers to remain enrolled in unwanted coverage after payment of binder. In addition, we seek comment

on whether it would be appropriate to grant State Exchanges the flexibility to adopt one or both of these thresholds, even if they remain unavailable for Exchanges on the Federal platform. We also seek comment on any other feedback interested parties may have on other changes HHS can make to the premium payment threshold policy.

15. Extend the Removal of the 150 Percent FPL SEP Beyond Plan Year 2026 (§ 155.420(d)(16))

To align Exchange regulations with section 71304 of the WFTC legislation, we propose to remove § 155.420(d)(16) such that all Exchanges will continue to be prohibited from offering the 150 percent FPL SEP after PY 2026. In addition to removing § 155.420(d)(16), we also propose conforming amendments to remove §§ 155.420(a)(4)(ii)(D) and 155.420(b)(2)(vii), and to revise § 155.420(a)(4)(iii).

The “150 percent FPL SEP” refers to a monthly SEP that was available, at the option of the Exchange, to individuals who were eligible for APTC and who had household income no greater than 150 percent FPL. This SEP enabled qualified individuals to enroll in an Exchange plan at any time and to change their Exchange plan up to once per month. We originally established the 150 percent FPL SEP in regulation, at the option of the Exchange, in part 3 of the 2022 Payment Notice (86 FR 53412). At the time, we stated that the primary objective of the 150 percent FPL SEP was to “make affordable coverage available to more consumers,” by making it easier for individuals to access the enhanced tax credits provided by section 9661 of the ARP (86 FR 53432). As finalized in part 3 of the 2022 Payment Notice, a consumer was required to have an applicable percentage of zero, meaning that they had access to a silver plan with a zero-dollar monthly premium after the application of APTC, to qualify for the SEP. In the 2025 Payment Notice (89 FR 26218), we removed the requirement that an individual have an applicable percentage of zero to qualify for the 150 percent FPL SEP. In this rulemaking, we cited a commitment to “ensuring that affordable Exchange coverage is available for individuals with lower household incomes,” and required that an individual be eligible for APTC to qualify for the SEP (89 FR 26320).

In the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074), we finalized a policy that prohibited Exchanges from offering the 150 percent FPL SEP, effective from August 25, 2025, until the end of PY 2026, at which

time the prohibition would “sunset” and Exchanges could begin offering the 150 percent FPL SEP again. We stated that pausing the availability of the 150 percent FPL SEP was necessary due to a rise in improper enrollments, including misuse of the SEP by agents, brokers, and web-brokers (90 FR 27114). Exchanges would have been permitted to begin offering the 150 percent FPL SEP again in PY 2027, and this pause was finalized in part due to significant concerns raised by commenters regarding the impact of a wholesale repeal of the SEP on low-income Americans who properly use this SEP pathway (90 FR 27114). We reasoned that after the enhanced subsidies expired and individuals were exposed to greater premium costs, the ability of individuals or actors on behalf of individuals to improperly enroll would be diminished, mitigating the risk of allowing Exchanges to offer the 150 percent FPL SEP (90 FR 27114).

The 2025 Marketplace Integrity and Affordability final rule was finalized on June 25, 2025. Shortly thereafter, on July 4, 2025, the WFTC legislation was signed into law. Section 71304 of the WFTC legislation amended section 36B of the Code such that a plan is not considered a QHP, and therefore no PTC is allowed for coverage under the plan, if the plan is enrolled in through an SEP that is based solely on the basis of the relationship of an individual's expected household income to the FPL and not on a change in circumstance (an “income-based SEP”). This provision is effective January 1, 2026.

Section 1411(a)(2)(A) of the Affordable Care Act provides that for, an individual who is claiming APTC or CSRs, the Secretary must determine whether the individual meets the income and coverage requirements of section 36B of the Code and section 1402 of the Affordable Care Act, respectively. HHS has interpreted section 1411(a)(2)(A) of the Affordable Care Act to require an Exchange to align its APTC eligibility rules with the Code's PTC eligibility rules. Therefore, HHS interprets section 71304 of the WFTC legislation to prohibit an Exchange from paying APTC for anyone enrolled in a plan if any individual enrolls in the plan through an income-based SEP, like the 150 percent SEP, that is not in connection with the occurrence of an event or change in circumstances specified by the Secretary.

Under the regulations finalized in the Marketplace Program Integrity Rule (90 FR 27074), Exchanges would be permitted to resume offering the 150 percent FPL SEP beginning in PY 2027.

However, due to requirements established by section 71304 of the WFTC legislation, we have determined that permitting Exchanges to offer the 150 percent FPL SEP would provide no additional value and could potentially harm consumers. Throughout prior rulemaking on this topic, we have consistently stated that the primary goal of the 150 percent FPL SEP was to increase consumers' access to affordable coverage (see 86 FR 53432 and 89 FR 26320). Because consumers who enroll through the 150 percent FPL SEP are no longer allowed APTC for their coverage, permitting Exchanges to offer the 150 percent FPL SEP can no longer achieve this stated objective. Additionally, permitting Exchanges to offer the 150 percent FPL SEP could harm APTC-eligible consumers who enroll through the SEP, as section 71304 of the WFTC legislation prohibits payment of APTC to a plan if any enrollee in that plan enrolled through an income-based SEP.

For the reasons described in this section, we propose to eliminate the "sunset" of the prohibition on Exchanges offering the 150 percent FPL SEP after PY 2026. To accomplish this, we propose to remove the paragraph currently at § 155.420(d)(16). We further propose conforming amendments to remove the paragraphs currently at § 155.420(a)(4)(ii)(D) and § 155.420(b)(2)(vii), which relate to plan category limitations and effective dates for the 150 percent FPL SEP, respectively. Finally, we propose a conforming amendment to § 155.420(a)(4)(iii), related to plan category limitations, to remove a reference to the 150 percent FPL SEP.

We seek comment on this proposal.

16. Special Enrollment Period Verification (§ 155.420(g))

In the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074), we finalized the removal of the restriction for Exchanges on the Federal platform to only conduct Special Enrollment Period Verification (SEPV) for Loss of Minimum Essential Coverage (MEC) at § 155.420(g). This allowed the Federal Exchange to conduct SEPV for additional SEPs. We also finalized a regulation that required Exchanges on the Federal platform to conduct SEPV for at least 75 percent of new enrollments. The final rule included a provision that both of these provisions were set to sunset on December 31, 2026.

We are reproposing these provisions in this rule as their implementation was stayed by the Court in *City of Columbus et al. v. Kennedy et al.* on August 22,

2025.¹¹⁶ In reproposing these provisions following the Court's stay, this proposal reflects changes in circumstances and new supporting information since the original policy was established. This includes the passage of the WFTC legislation and additional insights from the resumption of SEPV for Loss of Minimum Essential Coverage (MEC) that occurred on May 16, 2025 in compliance with current SEP in verification regulations at § 155.420(g) for Exchanges on the Federal platform. Our proposal for the two SEPV policies does not include a sunset provision.

We included the sunset provision in the 2025 Marketplace Integrity final rule because we recognized that the then-imminent program integrity concerns were being driven by the existence of fully-subsidized plans. We noted that the expiration of the enhanced subsidies coupled with the temporary program integrity requirements enacted by the rule would right-size Exchange enrollment in PY 2026 and would obviate the need for ongoing higher levels of program integrity policies. We stated that as the excess levels of improper enrollments are reduced in PY 2026, we expected 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 the rule. In other words, the burden of continuing such policies would have reached a point at which they would outweigh any benefits.

We now believe reproposing these policies (without a sunset) is necessary to ensure integrity in the Exchanges and help limit fraudulent enrollments. The proposal to require Exchanges on the Federal platform to conduct SEPV for the loss of MEC SEP is a return to a previous policy that was implemented pursuant to the 2017 Marketplace Stabilization rule. The SEP verification policy in the 2017 rule was driven in part by a 2016 GAO undercover test study of SEPs. The study observed that self-attestation could allow applicants to obtain subsidized coverage they would otherwise not qualify for and then found 9 out of 12 of GAO's fictitious applicants were approved for coverage on the Federal and selected State Exchanges.¹¹⁷ As a result we implemented verification for the largest SEPs on the Federal exchange.

Once SEPV was implemented, we studied how the consumer experience

was impacted. For PY 2017, a 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 COVID-19 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 increased to 86 percent by 30 days.¹¹⁸ 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. The data shows that the value of SEPV processing and the program integrity benefits it provides to the Exchanges is greater than the minimal burdens those same processes place on individuals.

We are proposing the 75 percent verification threshold for new SEP enrollments because we believe that most Exchanges would be able to meet it by verifying at least two or three of their largest SEP types based on current SEP volumes. The determination of how many enrollments would constitute 75 percent would be required to be based on enrollment through all SEPs in the prior plan year. 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. We are not proposing to require Exchanges to verify eligibility for all SEPs, because we have determined that the cost to verify eligibility for SEPs with very low utilization rates could be greater than the benefit of verifying eligibility for them.

For SEPs that are being verified, the Exchange would "pend" the consumer's enrollment, meaning that it would not be effectuated until the Exchange verified eligibility for enrollment through the SEP. If the Exchange is unable to verify such eligibility, then the consumer would not be eligible for enrollment through the Exchange under that SEP, and any plan selection under

¹¹⁶ *City of Columbus v. Kennedy*, 796 F. Supp. 3d at 160.

¹¹⁷ 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>.

¹¹⁸ More consumers resolve passed 30 days due to extensions that they are eligible to receive.

that SEP would be canceled (meaning, terminated before coverage is effectuated) and would not result in enrollment.

Verification for the loss of MEC SEP, which is required under § 155.420(g), was paused through the Covid-19 PHE to ensure consumers could maintain access to continuous coverage. This pause in verification ended on May 16, 2025. After resuming verification for the Loss of MEC SEP on May 16, 2025, we noticed shifts in enrollment trends begin to occur.¹¹⁹ Prior to the resumption of verification, in April of 2025, the Loss of MEC SEP accounted for approximately 330,000 SEP enrollments which was 48 percent of all SEP enrollments at that time in Exchanges that use the Federal platform. As of September 2025, the Loss of MEC SEP accounted for 95,000 SEP enrollments, which was down to 27 percent of all SEP enrollments at that time.¹²⁰ We also noticed during this same period that several other SEP types had their overall percentage of SEP enrollments increase quite substantially. For example, the Move SEP went from 1 percent to 21 percent of all SEPs, and the Medicaid/CHIP Denial SEP increased from 8 percent to 24 percent of all SEP enrollments. This data suggests that consumers shifted their SEP attestation so as not to have to provide verification of eligibility for the SEP.

We acknowledge that some shift in SEP volumes was expected due to our best SEP logic, which is a set of hierarchy rules that Exchanges on the Federal platform use to determine what the “best SEP” is for a consumer (generally based on the most advantageous coverage effective date for the qualifying life event experienced by the consumer, verifiable with documents as required), in the event that they attest to multiple SEP qualifying events, such as losing MEC, while also gaining a dependent. Essentially, consumers are often eligible for more than one SEP type and, once verification resumed, another SEP type may become the best SEP for a consumer. However, the substantial shift cannot be explained by that logic alone as these trends do not match any of our historical SEP enrollment data.

When SEPV was first implemented in 2017 and 2018, we noticed shifts in SEP enrollment patterns that resulted in non-verified SEPs making up a larger

portion of the total SEP population. For example, the overall portion of consumers granted an SEP for acquiring a status that made them eligible for the Exchange increased from 2.5 percent in 2017 to 10 percent in 2018. During that same period, the Loss of MEC SEP decreased from 60 percent of all SEPs in 2017 to 54 percent in 2018, and the Medicaid/CHIP Denial SEP decreased from 24 percent in 2017 to 19 percent of all SEPs in 2018. From 2019 to 2024, although SEP enrollment volume increased drastically, the proportion of enrollment though each SEP stayed relatively similar. The introduction of the under 150 percent FPL SEP did result in the volume of other non-verified SEPs decreasing. The only notable changes were that the total portion of loss of MEC SEPs increased 5 percent and Medicaid/CHIP denial decreased 6 percent. Given the mass shift away from the loss of MEC SEP throughout 2025 and the significant growth in non-verified SEPs during the same time frame, we believe there is a high likelihood action is being taken to intentionally avoid SEP verification. We believe this trend is being driven primarily by agent and broker activity as 86 percent of SEP enrollments are through agents and brokers.

In addition to trying to mitigate the concern that individuals are attesting to SEPs they are not eligible for in order to avoid verification, we believe SEP verification will also help deter bad actors and those who are ineligible to enroll in coverage from gaining access to the Exchanges. We believe that this will help to reduce rates by preventing individuals who are waiting until they are sick to enroll from utilizing SEPs for which they may be ineligible. As we explained in the 2025 Marketplace Affordability and Integrity rule, we believe that continued access to zero-dollar bronze plans increases the risk of fraudulent enrollments and ineligible individuals gaining access to coverage through SEPs that do not require verification. We believe that increased SEP verification, as we stated in that rule, would reduce the risk of fraud and ineligible enrollments related to zero-dollar bronze plans in the FFE.

For the reasons provided above, we are reproposing without a sunset at § 155.420(g), the provision to remove the restriction for Exchanges on the Federal platform to only conduct SEPV for Loss of MEC, and the provision to require Exchanges on the Federal platform to conduct SEPV for at least 75 percent of new enrollments.

We seek comment on this proposal.

17. Expansion of Hardship Exemption Eligibility (§ 155.605(d)(1))

We propose to amend § 155.605(d)(1) to codify the expansion of hardship exemption eligibility to individuals who are ineligible for APTC or CSR due to projected household income below 100 percent or above 250 percent FPL.

Section 5000A(e)(5) of the Code establishes an exemption from the individual shared responsibility payment based on hardship or lack of affordability, and section 1302(e) of the Affordable Care Act limits eligibility for catastrophic coverage to individuals under age 30 at the start of the plan year or those who have received a hardship or affordability exemption. Under § 155.605(d), hardship exemptions include circumstances that prevent an individual from obtaining coverage through a QHP. Section 155.605(d)(1) states that the Exchange must grant a hardship exemption to an individual for at least the month before, the month or months during which, and the month after a specific event or circumstance, if the Exchange determines that: (1) the individual experienced financial or domestic circumstances, including an unexpected natural or human-caused event, such that he or she had a significant, unexpected increase in essential expenses that prevented him or her from obtaining coverage under a QHP; (2) the expense of purchasing a QHP would have caused the individual to experience serious deprivation of food, shelter, clothing or other necessities; or (3) the individual has experienced other circumstances that prevented him or her from obtaining coverage under a QHP.

State Exchanges may choose to process exemptions, or they may delegate exemption processing to HHS. Most State Exchanges currently delegate hardship exemption processing to HHS.¹²¹ HHS published guidance on September 4, 2025, that expanded eligibility for a hardship exemption to individuals ineligible for APTC or CSRs due to projected household income for consumers in FFE States, SBE-FP States, and State Exchange States that delegate their exemption processing to HHS.¹²² The proposal to amend § 155.605(d)(1) would expand hardship exemption eligibility to consumers

¹²¹ California, Connecticut, Maryland, and the District of Columbia currently do not delegate hardship exemption processing to HHS.

¹²² CMS. (2025, September 4). Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-sharing Reductions Due to Income, and Streamlining Exemption Pathways to Coverage. Available at <https://www.cms.gov/files/document/guidance-hardship-exemptions.pdf>.

¹¹⁹ We note that it is too soon for CMS to observe these trends as of the date the Program Integrity final rule was published on June 25, 2025.

¹²⁰ These numbers are derived from internal FFE SEP enrollment data.

ineligible for APTC or CSRs due to projected household income in all States. We propose to make this change to improve access to affordable coverage to consumers in all States as we believe there are a substantial number of consumers for whom purchasing a QHP relative to a catastrophic plan could cause a financial hardship. From the year before the Affordable Care Act's main regulations took effect in 2013 to 2026, average monthly premiums on the individual market jumped from \$244 to \$779—a 219 percent increase, with premiums increasing by 26 percent in 2026 alone.¹²³ By comparison, inflation since 2013 increased by 39 percent and average hourly earnings for private sector employees increased by 53 percent.¹²⁴ As these data show, premiums continue to outpace income growth, creating affordability challenges even for consumers who may not qualify for financial assistance. We believe the substantial premium increases accumulated since 2013, and the recent spike in 2026, warrant a broad nationwide hardship exemption to allow individuals aged 30 and older to enroll in catastrophic coverage, if otherwise eligible under the proposed household income parameters. We propose applying this exemption uniformly across all States to ensure consistent consumer protection and access to catastrophic coverage.

To avoid confusion and inequities for consumers, States that currently process exemptions independently may implement the expanded criteria within their existing systems or delegate processing to HHS. This proposal does not preempt State authority under section 1321 of the Affordable Care Act, which provides States flexibility in the operation and enforcement of Exchanges and related requirements. States retain discretion to determine how to operationalize this policy—either by adopting the expanded criteria or continuing to delegate exemption processing to HHS. We would provide technical assistance to support implementation and ensure that States can exercise this flexibility while maintaining consistent consumer protections nationwide.

We seek comment on the proposal to amend § 155.605(d)(1) to codify and expand hardship exemptions for individuals ineligible for APTC or CSRs due to projected household income. If finalized as proposed, the expanded

hardship exemption policy would take effect on the effective date of the final rule.

18. Amending Exchange Network Adequacy Standards (§ 155.1050)

Given our network adequacy review proposals at § 156.230 and § 155.1050(d) (which are described in greater detail later and in section III.E.10. of this proposed rule), we propose, for plan years beginning on or after January 1, 2027, to restore network adequacy authority back to the State Exchanges and SBE-FPs through the removal of requirements at § 155.1050(a)(2)(i) and (ii) which require State Exchanges and SBE-FPs to establish and impose quantitative time and distance network adequacy standards that are at least as stringent as standards for QHPs on the FFEs. We propose to amend § 155.1050(a)(2) to return to the requirement that State Exchanges and SBE-FPs ensure that each QHP provides sufficient access to providers in a manner that meets applicable standards specified in § 156.230(a)(1)(ii) and (iii) for network plans, or proposed § 156.236(a) for non-network plans, as applicable. These proposals seek to align § 155.1050 with the proposed changes in § 156.230.

In the 2025 Payment Notice (89 FR 26218), we finalized § 155.1050(a)(2)(i)(A) to require that, for plan years beginning on or after 2026, State Exchanges and SBE-FPs must establish and impose quantitative time and distance network adequacy standards for QHPs that are at least as stringent as standards for QHPs participating on the FFEs under § 156.230. We also finalized § 155.1050(a)(2)(i)(B) which requires that, for plan years beginning on or after January 1, 2026, State Exchanges and SBE-FPs conduct quantitative network adequacy reviews to evaluate a plan's compliance with network adequacy standards under § 156.230(a)(1)(ii), (a)(1)(iii), and (a)(2)(i)(A) prior to certifying any plan as a QHP, while providing a QHP certification applicant the flexibilities described under § 156.230(a)(2)(ii) and (a)(3) and (4).

We propose to remove these requirements to align with our proposals to add § 155.1050(d) and revise § 156.230 throughout to specify its applicability to QHP issuers that use a provider network in FFE States, including States performing plan management, that do not elect to conduct their own provider access reviews or that HHS has determined have not demonstrated sufficient authority and the technical capacity to conduct network adequacy reviews by

satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program as described later in this section and in section III.E.10. of this proposed rule. We also propose these changes in recognition of the longstanding authority State Exchanges and SBE-FPs previously had to develop and enforce network adequacy standards and, given this past authority and experience, their network adequacy review capabilities and expertise to date.

The proposal also seeks to restore the authority that State Exchanges and SBE-FPs originally had in establishing network adequacy standards for their QHPs and issuers, acknowledging that State Exchanges and SBE-FPs have demonstrated they have the experience and expertise to be the best positioned entities to develop network adequacy standards for their distinct consumer markets.

Through our recent assessment of State Exchange and SBE-FP implementation of the network adequacy policy finalized in the 2025 Payment Notice, many State Exchanges and SBE-FPs demonstrated they have network adequacy standards and reviews in place that met or exceeded the requirements finalized in the 2025 Payment Notice. We are aware that some State Exchanges made updates in the lead up to PY 2026. State Exchanges and SBE-FPs provided us with detailed answers to a survey on existing authorities and policies in place and we met with each State Exchange and SBE-FP to discuss in detail what they were currently doing to assess network adequacy and any modifications they were working toward prior to PY 2026. State Exchanges and SBE-FPs described a wide variety and varying mixes of approaches including assessing compliance with time and distance standards, as was required in the 2025 Payment Notice, assessing compliance with time or distance individually due to geographical considerations, appointment wait times, or provider enrollee ratios.

The variety amongst the State Exchanges and SBE-FPs regarding how they chose to implement their unique approaches underscored the importance of restoring authority to State Exchanges and SBE-FPs, since these States can better take into consideration the needs of specific enrollee populations stemming from factors such as provider supply shortages and topography. Indeed, while some State Exchanges and SBE-FPs made modifications or updates to their network adequacy policies in the lead-up to implementation, we ultimately determined that most State

¹²³ Average enrollment weighted monthly premium from MLR data for 2013, and from unified rate review template (URRT) filings for 2026.

¹²⁴ BLS CPI-U and Current Employment Statistics Survey.

Exchanges and SBE-FPs were either already aligned with the requirements described at § 155.1050(a)(2)(i) or were granted the exception described under § 155.1050(a)(2)(ii), meaning we determined that the State established and imposed time and distance standards at least as stringent as those for QHPs on the FFEs, or that the State established and enforces alternate quantitative network adequacy standards that are reasonably calculated to ensure a level of access to providers that is as great as that ensured by the Federal network adequacy standards established for QHPs under § 156.230(a)(1)(iii), (a)(2)(i)(A), and (a)(4).

This proposal also seeks to align with proposed § 155.1050(d) and removes an unnecessary, redundant, layer of Federal regulatory burden on State Exchanges and SBE-FPs while maintaining consumer protections through the existing, robust State-level processes for setting network adequacy requirements for issuers and reviewing QHP network adequacy within their respective State Exchange or SBE-FP that such State Exchanges and SBE-FPs demonstrated to us were already in place prior to PY 2026. Due to the well-established, long-existing approaches that State Exchanges and SBE-FPs demonstrated to us were already in place, with many State Exchanges and SBE-FPs demonstrating through the surveys and subsequent conversations that they were already conducting network adequacy reviews in compliance with § 155.1050(a)(2)(i) and the remainder of State Exchanges and SBE-FPs were conducting network adequacy reviews that satisfied the criteria for an exception described at § 155.1050(a)(2)(ii), we have a high level of confidence that restoring § 155.1050(a)(2) to the requirements in place prior to 2025 would not result in consumers losing reasonable access to services without unreasonable delay.

Separately, concurrent with the proposal to amend § 156.230, to implement changes to reviews of network adequacy for QHP issuers in FFE States that demonstrate sufficient authority and the technical capacity to conduct such reviews and elect to do so, we propose the addition of § 155.1050(d) which would establish an Effective Provider Access Review Program.

We propose at § 155.1050(d)(1) that, beginning PY 2027, we would defer provider access reviews of QHP issuers' plans, with or without a provider network, applying for certification to be offered as a QHP through an FFE, to States that elect to conduct such

provider access certification reviews, provided the State has demonstrated sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program under proposed § 155.1050(d)(2) through (d)(4). We propose at § 155.1050(d)(2) to clarify that FFE States considered to have an Effective Provider Access Review Program must ensure that a QHP issuer that uses a network of providers ensures that the in-network providers, as available to all enrollees, include essential community providers (ECPs) in accordance with § 156.235, and maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay. The QHP issuer's provider network must also be consistent with the rules for network plans in section 2702(c) of the PHS Act.

At § 155.1050(d)(3), we propose that FFE States considered to have an Effective Provider Access Review Program must ensure that a QHP issuer that does not use a network of providers (a non-network plan) provides access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full, including ECPs and providers that specialize in mental health and substance use disorder services, to ensure that services will be accessible without unreasonable delay.

At § 155.1050(d)(4), we propose the factors necessary for a State operating on the FFE to be considered to have an Effective Provider Access Review Program. We also propose to revise § 155.1050(a)(1) to clarify that an FFE State that has elected to conduct provider access reviews and has been determined to have an Effective Provider Access Review Program must ensure that each QHP provides sufficient access to providers in a manner that meets the standards specified in § 156.230(a)(1)(ii) and (a)(1)(iii) for network plans, or proposed § 156.236(a) for non-network plans, as applicable. A detailed discussion of this proposal can be found in section III.E.10. of this proposed rule. Additionally, we would encourage State Exchanges and SBE-FPs to use their network adequacy authority to conduct similar provider access reviews that consider criteria consistent with those outlined at § 155.1050(d)(2) through (d)(4) and described in section III.E.10. of this proposed rule.

In summary, we propose to amend § 155.1050(a)(2) to eliminate, for plan years beginning on or after January 1, 2027, the requirements under § 155.1050(a)(2)(i) and (ii) for State Exchanges and SBE-FPs. Instead, we propose to revise § 155.1050(a)(2) to require that State Exchanges and SBE-FPs ensure that each QHP provides sufficient access to providers in a manner that meets applicable standards specified in § 156.230(a)(1)(ii) and (a)(1)(iii) for network plans, or proposed § 156.236(a) for non-network plans, as applicable. We also propose the addition of § 155.1050(d), which is described in greater detail in section III.E.10. of this proposed rule.

We seek comment on this proposal. We also seek comment on what level of transparency is necessary and appropriate to safeguard public trust in Effective Provider Access Review Programs. While we are not specifically contemplating any particular form of new disclosure in this space at this time, we are interested in public feedback on which elements of process and which outputs of Effective Provider Access Review Programs should be subject to public disclosure.

19. Effective Essential Community Provider Review Program (§ 155.1051)

Beginning PY 2027, we propose to allow FFE States, including States performing plan management, to elect to conduct their own ECP certification reviews of an issuer's plans with or without a provider network in their State applying for certification as a QHP to be offered through an FFE. We would allow FFE States to conduct such ECP certification reviews provided the State demonstrates sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria established by HHS to be considered to have an Effective ECP Review Program, which we propose to implement at § 155.1051. This proposal is discussed in more detail in section III.E.11. of this proposed rule.

20. General Program Integrity and Oversight Requirements (§ 155.1200)

We propose to amend § 155.1200 to add new paragraph (e) to permit State Exchanges to satisfy certain requirements of the independent external programmatic audit, as outlined in paragraph (d), by completing the proposed State Exchange Improper Payment Measurement (SEIPM) process that would be established at 45 CFR part 155, subpart Q. We also propose to amend § 155.1200(d) to reduce duplication between the proposed State Exchange SEIPM program described in

proposed subpart Q and the annual independent external programmatic audit requirements and standards described at § 155.1200(c) and (d).

The Payment Integrity Information Act of 2019 (PIIA) (Pub. L. 116–117) requires Federal agencies to annually estimate and report on improper payments in the programs they administer that have been determined to be susceptible to significant improper payments. Pursuant to the PIIA, we propose to establish a SEIPM program, as we have determined that APTC payments administered by State Exchanges are susceptible to significant improper payments and are subject to additional oversight.¹²⁵ The PIIA defines significant improper payments as those exceeding either \$100 million or exceeding \$10 million and 1.5 percent of the program outlays. The proposed SEIPM program requirements are set forth in new proposed subpart Q, as discussed in section III.D.21. of this proposed rule.

The proposed SEIPM program would specify a methodology to develop State Exchange improper payment estimates and provide for the accurate calculation, and subsequent reporting, of an improper payment rate in HHS' Agency Financial Report (AFR). To ensure the accurate and consistent calculation of improper payments via the SEIPM program, we propose to require that State Exchanges provide HHS with access to certain State Exchange data, including eligibility determinations and enrollment information. We further propose that State Exchanges found to have significant improper payments could, to correct improper payment root causes, be required to develop corrective action plans (CAPs).

Our authority to oversee the State Exchanges arises from the program integrity and oversight requirements they must meet that are specified at section 1313(a) of the Affordable Care Act and at §§ 155.1200 and 155.1210. Key annual State Exchange reporting requirements at § 155.1200(b) include the annual submission of: (1) a financial statement in accordance with generally accepted accounting principles; (2) an annual report showing compliance with Exchange requirements; and (3) performance monitoring data.

Pursuant to § 155.1200(c) and (d), each State Exchange is also required to engage or contract with an independent qualified auditing entity that follows generally accepted government auditing

standards to perform annual independent external financial and programmatic audits that address compliance with 45 CFR part 155, subparts D and E, or other 45 CFR part 155 requirements as specified by HHS. State Exchanges must provide HHS the audit results, including CAPs to address any audit-identified material weaknesses or significant deficiencies, and we monitor these CAPs until findings are resolved, pursuant to § 155.1200(c)(2). These audits allow us to oversee State Exchange compliance with eligibility and enrollment standards. In sub-regulatory guidance, we specify that the scope of the audits must also include 45 CFR part 155, subparts C and K.¹²⁶

We propose to amend § 155.1200(d) to reduce duplication between the proposed SEIPM program described in subpart Q and the annual independent external programmatic audit requirements and standards described at § 155.1200(c) and (d). We propose to add § 155.1200(e) to permit a State Exchange to satisfy certain annual independent external programmatic audit requirements, as described at § 155.1200(d), by completing the proposed required annual SEIPM program process. These certain audit requirements would be limited to compliance with 45 CFR part 155, subparts D and E, and would be specified in guidance we would issue. We also propose to amend § 155.1200(d) to cross-reference proposed § 155.1200(e) to minimize duplication between the annual programmatic audit requirement and proposed SEIPM program. This would allow us to continue to require an annual independent programmatic audit of other subparts beyond eligibility and enrollment, while reducing duplication for oversight of eligibility and enrollment provisions.

We believe this policy would reduce duplicative efforts and burden on State Exchanges that would otherwise be required to fully comply with the programmatic audit requirements and SEIPM, while also maintaining the programmatic audits for requirements not reviewed as part of SEIPM.

We seek comment on these proposals.

21. State Exchange Improper Payment Measurement (SEIPM) (§§ 155.1600 Through 155.1650)

Under this proposed rule, we propose to establish the SEIPM, pursuant to the

PIIA,¹²⁷ to measure improper payments of APTC administered by a State Exchange. To codify the proposed SEIPM requirements, we propose to establish a new subpart Q at 45 CFR part 155. The PIIA requires Federal agencies to periodically review programs and activities to identify those susceptible to significant improper payments, and to report improper payment estimates for such programs. The PIIA defines significant improper payments as those exceeding \$100 million or those exceeding \$10 million and more than 1.5 percent of program outlays. In FY 2016, we conducted improper payment risk assessments for the Health Insurance Exchange programs and concluded that the APTC program is susceptible to significant improper payments. Between FY 2017 and FY 2019, we developed and piloted activities for measuring improper payments of APTC, which led to developing the Exchange Improper Payment Measurement Program for Exchanges administered through the FFE. Through that initiative, HHS began annual reporting of improper payment estimates in the FY 2022 Annual Financial Report (AFR) for APTC administered through the FFE.¹²⁸ However, due to our lack of regulatory authority to collect the same information from State Exchanges, we could not do the same for APTC administered through State Exchanges.

As a result, we proposed in the 2023 Payment Notice proposed rule (87 FR 584) to establish the SEIPM program, which would have required State Exchanges to submit certain information to HHS so that HHS could report an improper payment estimate of APTC administered by State Exchanges. We proposed that it would begin in calendar year 2024, but a significant volume of public comments stating that State Exchanges would need additional time and guidance to prepare for SEIPM persuaded us not to finalize that proposal. Subsequently, in the 2024 Payment Notice (88 FR 25740), we finalized the Improper Payment Pre-Testing and Assessment Program (IPPTA). The purpose of that program is to: (1) prepare State Exchanges for the planned measurement of improper payments, (2) test processes and procedures that support HHS' review of determinations of APTC made by State Exchanges, and (3) provide a mechanism for HHS and State

¹²⁵ HHS has already implemented an Exchange Improper Payment Measurement (EIPM) process to review potential improper APTC payments in the Federally-facilitated Exchange.

¹²⁶ *State-based Marketplace Independent External Audit Technical Assistance*. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/independent_external_audit_ta.pdf.

¹²⁷ 31 U.S.C. 3352 (2020).

¹²⁸ CMS. Exchange Improper Payment Measurement (EIPM). Available at <https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/exchange-improper-payment-measurement-eipm>.

Exchanges to share information that will aid in developing an efficient measurement process. HHS is continuing IPPTA through the end of 2026.

IPPTA is currently underway and the first cohort of eight State Exchanges have completed all of the information submission requirements for ten or more sampled tax households. We have completed the review process for the first cohort of State Exchanges and have communicated the findings to those State Exchanges. For the ten States Exchanges in the second cohort, as of this time, data collection has been completed for four of the States Exchanges and the remaining six State Exchanges are in the process of preparing the review data. The information submission is expected to be completed by March of 2026. The main challenge associated with IPPTA, which would carry through to SEIPM, relates to the quantity of data that the State Exchange must submit in order for HHS to accurately determine whether each payment of APTC was proper or improper. For each tax household, there may be multiple QHP policies, and multiple enrollees who were determined eligible for APTC, all of which invoke specific requirements for determining eligibility. These factors cause considerable volume and complexity in the data that would be required for SEIPM.

Additionally, each State Exchange operates its own platform with a unique data architecture, making it challenging to develop a unified process by which State Exchanges could submit the requisite information. For the purposes of IPPTA, we developed a Data Request Form (DRF) to collect the information that proved to be an effective tool for six of the eight State Exchanges in the first cohort. For the other two State Exchanges, some of the data was collected manually and not through the DRF. HHS collected some of the data manually for those two State Exchanges because they were unable to successfully submit all of the data required for measurement in the DRF format and structure. As a lesson learned from that data collection process, we are proposing to allow a more flexible mechanism for data collection in SEIPM. For the second cohort of 10 State Exchanges, it is too early in the IPPTA cycle to determine if alternate means of collecting the data will be necessary. However, given our success with the first cohort, we expect to collect the data that is necessary for the completion of IPPTA.

To mitigate these challenges, we have automated the data validation process

that allows us to assess each submitted DRF and to coordinate with the State Exchanges to correct data when inconsistencies are identified. For SEIPM, we would use the DRF while also allowing flexibility in data submissions where there are conflicts in structure between the DRF and the State Exchange data architecture. In these instances, we would allow data to be submitted in native formats, which would lessen the burden on State Exchanges.

We now propose to establish a new subpart Q at 45 CFR part 155 (containing §§ 155.1600 through 155.1650) to codify the SEIPM requirements. We propose to require State Exchanges to annually submit to HHS the information required for HHS to produce an estimate of improper payments in accordance with OMB Circular No. A–123 requirements.¹²⁹ We propose to measure all State Exchanges annually unless we specify otherwise and to report the calculated estimate of improper payments in the HHS AFR. State Exchanges already are required to conduct annual independent external programmatic audits, so we propose to minimize duplication of those audit requirements with the proposed SEIPM program, as described in proposed § 155.1200(e). We additionally propose that any State Exchange in its first year of operation would be required to participate in a 1-year SEIPM preparation phase prior to being required to satisfy the SEIPM requirements. The proposed regulations at subpart Q would be applicable beginning in January 2027.

This proposal would address a critical gap in improper payment oversight, as the PIIA requires Federal agencies to estimate and report on improper payments in programs determined to be susceptible to significant improper payments. While we have established an improper payment measurement for the FFE, (that is, the Federal Exchange Improper Payment Measure or FEIPM),¹³⁰ State Exchanges have operated without comparable systematic measurement of APTC improper payments. The FFE's improper payment measurement is overseen by the Payment Accuracy and Reporting Group (PARG), within the CMS Office of

Financial Management (OFM), which has developed comprehensive methodologies and systems to ensure accurate measurement and reporting. By extending similar measurement methodologies to State Exchanges through SEIPM, HHS would ensure consistent oversight and accountability across all exchange types, promoting parity in program integrity efforts nationwide.

a. Purpose and Scope (§ 155.1600)

We propose to add a new subpart Q to 45 CFR part 155, which would establish State Exchange responsibilities.

We propose to add a new § 155.1600 that would convey the purpose and scope of the SEIPM. At § 155.1600(a), we propose the SEIPM would be an initiative through which HHS measures improper payments of APTC that are administered by State Exchanges, described in more detail in proposed § 155.1610. We propose to use the results of SEIPM to produce an estimate of improper payments of APTC aggregated across State Exchanges.

At § 155.1600(b), we propose that unless specified otherwise by HHS, all State Exchanges on an annual basis would be required to submit information that is necessary to support the SEIPM processes. The data and information we would require from State Exchanges would be essential for us to conduct accurate improper payment measurement, as it is not available through any other existing sources or systems. Unlike the FFE where we have direct access to enrollment and payment data, State Exchanges operate independent systems that contain eligibility determinations, enrollment records, and APTC calculation data necessary for HHS to make improper payment assessment under the SEIPM. Without State Exchanges submitting the proposed information, we would be unable to fulfill our statutory obligations under the PIIA to measure and report improper payments. The proposed annual submission requirement would ensure that we have access to the most current and complete data necessary to produce statistically valid improper payment estimates and identify areas for program improvement.

At § 155.1600(c), we propose that HHS would publish in its AFR an estimate of improper payments aggregated across all State Exchanges. Publication in the HHS AFR would ensure that APTC improper payment estimates are subject to the same transparency and accountability standards as other major HHS programs.

¹²⁹ OMB. (2021, March 5). Transmittal of Appendix C to OMB Circular A–123, Requirements for Payment Integrity Improvement. Available at <https://www.whitehouse.gov/wp-content/uploads/2021/03/M-21-19.pdf>.

¹³⁰ CMS. Exchange Improper Payment Measurement (EIPM). Available at <https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/exchange-improper-payment-measurement-eipm>.

b. Applicability Date (§ 155.1605)

In this section, we propose to add new § 155.1605, which would establish SEIPM's applicability date.

At proposed new § 155.1605(a), we propose that this subpart would be applicable beginning January 1, 2027, which we believe would provide State Exchanges with sufficient time to begin the SEIPM. For State Exchanges that have participated in IPPTA, the proposed January 1, 2027, applicability date would mean that those State Exchanges would submit the proposed required information and would be subject to improper payment measurement under the SEIPM beginning in 2027 for PY 2026, with the improper payment estimate being reported for the first time in 2028. This proposed timeline would allow State Exchanges to establish the operational infrastructure and baseline processes to support the SEIPM, such as conducting comprehensive system assessments to identify data collection and reporting capabilities; developing or modifying existing information systems to capture and transmit the required the SEIPM data elements; establishing internal policies and procedures for data validation and quality assurance; training staff on the SEIPM requirements and reporting protocols; and conducting testing and validation of new systems and processes before the effective date. Additionally, the foundational framework established through IPPTA would have provided State Exchanges with sufficient experience and understanding of their data capabilities and measurement processes to support the transition to SEIPM by January 1, 2027. Any technical adjustments, data collection refinements, or procedural clarifications identified during the IPPTA implementation could be incorporated into the SEIPM through sub-regulatory guidance, allowing for improvements without requiring additional rulemaking or timeline extensions. State Exchanges in the first year of operation would undergo the preparation phase proposed in § 155.1640 and would begin the Measurement Year in 2028 for PY 2027.

c. Definitions (§ 155.1610)

We propose to add § 155.1610 to codify the following definitions that would be used in this subpart that are specific to SEIPM and key to understanding its processes and procedures:

- *Annual Program Schedule* would mean the document issued by HHS to each State Exchange that would

prescribe the dates for which key SEIPM milestones must be met.

- *Administrative Appeal* would mean the process by which a State Exchange may request HHS to review and reconsider a Difference Resolution Decision. The appeal would be the second and final level for a State Exchange to contest findings of error or improper payment as it relates to APTC.

- *Administrative Appeal Decision* would mean the HHS final appeal decision resulting from a State Exchange's request for an appeal of one or more error or improper payment findings that are documented in a Sampled Unit Assessment Package.

- *Corrective Action Plan (CAP)* would mean the plan a State Exchange develops to correct errors resulting in improper payments identified through SEIPM.

- *Difference Resolution* would mean the process by which a State Exchange may initially request HHS to reconsider one or more error or improper payment findings documented in a Sampled Unit Assessment Package. The Difference Resolution would be the first level of review.

- *Difference Resolution Decision* would mean the HHS decision resulting from a State Exchange's request for a Difference Resolution of one or more findings that are documented in a Sampled Unit Assessment Package.

- *Error* would mean a finding by HHS that a State Exchange did not correctly apply a requirement of subparts D and E of this part related to: (1) eligibility for, and enrollment in, a QHP; (2) eligibility for APTC, and calculated amount of APTC; (3) redeterminations of eligibility during a plan year; (4) eligibility redeterminations for the purposes of re-enrollment.

- *Measurement Year* would mean the calendar year in which the processes described in § 155.1625 would be initiated. The Measurement Year immediately follows the plan year and would be the second year of the SEIPM Cycle.

- *Reporting Year* would mean the calendar year in which HHS would report the improper payment rate for State Exchanges as required under § 155.1625(c), following completion of the measurement processes for the applicable plan year. The Reporting Year would immediately follow the Measurement Year and would be the last year of the SEIPM Cycle.

- *Sampled Unit Assessment Package* would mean the collection of findings and supporting documentation that HHS would prepare in order to record errors at the tax household level using the process described § 155.1625.

- *State Exchange Improper Payment Measurement* or *SEIPM* would mean the process by which HHS would estimate improper payments of APTC that are administered by State Exchanges as required under the PIIA, which would include a review of a State Exchange's determinations regarding (1) eligibility for and enrollment in a QHP; (2) eligibility for APTC, and calculated amount of APTC; (3) redeterminations of eligibility determinations during a plan year; (4) eligibility redeterminations for purposes of re-enrollment.

- *SEIPM Cycle* would mean the 3-year period consisting of the plan year, Measurement Year, and Reporting Year during which the complete APTC-related improper payment measurement and reporting processes would occur.

- *Tax household* would mean the applicant, the applicant's spouse if the applicant is married and files a joint return, and all individuals who are dependents of the applicant or spouse as defined in 26 U.S.C. 152.

d. Information Submission (§ 155.1615)

We propose to add § 155.1615 to specify what information State Exchanges would be required to submit under the SEIPM program. The collection of such information would be necessary to allow HHS to produce a statistically valid estimate of improper payments of APTC. The general framework of this proposed provision would be that the information submission would consist of three parts: (1) the program documentation that would be used to inform the review criteria; (2) the universe, which would be a summary listing of the tax households that received APTC payments for the respective plan year, from which HHS would select a random sample; (3) tax household data which would be the detailed level of data for each sampled tax household necessary for making a determination as to whether each APTC payment was proper or improper.

At § 155.1615(a), we propose that HHS would issue an Annual Program Schedule to all State Exchanges no later than January 5th of the Measurement Year. We propose that the Annual Program Schedule would specify the dates for which all the proposed information required under this section would be due to HHS. This timeline would ensure that State Exchanges receive clear guidance and sufficient advance notice of their submission requirements at the beginning of each Measurement Year, enabling State Exchanges to plan and allocate appropriate resources for compliance

with the program's data collection and documentation requirements.

At § 155.1615(b), we propose that, on an annual basis, each State Exchange would be required to submit or make available to HHS the information specified in paragraphs (b)(1) through (b)(3).

At § 155.1615(b)(1), we propose that each State Exchange would be required to submit or make available to HHS program documentation that would consist of policy, operational, and technical documentation concerning business rules and APTC calculations that pertain to enrollment and eligibility processes of the State Exchange, as well as information that describes the data system architecture of the State Exchange such as entity relationship diagrams and data dictionaries. Additional parameters for the information described would be communicated in sub-regulatory guidance. The program documentation would be essential for establishing the improper payment measurement framework for each State Exchange because it would enable us to assess whether the State Exchange's policies and procedures align with Federal requirements and would be used to develop State-specific review criteria that reflect each State Exchange's unique operational framework.

We propose at § 155.1615(b)(2) that a State Exchange would be required to submit or make available to HHS the universe of data from which HHS would draw the sample. That universe would, for the plan year being reviewed, consist of a listing of the population of tax households that have associated QHP enrollments and payments of APTC. We propose that for each tax household within the universe, the State Exchange would be required to submit or make available to HHS the following information: (1) Exchange assigned policy identifier; (2) tax household grouping identifier; (3) SSN inconsistency indicator; (4) citizenship inconsistency indicator; (5) lawful presence inconsistency indicator; (6) annual income inconsistency indicator; (7) non-employer sponsored minimum essential coverage inconsistency indicator; (8) employer sponsored minimum essential coverage inconsistency indicator; (9) incarceration inconsistency indicator; (10) residency inconsistency indicator; (11) number of tax household members; and (12) APTC amount paid over the duration of the plan year. The inconsistency indicators would be a data value for each tax household identifying the presence or number of data match inconsistencies of the

specified type. As an example, for the first tax household in the universe, if the data within the State Exchange established that the consumer's attested citizenship status did not match the source of record to which the Exchange is required to verify citizenship status, the citizenship inconsistency indicator would be populated to show that an inconsistency existed for that tax household.

Statistical validity requires that the sample be drawn from a comprehensive and accurately defined population to ensure that the resulting estimates are representative of the entire APTC program within each State Exchange. This provision would be necessary because without access to the complete universe of tax households having QHP enrollments and APTC payments, we would be unable to establish sampling strata or to calculate the sampling weights that would inform the aggregate improper payment rate. Additionally, information about eligibility verification inconsistencies within the universe would allow for risk-based stratification, ensuring that tax households with recorded inconsistencies would appropriately be represented in the sample to improve the precision and accuracy of error rate calculations. For instance, the improper payment risk may be higher in tax households with recorded inconsistencies because it would trigger additional required enrollment and eligibility verification processes that State Exchanges would need to conduct manually, leaving them susceptible to human error.

The total APTC payment amounts for each tax household in the universe would be necessary to calculate proper monetary weights for the improper payment estimates, ensuring that the financial impact of errors would be accurately reflected in the final statistics. This comprehensive approach would enable HHS to produce improper payment estimates meeting the requirements of PIIA.

At § 155.1615(b)(3), we propose that a State Exchange would be required to submit or make available to HHS tax household data for each sampled tax household. The tax household data would consist of the comprehensive information that is necessary for HHS to use in conducting the processes described at § 155.1625.

At § 155.1615(b)(3)(i), we propose that State Exchanges would be required to submit or make available to HHS, for each sampled tax household, information pertaining to the calculation of the APTC benefits paid, including monthly enrollment premium amounts, monthly APTC payment

amounts, monthly Second Lowest Cost Silver Plan Premium amounts, and the amount of each monthly premium that is attributable to EHB. This information would be essential for us to verify the accuracy of APTC calculations and ensure that APTC were computed correctly based on the applicable benchmark plan and EHB requirements. We propose at § 155.1615(b)(3)(ii) that State Exchanges would be required to submit or make available to HHS enrollment information that would include information relevant to dates and amounts of effectuation payments, premium payment amounts, and policy start and end dates. This enrollment data would enable HHS to confirm that APTC payments were made for valid coverage periods and that the timing and amounts of payments align with policy effectuation and premium payment requirements. We further propose, at § 155.1615(b)(3)(iii), that State Exchanges would be required to submit or make available to HHS information relevant to the determination of eligibility for a SEP, where applicable, which would include information collected by the State Exchange about consumer attestations and representations regarding SEP eligibility criteria, copies of documentary evidence submitted by applicants, electronic verification information, and timing information. This SEP-related information would allow HHS to assess whether APTC payments were appropriately authorized during SEPs and whether proper verification procedures were followed to confirm SEP eligibility.

At § 155.1615(b)(3)(iv), we propose that State Exchanges would be required to submit or make available to HHS information about the timing of QHP certification or approval, the coverage area of the associated QHP, and the timing of any QHP decertification or suppression. This QHP certification information would be necessary to verify that APTC payments were made only for QHPs that were properly certified and available in the consumer's coverage area during the relevant time periods.

At § 155.1615(b)(3)(v), we propose that, to the extent applicable, for each person who is included in the APTC payment calculation, the State Exchange would submit or make available to HHS: (A) information collected by the State Exchange about consumer attestations regarding QHP and APTC eligibility factors and demographic information relevant to initial QHP enrollment and eligibility; (B) APTC eligibility and payment determinations, including evidence of required data verifications,

and which could also include the electronic source consulted, the timing of required verifications, and the results of the verification; (C) information relevant to QHP and APTC manual eligibility verifications and the resolution of electronic verification inconsistencies, which could include copies of documentary evidence submitted by QHP enrollees, the timing of submissions, the timing of adjudication, and information about good faith extensions; and (D) information relevant to QHP and APTC eligibility redeterminations, such as information about automatic annual redeterminations, the timing and results of periodic examinations of data sources, and policy or application changes initiated by the consumer and resultant electronic or manual eligibility verifications. This comprehensive individual-level information would enable HHS to reconstruct and validate the complete eligibility determination process for each household member, ensuring that APTC payments were based on accurate demographic information and proper verification procedures, and were made through appropriate eligibility determinations and redeterminations.

These data elements have been proven effective through their use in the FFE improper payment measurement program, where they have enabled reliable assessment of APTC payment accuracy and identification of root causes of improper payments, and demonstrated they provide the necessary information to conduct comprehensive improper payment reviews. Additionally, through IPPTA, we have completed the collection of this data for the first cohort of eight State Exchanges for 10 or more sampled tax households. In making the transition from IPPTA to SEIPM, we believe that each State Exchange would be able to use the automation developed during IPPTA to scale the process for submitting data for a larger number of samples. We seek comments on whether there are additional data elements that would be required under this section to support accurate improper payment measurement, or whether any of the proposed data categories would present operational challenges for State Exchanges. We also solicit comments on alternative data submission mechanisms that could streamline the process while maintaining data security and integrity, including comments on the feasibility of automated data transmission methods, preferred file formats, or technical specifications that would facilitate

efficient data exchange between State Exchanges and HHS.

At § 155.1615(b)(3)(vi), we propose that the State Exchange would submit or make available to HHS any consumer submitted documents that were used to establish new or continued eligibility for enrollment in a QHP and APTC.

e. Sampling Procedures (§ 155.1620)

We propose to add § 155.1620 to address the sampling procedures. At § 155.1620(a), we propose that at the beginning of each calendar year, HHS would calculate a sample size in aggregate across all State Exchanges. The sampling methodology would be designed to achieve two complementary objectives: produce a highly precise aggregate estimate for all State Exchanges and generate individual State Exchange estimates for program management purposes. While some individual State Exchange estimates might have wider confidence intervals than others due to smaller sample sizes, they would meet minimum statistical validity thresholds and provide valuable insights for State-specific program improvements and oversight activities.

We propose that we would aggregate the estimated dollar amounts of improper payments from each State Exchange to calculate a total estimated amount of improper payments for all participating State Exchanges. This aggregation process would mathematically combine the individual State Exchange improper payment estimates to produce a comprehensive national estimate. The aggregated estimate would be weighted by State Exchange size, such that a State with \$5 billion in APTC would be weighted more heavily in the aggregate State Exchange improper payment rate than a State with \$1 billion in APTC. This weighting approach would ensure that the aggregate State Exchange improper payment rate would accurately reflect the relative financial impact of each State Exchange's improper payment performance on the overall APTC program.

This dual-purpose sampling approach would balance statistical rigor with practical program management needs, ensuring that HHS could meet Federal reporting requirements for precise program level estimates while providing State Exchanges with actionable data for program improvement efforts. The methodology would recognize that perfect precision at the individual State Exchange level would require prohibitively large sample sizes, while the primary statutory requirement is for accurate improper payment

measurement and reporting at a program level.

At § 155.1620(a)(1), we propose that the sample size would be calculated to estimate an improper payment rate. That rate would be estimated across all Exchanges using Generally Accepted Accounting Principles (GAAP).

At § 155.1620(a)(2), we propose to develop sample sizes specific to each State Exchange, which would take into consideration several factors in determining each State Exchange's sample size for the current SEIPM cycle. The first factor, at § 155.1620(a)(2)(i), would be overall APTC expenditures associated with the State Exchange; higher APTC expenditures would generally warrant larger sample sizes as they would represent greater financial risk to the Federal Government and have more significant impact on aggregate national improper payment estimates. The relative amount of a State Exchange's APTC payments amplifies the importance of accurate measurement. For example, if a single State Exchange accounts for 20 percent of overall APTC payments made across all State Exchanges, any improper payments within that State would have a proportionally larger impact on the aggregate national improper payment rate. The large share of total APTC payments would necessitate a larger sample size to meet the statistical precision goals and also would not introduce excessive uncertainty into the national aggregate estimate.

At § 155.1620(a)(2)(ii), we propose to take into consideration a second factor, State-level precision goals for current SEIPM cycle. Precision goals would establish the acceptable margin of error for improper payment rate estimates at the State level. We propose that we would set precision targets that balance statistical reliability with operational feasibility, taking into account factors such as State-specific APTC volumes, available resources, and the need for meaningful measurement. We propose that precision goals could vary by State based on Exchange size, with larger Exchanges held to tighter precision standards due to their greater impact on aggregate national estimates. These precision goals would ensure that State-specific improper payment rates would be statistically meaningful and could support targeted corrective actions while balancing measurement accuracy with resource constraints.

At § 155.1620(a)(2)(iii), we propose to consider a third factor, the improper payment rate from the State Exchange's previous SEIPM cycle. State Exchanges that are measured as having higher improper payment rates could require

larger sample sizes to achieve the same level of statistical precision and confidence as State Exchanges that are measured as having lower improper payment rates. Additionally, State Exchanges that demonstrate high variability in their previous cycle measurements could need increased sampling to establish more reliable baseline estimates. Conversely, State Exchanges with consistently low and stable improper payment rates could support smaller sample sizes to maintain adequate precision and confidence, which would allow for efficient resource allocation across the SEIPM program.

At § 155.1620(a)(3), we propose that we would establish minimum and maximum sample sizes to ensure statistical validity while maintaining operational feasibility across State Exchanges of varying sizes. While the sampling methodology design would produce statistically valid improper payment estimates at both the aggregate State Exchange level and individual State Exchange levels, we recognize that the precision of improper payment estimates at the State Exchange level would vary based on State Exchange size and corresponding sample sizes. State Exchanges with smaller APTC populations may have smaller sample sizes resulting in wider confidence intervals and higher margins of error for their individual estimates. Despite these precision limitations, individual State Exchange estimates would meet minimum statistical validity thresholds and would provide meaningful data for program oversight and improvement purposes. SEIPM's primary focus would remain producing a precise and reliable estimate for all State Exchanges, where individual State Exchange results would provide State-specific insights within the constraints of their respective sample sizes.

At § 155.1620(b), we outline proposed sample selection procedures. We propose that, on an annual basis, HHS would select random samples of tax households from the data provided by each State Exchange as described in § 155.1615(b)(2). We propose to use the tax household as the sampling unit because a tax household encompasses all individuals whose income and circumstances are considered together for APTC purposes, which would make it the most appropriate and meaningful unit for measuring payment accuracy.

At § 155.1620(c), we outline proposed State Exchange coordination and notification procedures that would be necessary to support SEIPM. We propose at § 155.1620(c)(1) that, following receipt of the universe data

from State Exchanges as described in § 155.1615(b)(2), HHS would notify each State Exchange of the specific records selected for review. Such notification would include: (i) the total number of sampled tax households selected for the State Exchange; (ii) a unique identifier for each sampled tax household; and (iii) any specific instructions or requirements needed to facilitate HHS' review of the sampled records. This information would be intended to give State Exchanges the information necessary to provide the documentation required. This process would help ensure that State Exchanges have clear notification of the specific tax households that have been sampled. This would also help foster efficiencies and accurate submission of the tax household data required under § 155.1615(a)(3).

We would protect all data exchanged during the SEIPM process in accordance with the Federal Information Security Modernization Act of 2014 (FISMA), which mandates comprehensive security controls for Federal information systems, and the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules (45 CFR parts 160 and 164), which require administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and availability of all electronically protected health information. Additionally, all data transmissions would utilize encryption protocols compliant with National Institute of Standards and Technology (NIST) Special Publication 800–53 security controls and our Acceptable Risk Safeguards (ARS) framework, with access restricted to authorized personnel only through role-based access controls and continuous monitoring as required under the Federal Information Security Management Act.

At § 155.1620(c)(2), we propose that HHS would provide the sampled records notification described in paragraph (c)(1) of this section no later than 60 calendar days after receipt of the universe data from all State Exchanges. This 60-day timeframe would ensure that HHS would have sufficient time to complete the sampling process across all participating State Exchanges. The proposed timeline would account for the complexity of coordinating sampling activities across multiple State Exchanges with varying data submission schedules and allow for quality assurance review of the sampling methodology before notification. This approach would balance the need for thorough sampling coordination with the operational

requirements for timely completion of improper payment measurement processes.

At § 155.1620(c)(3), we propose to establish procedures for extending the sampling notification timeline when unforeseen circumstances would warrant additional time for HHS to complete the sampling process. We propose at § 155.1620(c)(3)(i) that HHS could extend the 60-day timeline specified in paragraph (c)(2) of this section under three specific circumstances: when technical issues would prevent completion of the sampling process within the standard timeframe; when data quality issues would require additional coordination with State Exchanges before sampling can be completed; or when other circumstances beyond HHS' control would necessitate additional time to ensure accurate sampling methodology.

We propose at § 155.1620(c)(3)(ii) to establish notification and transparency requirements when HHS would determine an extension would be necessary. Under paragraph (c)(3)(ii), HHS would: (A) notify all affected State Exchanges in writing of the extension and the revised notification date; (B) provide the reason for the extension; and (C) confirm the impact, if any, on subsequent SEIPM cycle timelines. This provision would reflect that unforeseen technical or operational challenges potentially could arise when coordinating complex sampling across multiple State Exchanges. Where not properly addressed, such challenges could compromise the sampling methodology accuracy or completeness, so this provision would balance the need for timely program milestone progress with the requirement for statistically sound sampling procedures. By limiting extensions to specific, defined circumstances and requiring transparent communication with State Exchanges, this approach would maintain accountability while providing necessary operational flexibility to ensure the integrity of the SEIPM measurement process.

The notification requirements proposed at § 155.1620(c)(3)(ii)(A) through (C) would also ensure that State Exchanges would remain informed of any timeline adjustments and could plan for the case documentation preparation activities. This transparency would support the collaborative nature of the SEIPM program while maintaining predictable timelines for all participating parties.

f. Determining Payment Errors
(§ 155.1625)

Proposed new § 155.1625 outlines the process by which HHS would determine payment errors. At § 155.1625(a), we propose procedures for HHS' review of records obtained through SEIPM and identification of payment errors from such records. We propose at § 155.1625(a)(1) that HHS would, for each sampled record, conduct a comprehensive review using standardized review criteria designed by HHS. This approach would ensure consistency in methodology across all participating State Exchanges while accommodating necessary variations in review procedures where State Exchanges have effectuated State-specific operational approaches. We would design the criteria to minimize reviewer variability while maintaining the flexibility needed to address State-specific operational differences for which Federal regulations allow. The review criteria would be established using the requirements described in this part in conjunction with the program documentation that would be submitted by each State Exchange. We would make available a general overview of the review methodology on the CMS website.

At § 155.1625(a)(2), we propose to conduct reviews using the tax household information provided under § 155.1615(b)(3), including any relevant consumer-submitted documents that would be gathered by the State Exchange as part of the enrollment process and provided to HHS. This approach would ensure that HHS reviews would be based on the same information that was available to State Exchanges at the time of their original APTC-related determinations.

At § 155.1625(a)(3), we propose that the review would identify whether the State Exchange made any errors related to the following resulting in improper payment of APTC: (i) enrolling or re-enrolling a consumer into a QHP for which APTC was paid; (ii) consumer eligibility for APTC being paid on their behalf; (iii) calculating the APTC amount that was paid on the consumer's behalf; (iv) taking required actions upon changes to a consumer's application that would affect APTC-related eligibility or payment amount. This approach would ensure that HHS could identify and measure all types of improper payments related to APTC, providing a complete assessment of payment accuracy meeting Federal improper payment measurement requirements under the PIIA while supporting program integrity objectives.

At § 155.1625(a)(4), we propose to apply consistent review standards based on the APTC-related determination requirements established in 45 CFR part 155, subparts D and E, and other applicable provisions of part 155. By anchoring review standards in existing regulations, we would ensure that the State Exchange's performance would be evaluated against the same statutory and regulatory framework that governs their APTC-related determinations. This regulatory framework would ensure that any identified errors would be based on clear violations of established requirements rather than subjective interpretations of the program's goals.

We propose at § 155.1625(b) how HHS would evaluate each error to determine an improper payment amount. At § 155.1625(b), we propose that, for each error identified, we would: (1) calculate the correct APTC amount, based on the requirements of section 36B of the Internal Revenue Code and the applicable implementing regulations; (2) determine an improper APTC payment amount, which is the difference between the amount paid and the correct amount; (3) document the error within a Sampled Unit Assessment Package and provide the Sampled Unit Assessment Package to the State Exchange; (4) extrapolate the identified improper payments from the sample to estimate the total improper payment amount for the State Exchange's entire universe of APTC payments, using statistically valid methodologies that comply with OMB Circular No. A-123 guidance on improper payment estimation.

At § 155.1625(c), we propose how HHS would report improper payment rates. We propose at § 155.1625(c) that HHS would make available to the public in the AFR: (1) an aggregate improper payment rate estimated across the FFE and all State Exchanges; and (2) an aggregate improper payment rate estimated across all State Exchanges, pursuant to 31 U.S.C. 3352(c)(1)(B); and also that HHS would provide to each State Exchange a report that would document the State-specific improper payment rate and error analysis. This reporting approach would ensure PIIA compliance while providing State Exchanges with actionable data to improve their program operations and reduce future improper payments. The State-specific reports would facilitate corrective action planning, while the aggregate public reporting would support congressional oversight and public accountability for the overall integrity of the APTC program.

g. Difference Resolution and
Administrative Appeal Process
(§ 155.1630)

In new § 155.1630, we propose procedures for Difference Resolution and administrative appeals of SEIPM findings. This section proposes a process that would allow State Exchanges to challenge HHS determinations regarding error findings and associated determinations of improper payments. This comprehensive dispute resolution framework would ensure that State Exchanges receive fair consideration of their challenges to SEIPM findings while maintaining the integrity and efficiency of the improper payment measurement process. The proposed procedures would provide State Exchanges with meaningful opportunities to present evidence and legal arguments, while also supporting HHS' statutory obligations to produce timely and accurate improper payment estimates under PIIA. Additionally, the structured approach would promote consistency in how disputes would be handled across all State Exchanges, while reducing administrative burden and ensuring that legitimate concerns about error classifications or methodological applications would receive appropriate review and consideration.

At § 155.1630(a), we propose the Difference Resolution process. We propose at § 155.1630(a)(1) that the State Exchange could make a written Difference Resolution request to HHS in accordance with proposed § 155.1630(c) to dispute HHS' error and improper payment findings within 30 calendar days after the issuance of a Sampled Unit Assessment Package. The proposed 30-day timeframe for State Exchanges to submit written Difference Resolution requests would balance the need to give State Exchanges sufficient time to review the Sampled Unit Assessment Package with the need for administrative efficiency and timely resolution of the SEIPM process.

At § 155.1630(a)(2), we propose procedures for HHS' review of Difference Resolution requests. We propose that upon receipt of a Difference Resolution request, HHS would: (i) engage with the State Exchange in a collaborative process to examine the disputed findings and any additional documentation provided by the State Exchange, (ii) evaluate the disputed findings by applying the same protocol used in the original review while considering whether the State Exchange's position was supported by the existing or newly provided

evidence, and (iii) prepare the Difference Resolution Decision. This collaborative approach would ensure that State Exchanges would have a meaningful opportunity to present their perspective and provide additional context that may not have been available during the initial assessment, while maintaining consistency in evaluation standards. The process would balance the need for thorough consideration of State Exchange concerns with administrative efficiency, promoting fair resolution of disputes while preserving the integrity of the SEIPM measurement methodology.

We propose at § 155.1630(a)(3) that HHS would communicate the Difference Resolution Decision to a State Exchange within 90 calendar days of receiving the written request for a Difference Resolution. The Difference Resolution Decision would include a summary of the analysis and rationale that informed the decision. This timeline would balance the need for thorough review of a State Exchange's dispute with administrative efficiency requirements, and allow sufficient time for comprehensive analysis while ensuring timely resolution.

Proposed § 155.1630(b) would establish an internal agency administrative appeal process for HHS' Difference Resolution Decision. At § 155.1630(b)(1), we propose that, for a finding that the State Exchange and HHS could not resolve through Difference Resolution, the State Exchange could make a written request for an administrative appeal to HHS in accordance with proposed § 155.1630(c) within 15 business days after the issuance of the Difference Resolution Decision. We believe the 15 business day timeline for filing an administrative appeal would strike an appropriate balance between providing State Exchanges adequate time to prepare comprehensive administrative appeals while ensuring prompt resolution of disputes and maintaining administrative efficiency. This shorter appeal period, compared to the initial 30-day timeline to request Difference Resolution, would reflect that the basis of the administrative appeal would have been established and well-described during the Difference Resolution phase, and that the State would not be able to submit new evidence or documentation that had not already been submitted during the Difference Resolution process, although it could provide additional context to clarify evidence that had been submitted. As a result, we expect that fifteen business days would provide State Exchanges with sufficient opportunity to review the Difference

Resolution Decision and prepare a focused administrative appeal that would build upon the previously established record. Furthermore, the administrative appeal timeframe would help ensure that the overall SEIPM cycle would remain on schedule, preventing delays that could affect HHS' ability to meet Federal improper payment reporting deadlines and provide timely program oversight.

At § 155.1630(b)(2), we propose that upon receipt of an administrative appeal request, HHS would (i) assign the administrative appeal request to one or more qualified reviewers who were not part of the State Exchange team; (ii) conduct a comprehensive review of the disputed findings using the administrative record established during the Difference Resolution process; (iii) evaluate the disputed findings by applying the same protocol used in the original review while considering whether the State Exchange's position is supported by the evidence; and (iv) prepare the administrative appeal decision for the completed review based on a preponderance of the evidence. At § 155.1630(b)(3), we propose that HHS would issue the administrative appeal decision within 90 calendar days of receipt of the written request for administrative appeal. The administrative appeal decision would include a summary of the analysis and rationale that informed the decision.

HHS would utilize internal staff to conduct administrative appeal adjudications under this provision. The agency would assign qualified internal reviewers who possess appropriate expertise in Federal eligibility and payment requirements and who had not been involved in the original review to ensure objectivity in the administrative appeals process. These reviewers would independently review the appeal, without consultation with the individuals who had executed the dispute resolution. This approach would maintain program consistency while providing State Exchanges with an independent review of disputed findings. The internal agency administrative appeal process described in this section would be an administrative review conducted by agency staff, not a judicial proceeding or formal adjudication requiring an Administrative Law Judge.

The 90-day timeline would provide sufficient opportunity for thorough analysis of complex eligibility and payment determinations while ensuring timely resolution that would support the overall SEIPM cycle schedule. The requirement to include analysis and rationale in the administrative appeal

decision would promote transparency and enable State Exchanges to understand the basis for final determinations, supporting both accountability and potential future process improvements.

We propose at § 155.1630(c) that all Difference Resolution and appeal requests would be required to contain the following: (1) a clear statement of the specific finding(s) being challenged; (2) all factual and legal bases for filing the request; and (3) evidence directly related to the finding(s), which could include: (i) clarifying information regarding data interpretation; or (ii) legal citations supporting the State Exchange's position. These submission requirements would ensure that HHS would receive sufficient information to conduct meaningful review of disputed findings while enabling State Exchanges to present their strongest arguments and supporting evidence in a structured format that would promote efficient dispute resolution.

We propose at § 155.1630(d) the treatment of pending Difference Resolution Requests and appeal requests. At § 155.1630(d)(1), for Difference Resolution Requests or administrative appeals resolved in favor of the State Exchange during the current SEIPM cycle, we propose that: (i) HHS would adjust the affected improper payment rate calculations for the SEIPM cycle; and (ii) updated aggregate rates would be reflected in current cycle reporting. This approach would ensure that corrections identified through the Difference Resolution or appeals process would be incorporated into the current measurement cycle's results, providing the most accurate and complete improper payment estimates for public reporting and program management purposes. By adjusting calculations and updating aggregate rates, HHS could maintain the integrity and reliability of SEIPM findings while ensuring that legitimate State Exchange concerns would be reflected in the final reported statistics for the applicable measurement period.

We propose at § 155.1630(d)(2) provisions for Difference Resolution Requests or administrative appeals resolved in favor of the State Exchange after completion of the SEIPM cycle. At § 155.1630(d)(2), we propose that, should the decision result in material changes to aggregate rates, HHS would publish amended aggregated improper payment rates in subsequent AFRs or other appropriate public reporting mechanisms as well as notifying affected State Exchanges of any amendments to previously published rates. Should a decision not result in

material changes to aggregate rates, no action would be taken. This framework would ensure that significant corrections identified through post-cycle Difference Resolution Requests or administrative appeals would be incorporated into the public record through amended reporting, maintaining the accuracy and integrity of published improper payment data while avoiding unnecessary administrative burden for minor adjustments that would not materially affect aggregate statistics. The notification requirement for affected State Exchanges would promote transparency and enable States to understand how successful challenges would impact previously published rates, support ongoing program improvement efforts, and maintain the integrity of the SEIPM measurement process.

At § 155.1630(e), we propose that for good cause HHS could extend the timelines for accepting a Difference Resolution request or administrative appeal request or for issuing a Difference Resolution Decision or Administrative Appeal Decision. Good cause would be established for situations including but not limited to: (1) the need for additional technical analysis or consultation with subject matter experts to resolve complex eligibility determination issues; (2) delays in receiving necessary supplemental information or clarification from the State Exchange; (3) the volume or complexity of the dispute requiring additional time to ensure a thorough and accurate decision; or (4) unforeseen circumstances, including system failures, staffing constraints, or other administrative challenges that could materially impact HHS' ability to complete the review. HHS's failure to timely issue a Difference Resolution or Administrative Appeal Decision would not indicate an acceptance of the State Exchange's position and would not be a basis to decide in favor of the State Exchange.

h. Corrective Action Plan (CAP) (§ 155.1635)

We are proposing to add § 155.1635 to, at our discretion, require a State Exchange to develop and submit a CAP to correct errors identified through the SEIPM process. Our goal would be to establish a set of minimum requirements, using the standards provided at Appendix C to OMB Circular No. A-123, to support State Exchanges in developing, implementing, and monitoring a CAP. Should this provision be finalized as

proposed, we would issue future sub-regulatory guidance to further detail CAP requirements and processes, and finalize an approved SEIPM CAP Paperwork Reduction Act (PRA) package following future notice-and-comment rulemaking. Should these provisions be finalized as proposed, the first improper payment report would be published in the Fall 2028 AFR and we would anticipate the first SEIPM CAP(s) would be due in early 2029.

At § 155.1635(a), we propose that HHS could, at its discretion, require a State Exchange to develop and submit a CAP to correct errors identified through the SEIPM process. We would not anticipate that SEIPM CAP standards and requirements would markedly differ from the standards employed by other improper payment measurement programs, such as the Medicaid and CHIP Payment Error Rate Measurement program.

At § 155.1635(b), we propose that a State Exchange's CAP would need to address errors that would be included in the State Exchange improper payment report described in § 155.1625(c)(2). At § 155.1635(b)(1), we propose that, in developing a CAP, a State Exchange would be required to conduct an error analysis, which could include reviewing causes, characteristics, and frequency of errors that are associated with improper payments. We propose that a State Exchange would be required to review the findings of the analysis to determine specific programmatic causes to which errors would be attributed, if any, and to identify root improper payment causes. Further, at § 155.1635(b)(2), we propose that the State Exchange would be required to determine the corrective actions that would be implemented to address improper payment root causes and prevent recurrence. Finally, at § 155.1635(b)(3), we propose that the CAP would be required to incorporate measurable milestones, accountability mechanisms, regular monitoring and validation of progress, documentation of implemented corrective actions, and regular status updates. We propose that the CAP would be required to include all of the following items for each identified error: (1) the specific corrective action; (2) status of the corrective action; (3) scheduled or actual implementation date of the corrective action; (4) key personnel that would be responsible for implementing each corrective action; and (5) a plan for monitoring the effectiveness of the corrective action.

At § 155.1635(c), we propose that a State Exchange would be required to develop a CAP implementation schedule, implement the CAP in

accordance with that schedule, and regularly evaluate whether the initiatives were effective at reducing or eliminating error causes. It would be critical that a State Exchange maintain regular communication with HHS regarding any evaluation findings, particularly to ensure that the State Exchange would determine specific programmatic causes to which errors would be attributed. Therefore, we propose that a State Exchange would be required to provide updates on CAP implementation progress in a manner and frequency specified by HHS, but at least annually.

At § 155.1635(d), we propose that if a State Exchange would: (1) fail to submit a CAP when one had been required; (2) submit an incomplete CAP that would fail to address all parts of a CAP as specified at 155.1635(b)(3); (3) fail to implement a CAP; or (4) submit a CAP otherwise found unacceptable by HHS following technical assistance provided by HHS, that HHS could determine that a State Exchange had failed to substantially comply with SEIPM requirements and could take actions outlined in § 155.1650 to ensure program integrity and effectiveness.

i. SEIPM Preparation Phase (§ 155.1640)

We propose new § 155.1640 to create a SEIPM preparation phase. At § 155.1640(a), we propose that any State Exchange in its first year of operation would be required to participate in a 1-year SEIPM preparation phase prior to participating in SEIPM. The proposed preparation phase would be designed to familiarize State Exchanges with the SEIPM processes and requirements. At the beginning of the following year, or, in other words, the second year of operation for the State Exchange, we propose that the State Exchange would undergo SEIPM to measure improper payments for the preceding plan year, its first year of operation. This implementation timeline would ensure that newly operating State Exchanges would have the opportunity to participate in the preparation phase before undergoing full SEIPM measurement, thereby preparing the State Exchange for the SEIPM measurement. In essence, HHS would ensure that a State Exchange would test processes and procedures to prepare for SEIPM.

We propose at § 155.1640(b) that, to satisfy the requirements of the SEIPM preparation phase, a State Exchange would be required to: (1) complete the information submission requirements in § 155.1615(b)(1) and (3) using information from the most current plan year for a sample size not to exceed 10

unique tax households that address scenarios specified by HHS; (2) undergo the review procedures in 155.1625(a) and (b); and (3) participate in HHS' technical assistance activities, which could include: (i) training on SEIPM requirements and procedures, (ii) system readiness assessments, (iii) data quality validation exercises, and (iv) process improvement recommendations. Such a preparation phase approach would promote administrative efficiency by ensuring State Exchanges would have adequate time and resources to develop robust improper payment measurement capabilities before full implementation. Without such a preparation period, State Exchanges could struggle to produce the data that would be necessary for determining accurate measurements.

At § 155.1640(c), we propose that, at the beginning of each calendar year, HHS would provide any State Exchange that would be subject to this section with a schedule that would span a 12-month period and that would specify when the requirements of this section would have to be completed.

j. Minimizing Potential Duplicate Audit Requirements (§ 155.1645)

We propose to add new § 155.1645 to permit HHS, to the extent possible, to minimize duplication between the requirements of the SEIPM program described in subpart Q and the annual independent external programmatic audit requirements and standards under § 155.1200(c) and (d). Under § 155.1200(c) and (d), each State Exchange is required to engage or contract with an independent qualified auditing entity to perform an annual independent external programmatic audit to review compliance with 45 CFR part 155 subparts D (eligibility) and E (enrollment), and other requirements under part 155, as specified by HHS, and to provide the audit results to HHS.

Among other things, this external auditing process allows HHS to oversee compliance with eligibility and enrollment standards to ensure that State Exchanges are conducting accurate eligibility determinations and enrollment transactions, including requirements across multiple State Exchange operational areas that exceed the scope of review under the SEIPM program because they do not involve payments of APTC. Section 155.1200(d) further requires that a State Exchange complete an audit to ensure appropriate financial and operational safeguards are in place to avoid making inaccurate eligibility determinations and enrollment transactions, which would

include those related to administering APTC and CSRs.

We note that §§ 155.1200 and 155.1210 were not intended to serve as the type of measurement program contemplated by the PIIA. Program integrity audits completed under § 155.1200(c) and (d), especially as they relate to requirements under subparts D and E, focus on reviewing the processes and procedures that a State Exchange has established to verify that a qualified individual meets eligibility requirements. These programmatic audits do not review, estimate, or report on the amounts or rates of improper payments resulting from inaccurate eligibility determinations and enrollment transactions. SEIPM would both ensure a review of the accuracy of State Exchange eligibility verification processes and identify improper APTC payments resulting from inaccurate eligibility determinations and enrollment transactions.

To meet the requirements of the PIIA, reduce burden on State Exchanges, and ensure consistency across State Exchanges in terms of our review methodology, we propose that a State Exchange's participation in SEIPM would satisfy certain duplicative annual independent external programmatic audit requirements, particularly the review of compliance with provisions of subparts D and E that may result in improper payment of APTC. Should this provision be finalized as proposed, we would issue sub-regulatory guidance to identify which programmatic audit requirements could be satisfied through completion of SEIPM for a given plan year. We believe this policy would reduce duplicative efforts and burden on State Exchanges that would otherwise be required to fully comply with programmatic audit requirements and SEIPM, while also maintaining the programmatic audits for requirements not reviewed as part of SEIPM.

k. Failure To Comply (§ 155.1650)

We propose to add new § 155.1650 that would address what would happen should a State Exchange fail to comply with the SEIPM requirements. This proposed section would create clear criteria for determining when a State Exchange had failed to substantially comply with SEIPM requirements and would establish appropriate remedial measures to ensure program integrity and effectiveness.

At § 155.1650(a), we propose to establish a general principle that would govern improper payment classification throughout the SEIPM program. We propose that HHS would classify APTC payments as improper when a State

Exchange failed to provide adequate documentation demonstrating that such payments were made in accordance with applicable Federal requirements. This principle would align with Federal improper payment measurement standards established under PIIA which require agencies to classify payments as improper when there is insufficient documentation to determine if a payment is proper or improper. The burden of providing adequate supporting documentation would rest with State Exchanges as the entities responsible for making APTC eligibility determinations and payment calculations, ensuring that Federal funds were distributed in accordance with Federal requirements.

We propose to specify at § 155.1650(b)(1) through (5) when HHS would determine a State Exchange had failed to substantially comply with this subpart by providing specific, measurable criteria addressing the most critical aspects of State Exchange participation in SEIPM, which would consist of the following: (1) failure to submit required data or documentation within the timelines specified in the Annual Program Schedule; (2) submitting data or documentation found to be incomplete, inaccurate, or in a format that would reasonably prevent effective review; (3) failure in the CAP process; or (4) a pattern, that is more than five instances during a SEIPM cycle, of non-response within 30 calendar days to HHS requests for clarification or additional information.

Such a proposed compliance framework would balance the need for clear, enforceable standards with recognition that State Exchanges operate complex systems and may encounter operational challenges. The proposed criteria would focus on substantial compliance failures that would genuinely impact the integrity and effectiveness of the SEIPM program as opposed to minor technical violations that would not materially affect improper payment measurement activities. Such standards would ensure that State Exchanges would provide necessary information within established timeframes to support the overall SEIPM cycle and enable HHS to meet Federal improper payment reporting obligations, while maintaining data quality sufficient to support reliable measurement results. The framework would promote accountability and ensure effective program administration across all participating State Exchanges, while maintaining the collaborative relationship necessary for successful SEIPM implementation. By establishing

clear expectations for data submission timeliness, quality standards, corrective action implementation, and ongoing communication, these proposed compliance criteria would support the accuracy of improper payment estimates and the overall integrity of the APTC program oversight process.

At § 155.1650(c), we propose to establish a process to provide State Exchanges notice and opportunity to address compliance deficiencies before HHS would implement remedial measures. We propose that before implementing measures under paragraph (d) of this section, HHS would provide written notice to the State Exchange specifying the nature of the noncompliance and the potential consequences, and allow the State Exchange a reasonable opportunity to cure the noncompliance or demonstrate that compliance has been achieved. This notice and cure provision would promote collaborative problem-solving between HHS and State Exchanges. The written notice requirement would ensure that State Exchanges would have clear understanding of the specific compliance deficiencies and the potential consequences of continued noncompliance, and would enable them to take appropriate corrective action. HHS would set the cure period to be commensurate with the complexity of the compliance issue.

At § 155.1650(d), we propose to establish a framework of remedial measures that HHS could implement should a State Exchange fail to substantially comply with SEIPM requirements and such failures undermine or prohibit HHS' efficient administration of Exchange improper payment measurement activities. This provision would provide HHS with appropriate enforcement tools to secure State Exchange compliance while maintaining program integrity and ensuring effective oversight of APTC administration. We propose that HHS could implement measures or procedures to secure the State Exchange's compliance with the requirements of this subpart which are proposed to include: (1) enhanced monitoring and reporting; (2) mandatory implementation of specific operational procedures or controls; and (3) on-site visits to State Exchange facilities to assess operational procedures, data systems, and compliance with program requirements.

This graduated enforcement approach would recognize that different compliance failures may require different remedial responses, allowing HHS to tailor interventions to the specific nature and severity of the

noncompliance. Enhanced monitoring and reporting requirements would provide ongoing oversight for State Exchanges experiencing compliance difficulties, while mandatory operational procedures or controls would address systemic deficiencies that could be contributing to improper payment risks. On-site visits would enable HHS to conduct comprehensive assessments of State Exchange operations, identify root causes of compliance failures, and provide targeted technical assistance to support improvement efforts.

At § 155.1650(e), we propose that HHS could initiate proceedings to revoke a State Exchange's authority to operate if a State Exchange continues to fail to comply after implementation of initial remedial measures under paragraph (d) of this section. Revoking a State Exchange's authority to operate would represent the most serious enforcement action available and would be reserved for cases where other remedial measures had failed to secure the State Exchange's compliance, and the State Exchange's continued operation would pose unacceptable risks to program integrity and enrollee protection.

We seek comment on these proposals.

E. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. FFE and SBE–FP User Fee Rates for the 2027 Benefit Year (§ 156.50)

For the 2027 benefit year, we propose an FFE user fee rate of 2.5 percent of total monthly premiums and an SBE–FP user fee rate of 2.0 percent of total monthly premiums.

Section 1311(d)(5)(A) of the Affordable Care Act permits an Exchange to charge assessments or user fees on participating health insurance issuers as a means of generating funding to support its operations. If a State does not elect to operate an Exchange or does not have an approved Exchange, section 1321(c)(1) of the Affordable Care Act directs HHS to operate an Exchange within the State. Accordingly, in § 156.50(c), we state that a participating issuer offering a plan through an FFE or SBE–FP must remit a user fee to HHS each month that is equal to the product of the annual user fee rate specified in the annual HHS notice of benefit and payment parameters for FFEs and SBE–FPs for the applicable benefit year and the monthly premium charged by the issuer for each policy where enrollment is through an FFE or SBE–FP. OMB Circular No. A–25 established Federal

policy regarding user fees and what the fees can be used for.¹³¹ OMB Circular No. A–25 provides that a user fee charge will be assessed against each identifiable recipient of special benefits derived from Federal activities beyond those received by the general public.

a. FFE User Fee Rate for the 2027 Benefit Year

Based on estimated costs, enrollment in the FFEs (including anticipated enrollment loss due to certain States transitioning from the FFE to SBE–FPs or from SBE–FPs to State Exchanges), and premiums for the 2027 benefit year, we propose a 2027 user fee rate for all participating FFE issuers of 2.5 percent of total monthly premiums.

Section 156.50(c)(1) provides that, to support the functions of FFEs, an issuer offering a plan through an FFE must remit a user fee to HHS, in the timeframe and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy where enrollment is through an FFE. As in benefit years 2014 through 2026, issuers seeking to participate in an FFE in the 2027 benefit year will receive two special benefits not available to issuers offering plans in State Exchanges: (1) the certification of their plans as QHPs; and (2) the ability to sell health insurance coverage through an FFE to individuals determined eligible for enrollment in a QHP. For the 2027 benefit year, issuers participating in an FFE will receive special benefits from the following Federal activities:

- Provision of consumer assistance tools;
- Consumer outreach and education;
- Management of a Navigator program;
- Regulation of agents and brokers;
- Eligibility determinations;
- Enrollment processes; and
- Certification processes for QHPs (including ongoing compliance verification, recertification, and decertification).

Activities performed by the Federal Government that do not provide issuers participating in an FFE with a special benefit are not covered by the FFE user fee.

The proposed user fee rate reflects our estimates for the 2027 benefit year of costs for operating the FFEs, premiums, enrollment, and transitions in Exchange

¹³¹ See OMB. (n.d.) Circular No. A–25 Revised. <https://www.whitehouse.gov/wp-content/uploads/2017/11/Circular-025.pdf>.

models from the FFE and SBE-FP models to either the SBE-FP or State Exchange models. The total enrollment in Exchanges in States anticipated to transition from operating an SBE-FP to a State Exchange model represents premiums for which we will no longer collect user fees, and the total enrollment in Exchanges in States anticipated to transition from an FFE to an SBE-FP model represents premiums for which we will assess user fees at the lower SBE-FP rate. Thus, these anticipated transitions impact our total projected collections, may affect the FFE and SBE-FP user fee rates, and are considered as part of our calculation of our proposed user fee rates.

To develop the proposed 2027 benefit year FFE user fee rate, we considered a range of costs, premiums, and enrollment projections. For the proposed 2027 benefit year user fee rates, we estimated that budget costs would be lower in 2027 than the budget costs that we used to project the 2025 and 2026 benefit year FFE user fee rates. Specifically, while we expect that small increases in costs from the 2026 benefit year to the 2027 benefit year would be due to the structure of contracts and inflationary pressure, recent efficiency exercises have reduced baseline cost structures that were used in the projection of budgets for benefit years 2025 and beyond.

We took several factors into consideration in choosing which premium and enrollment projections would inform the proposed 2027 FFE user fee rate. First, for our estimated premium trend rate projections, we expect premiums will increase in 2026. We also expect that while the rate of premium increase will be smaller in benefit year 2027, increases in premiums will persist.

For the 2021 through 2025 benefit years, the individual non-catastrophic market risk pool in all States generally experienced increased enrollment. Our 2026 estimates accounted for projected decreased 2026 benefit year Exchange enrollment in the individual market due to the impact of the expiration of the enhanced PTC subsidies. For the 2027 benefit year, we estimate a further decrease in Exchange enrollment in the individual market due to the expiration of subsidies at the end of the 2025 benefit year as well as the effects of the WFTC legislation and the Marketplace Integrity and Affordability final rule.^{132 133}

¹³² We considered the most recent projections from the Congressional Budget Office, as we have in prior rulemakings and our own internal data. See, for example, 89 FR 26218; see also,

After taking into consideration a projected reduced budget, enrollment decreases, and a higher premium trend rate, we propose a 2027 benefit year FFE user fee rate of 2.5 percent of total monthly premiums, which is the same as the 2026 benefit year FFE user fee rate. Based on our estimates, this proposed user fee rate would allow us to have sufficient funding available to fully fund user-fee-eligible FFE activities. We note that if any events occurring between this proposed rule and the final rule significantly change our estimated FFE operational costs, or if our enrollment or premiums projections change (especially based on the availability of more recent data), we may finalize FFE user fee rates that differ from these proposed rates to reflect those changes. We acknowledge that the 2026 open enrollment period closed prior to release of the proposed rule, but we did not consider that data in developing the proposed user fee rates because the data available at the time was too premature to use for our proposed rule estimates. Our intention is to reconsider the enrollment estimates for the final rule. If the actual 2026 enrollment numbers are lower than the projected enrollment numbers we used to set the proposed user fee, the final 2027 user fee rate may be higher. If the actual 2026 enrollment numbers are higher than our projected enrollment numbers, the 2027 user fee rate may be lower.

We seek comment on the proposed 2027 benefit year FFE user fee rate.

b. SBE-FP User Fee Rate for the 2027 Benefit Year

We propose to charge issuers offering QHPs through an SBE-FP a user fee rate of 2.0 percent of the monthly premium charged by the issuer for each policy under plans offered through an SBE-FP for the 2027 benefit year.

In § 156.50(c)(2), we specify that an issuer offering a plan through an SBE-FP must remit a user fee to HHS, in the timeframe and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy where enrollment is through an SBE-

Congressional Budget Office. (2025, September 18). The Estimated Effects of Enacting Selected Health Coverage Policies on the Federal Budget and on the Number of People With Health Insurance. <https://www.cbo.gov/system/files/2025-09/61734-Health.pdf>.

¹³³ Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. (June 25, 2025). 90 FR 27074.

FP. SBE-FPs enter into a Federal platform agreement with HHS to leverage the systems established for the FFEs to perform certain Exchange functions and enhance efficiency and coordination between State and Federal programs. The benefits provided to issuers in SBE-FPs by the Federal Government include use of the FFE information technology and call center infrastructure used in connection with eligibility determinations for enrollment in QHPs and other applicable State health subsidy programs, as defined at section 1413(e) of the Affordable Care Act, and QHP enrollment functions under 45 CFR part 155, subpart E. The user fee rate for SBE-FPs is calculated based on the proportion of total FFE costs associated with Federal activities that provide SBE-FP issuers with special benefits, including costs that are associated with the FFE information technology infrastructure, the consumer call center infrastructure, and eligibility and enrollment services.

To calculate the proposed SBE-FP user fee rate for the 2027 benefit year, we used the same assumptions related to budget, enrollment, and premiums as we used for the proposed FFE user fee rate. As we explained previously in this section, the user fee rate for SBE-FPs is calculated based on the proportion of the total FFE costs associated with Federal activities that provide SBE-FP issuers with special benefits, which we continue to estimate to be approximately 80 percent of total FFE costs. These FFE costs associated with Federal activities that provide SBE-FP issuers with special benefits include the costs associated with the FFE information technology infrastructure, the consumer call center infrastructure, and eligibility and enrollment services. Additionally, the proposed user fee rate for SBE-FP issuers for the 2027 benefit year includes assumptions about States transitioning from either the FFE model to an SBE-FP, or from an SBE-FP to a State Exchange for the 2027 benefit year, which impacts the SBE-FP enrollment projections.

Based on this methodology and our projected reduced budget, enrollment decreases, and a higher premium trend rate that are described in section III.E.1.a of this proposed rule, we propose a 2027 benefit year SBE-FP user fee rate of 2.0 percent of total monthly premiums which is the same as the user fee rate we established for the 2026 benefit year. Specifically, changes in budget, enrollment and premium trends have the same impact for the SBE-FP compared to the FFE. We note that if any events occurring between this proposed rule and the final rule

significantly change our estimated Federal platform operational costs, or if our enrollment or premiums projections change (especially based on the availability of more recent data), we may finalize SBE–FP user fee rates that differ from these proposed rates to reflect those changes.

We seek comment on the proposed 2027 benefit year SBE–FP user fee rate.

2. Permitting Plan-Level Adjustments for Multi-Year Catastrophic Plans (§ 156.80(d)(2)(ii))

As discussed in section III.E.6 of this proposed rule, we propose to modify the requirements for catastrophic plans at § 156.155(a)(6) to specify that a catastrophic plan has a plan term of either 1 year, or of multiple consecutive years not to exceed 10 years, and are seeking comment on whether to also specify such standards for individual market metal level plans. To align with that proposal and comment solicitation, and under our authority to implement the single risk pool requirements in section 1312(c)(1) and (2) of the Affordable Care Act, we propose to amend § 156.80(d)(2)(ii) to permit issuers of multi-year catastrophic plans to make plan-level adjustments to the index rate that reflect the length of the entire term. Such plan-level adjustments would account for the benefit design characteristics of such plans, such as their deductible and maximum out-of-pocket cost structure. The proposal to codify standards for catastrophic plans to have multi-year terms of up to 10 consecutive years would clarify certain aspects of the structure of multi-year plans, such as permitting such plans to cover certain additional preventive service benefits before an enrollee satisfies their deductible and annual limitation on cost sharing. Allowing issuers of multi-year catastrophic plans to make plan-level adjustments to the index rate would permit these issuers to take such plan design features into account when developing premiums for such plans. Given that these plan design features, which are discussed in section III.E.6. of this proposed rule, would be unique to multi-year catastrophic plans, it would be appropriate for issuers to take them into account when setting premiums for such plans, in accordance with section 2701 of the Public Health Service Act. An issuer's calculation of the magnitude of this plan-level adjustment must be accurate, and therefore, must be actuarially justified.

We seek comment on all aspects of this proposal, including whether a separate plan level adjustment based on term length should be permitted for multi-year catastrophic plans, and

whether and the degree to which the risk profile of multi-year catastrophic plans that are otherwise identical to single year catastrophic plans would justify plan-level adjustments over and above those that would be made to account for the different features of such plans.

3. State Selection of EHB-Benchmark Plan for Plan Years Beginning on or After January 1, 2020 (§ 156.111)

Section 1302 of the Affordable Care Act 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 requirements, the law directs that the EHBs be equal in scope to the benefits provided under a typical employer plan, and that they include at least the following 10 general categories and the items and services covered within the 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.

We established requirements relating to the coverage of EHBs in the EHB Rule (78 FR 12834). In the 2019 Payment Notice (83 FR 17009), we added § 156.111 to provide States with additional options from which to select an EHB-benchmark plan for plan years beginning on or after January 1, 2020. We revised the EHB-benchmark plan selection process in the 2023 Payment Notice (87 FR 27290) and the 2025 Payment Notice (89 FR 26218).

We are pausing review of State applications to select EHB-benchmark plans in accordance with § 156.111. We are actively conducting a comprehensive review of section 1302 of the Affordable Care Act, as we are considering future rulemaking to revise § 156.111 and other regulations relating to the EHBs.

4. Provision of EHB (§ 156.115(d))

We propose to revise § 156.115(d) to prohibit issuers from including routine non-pediatric dental services as an EHB.

In the EHB Rule (78 FR 12834), we finalized at § 156.115(d) that issuers of a plan offering EHBs may not include, among other services and benefits, routine non-pediatric dental services as an EHB, even if the State's current EHB-benchmark plan includes such services as covered benefits. Section 1302(b)(2)

of the Affordable Care Act directs the Secretary, in defining the EHBs, to ensure that they are equal in scope to the benefits provided under a typical employer plan. In the proposed EHB Rule (77 FR 70644), in support of the proposed prohibition at § 156.115(d), we noted that routine non-pediatric dental services are not typically included in the medical plans offered by employers and are often provided as excepted benefits¹³⁴ by the employer.

In the 2025 Payment Notice, we finalized removal of this prohibition at § 156.115(d) for plan years beginning on or after January 1, 2027. In support of this policy, we noted, as we did in the 2025 Payment Notice proposed rule (88 FR 82597), that a more natural reading of section 1302(b)(2) of the Affordable Care Act is one that considers all the benefits typically covered by employers, regardless of whether such benefits are historically considered a “health benefit” or whether such benefits are “typically covered” by an employer's major medical plan. We also stated that based on recent data, it appeared that routine non-pediatric dental services were commonly covered as an employer-sponsored or other job-based benefit to a degree that warranted removing the prohibition on coverage of these services as an EHB. We further explained that oral health has a significant impact on overall health and quality of life,¹³⁵ and that removing the prohibition on issuers from including routine non-pediatric dental services as an EHB would remove regulatory and coverage barriers to expanding access to routine non-pediatric dental benefits for those plans that must cover EHBs. We further stated that this policy would allow States to work to improve non-pediatric oral health and overall health outcomes, which are disproportionately low among marginalized communities such as people of color and people with low incomes.¹³⁶

However, to better align our regulation at § 156.115(d) with section 1302(b)(2)(A) of the Affordable Care Act, which directs that the scope of EHBs be equal to the scope of benefits provided

¹³⁴ For more information, see 45 CFR 144.103 for excepted benefits, 45 CFR 146.145(b)(3)(i) and (iii)(A) for limited scope dental benefits for group health plans, and 45 CFR 148.220(b)(1) for limited scope dental benefits in the individual market.

¹³⁵ Spanemberg, J.C., Cardoso, J.A., Slob, E.M.G.B., & Lopez-Lopez, J. (2019). Quality of life related to oral health and its impact in adults. *Journal of Stomatology, Oral and Maxillofacial Surgery*, 120(3), 234–239. <https://doi.org/10.1016/j.jormas.2019.02.004>.

¹³⁶ Northridge, M.E., Kumar, A., & Kaur, R. (2020). Disparities in Access to Oral Health Care. *Annual review of public health*, 41, 513–535. <https://doi.org/10.1146/annurev-publhealth-040119-094318>.

under a typical employer plan, we now propose to reinstate the regulatory prohibition on issuers from including routine non-pediatric dental services as an EHB. We acknowledge that in the 2025 Payment Notice proposed rule (89 FR 26342), we previously interpreted section 1302(b)(2)(A) of the Affordable Care Act as supporting a more natural reading that considers all the benefits typically covered by employers, regardless of whether such benefits are historically considered a “health benefit” or whether such benefits are “typically covered” by an employer’s major medical plan. Upon further consideration of the statutory framework, we now believe a more precise interpretation of section 1302(b)(2)(A) of the Affordable Care Act should apply.

Specifically, we believe the language of section 1302(b)(1) of the Affordable Care Act, which outlines the 10 EHB categories and specifically includes, “Pediatric services, including oral and vision care,” strongly suggests that Congress did not view routine non-pediatric oral and vision care as an EHB at the time the Affordable Care Act passed. This language indicates Congress’ intention to differentiate pediatric from non-pediatric dental services and explicitly limit EHB coverage to pediatric oral care. If Congress had intended for non-pediatric dental services to be included in the list of the 10 EHB categories it would have explicitly included these services, as it explicitly included pediatric oral care. Thus, the best reading of the statute, which only mentions pediatric oral care, indicates non-pediatric oral care was not meant to be included as an EHB.

We acknowledge that the 10 EHB categories set the floor for what constitutes EHB and that routine non-pediatric dental services could theoretically be added on top of this minimum set of EHBs. However, the EHB typicality standard at section 1302(b)(2)(A) of the Affordable Care Act requires the scope of EHB to be equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. As we stated in the 2025 Payment Notice (89 FR 26345), the statutory term “a typical employer plan” is ambiguous with regard to whether it references a single major medical plan, or the entire suite of benefits provided by the employer. Given Congress’ intent reflected in section 1302(b)(1) of the Affordable Care Act to specifically include pediatric oral care and not non-pediatric oral care as an EHB category, and the fact that standalone non-pediatric dental plans are excepted benefits, we now interpret

“a typical employer plan” under section 1302(b)(2)(A) to refer to an employer’s major medical plan rather than the entire suite of benefits typically covered by employers. This interpretation of the typicality standard, along with the statutory framework that distinguishes pediatric from non-pediatric dental services, warrants reinstating the regulatory prohibition on issuers from including routine non-pediatric dental benefits as an EHB.

Additionally, KFF Employer Health Benefits surveys in recent years show most employers do not include dental benefits as part of their traditional medical plan. In KFF’s 2019 survey, 59 percent of small firms (3–199 workers) and 92 percent of large firms (200 or more workers) offered separate dental benefits.¹³⁷ More recently in KFF’s 2023 survey, 90 percent of small firms and 94 percent of large firms offered separate dental plans.¹³⁸ Since these benefits are typically offered as separate insurance products and are not included in the traditional medical plan, they should not be included in the scope of benefits used to establish the scope of the typical employer plan. Additionally, while a high percentage of large firms offer separate dental benefits, small firms are less likely to offer any dental benefits (as indicated by the KFF survey data cited above) and small firms comprise the majority of employers in the U.S.¹³⁹ The 2019 KFF survey data was cited in the 2025 Payment Notice (89 FR 26343) as evidence that routine non-pediatric dental services are commonly covered as an employer-sponsored or other job-based benefit. However, the relevant consideration is not whether routine non-pediatric dental services are commonly covered as an employer-sponsored or other job-based benefit, but whether employers offer these benefits as part of their medical plans or as separate benefits. This separation of dental benefits from medical coverage as indicated by KFF’s surveys further supports the interpretation that Congress intended to omit non-pediatric dental coverage from the 10 categories of EHBs. Employers traditionally and commonly offering dental coverage as separate plans, as demonstrated by the

KFF surveys, is consistent with Congress’ determination that non-pediatric dental coverage should not be a part of the 10 EHB categories representing core medical benefits required to be offered in small group and individual plans.

Further, we acknowledge that oral health can have a significant impact on overall health and quality of life. We clarify that this proposed prohibition on including routine non-pediatric dental services as an EHB would not prevent States from addressing non-pediatric oral health and overall health outcomes through alternative policy mechanisms. For example, States could mandate coverage of routine non-pediatric dental services as a non-EHB and defray the cost associated with that benefit. We believe achieving better alignment of the regulatory requirements at § 156.115(d) with section 1302(b)(2)(A) of the Affordable Care Act regarding the EHB typicality standard outweighs these other policy considerations.

If this proposal to prohibit issuers from including routine non-pediatric dental services as an EHB were finalized, there would be fewer operational concerns for issuers associated with States adding routine non-pediatric dental services as an EHB. As we acknowledged in the 2025 Payment Notice (89 FR 26347), if States added routine non-pediatric dental services as an EHB, States would need to consider that some medical plans may not currently have infrastructure or experience working with Current Dental Terminology (CDT) codes that report dental procedures to dental payers. More specifically, for plans that do not directly reimburse using dental codes, the transition to new coding would require investments in technology, staff, and internal expertise. As we further explained in the 2025 Payment Notice (89 FR 26347), these investments may have led to additional premiums and an overall increase in health care spending. Under this proposal, issuers would not have to consider operational and cost concerns related to developing infrastructure around CDT codes. Additionally, as we explained in the 2025 Payment Notice (89 FR 26347), if States added routine non-pediatric dental services as an EHB, this may have required plans to establish new networks of dental providers if plans did not already have such networks available.

Furthermore, if this proposal were finalized, we believe there would be fewer impacts on cost-sharing and stand-alone dental plans (SADPs). As we stated in the 2025 Payment Notice (89 FR 26343), while section

¹³⁷ KFF, Employer Health Benefits: 2019 Annual Survey, available at <https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/>.

¹³⁸ KFF, Employer Health Benefits: 2023 Annual Survey, available at <https://www.kff.org/health-costs/report/2023-employer-health-benefits-survey/>.

¹³⁹ According to 2025 U.S. Bureau of Labor Statistics data, smaller firms (defined by BLS as up to 249 workers) comprise 73 percent of all firms. See U.S. Bureau of Labor Statistics, *Employment by size of establishment, private industry*, available at <https://www.bls.gov/charts/county-employment-and-wages/employment-by-size.htm>.

1302(b)(4)(F) of the Affordable Care Act permits a medical QHP sold on the Exchange to omit coverage of pediatric dental EHB services if an SADP is offered through an Exchange,¹⁴⁰ there is no statutory basis to extend this exception to routine non-pediatric dental services. Absent the change we are proposing, this would have meant that plans subject to an EHB-benchmark plan that includes routine non-pediatric dental services as an EHB would be prohibited from omitting such coverage on the basis that an SADP already provides such coverage through an Exchange. This would have required routine non-pediatric dental EHB services to be embedded in medical plans, which would have potentially impacted cost-sharing, as such embedded non-pediatric benefits would be subject to any applicable plan deductible, unless a State requires pre-deductible coverage. Depending on the benefits, pre-deductible coverage could have also made the plan incompatible with health savings accounts (HSAs). Additionally, requiring such embedded benefits would have conflicted with the established market structure in which non-pediatric dental services are more commonly provided through SADPs.¹⁴¹ Further, as we acknowledged in the 2025 Payment Notice (89 FR 26347), there could have been impacts on SADP premiums sold on the Exchange if a State added routine non-pediatric dental benefits as an EHB, leading to potential disparities between dental plan premiums on- versus off-Exchange. Under §§ 146.145(b)(3) and 148.220(b)(1), limited-scope dental plans are considered excepted benefits that are not required to provide EHBs. Thus, if a State adds routine non-pediatric dental benefits as an EHB, SADPs are not required to cover such benefits, whether on- or off-Exchange.

In addition, we note that this proposal to prohibit routine non-pediatric dental services from being covered as an EHB would not impact the typicality test at § 156.111(b)(2)(ii), as the methodology and requirements for the typicality test remain unchanged. The typicality test is a quantitative comparison that measures whether the actuarial value of a State's proposed EHB-benchmark plan falls within the range of actuarial values of typical employer plans in the State. As

we stated in the 2025 Payment Notice (89 FR 26346), nothing in regulation prohibits a State from including the quantitative value of routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia in its typicality analysis. Specifically, if a typical employer plan used in the typicality comparison includes any of these services, the actuarial value of those services may be included when calculating that employer plan's overall value for purposes of the typicality test. This does not mean, however, that these services may be covered as EHBs in the State's EHB-benchmark plan itself. In summary, while this proposal would change what services are permitted to be covered as an EHB, it would not alter how States conduct the typicality test or what may be considered when calculating the actuarial value of typical employer plans for comparison purposes. States would still be required to ensure the value of covering all the benefits in the State's proposed EHB-benchmark plan is between (or equal to) the value of the least and most generous typical employer plans in the State.

We acknowledge that under the current policy, States could have submitted applications to HHS to add routine non-pediatric dental services as an EHB by the May 7, 2025 deadline for effectiveness in PY 2027 via the EHB-benchmark update application process under § 156.111. Although no States submitted applications to make this change by the May 7, 2025 deadline, other States may have already begun work towards their applications to update their EHB-benchmark plan to add routine non-pediatric dental services as an EHB for a future plan year. This proposal, if finalized, would therefore frustrate these States' efforts.

We seek comment on the proposal to revise § 156.115(d) to prohibit issuers from including routine non-pediatric dental services as an EHB, including the impact this proposal, if finalized, would have on health insurance coverage in the individual, small group, and large group markets, as well as on self-insured plans. If finalized as proposed, this proposed policy to prohibit coverage of routine non-pediatric dental services as an EHB would be effective upon the effective date of the final rule.

5. Publication of the 2027 Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage in Guidance (§ 156.130(e))

As established in part 2 of the 2022 Payment Notice (86 FR 24238), starting with the 2023 benefit year, for benefit years in which we are not making changes to the methodology to calculate the premium adjustment percentage index (PAPI), the required contribution percentage, and maximum annual limitations on cost sharing and reduced maximum annual limitation on cost sharing, we publish these parameters in guidance annually by January of the year preceding the applicable benefit year. In the 2025 Marketplace Integrity and Affordability final rule (90 FR 27166 through 27168), we finalized a change to the methodology for calculating these parameters starting with the 2026 benefit year such that we will use private health coverage premiums (excluding Medigap and the medical portion of accident insurance ["property and casualty" insurance]) as the definition of premiums for calculating the premium adjustment percentage and related parameters. We are not proposing to change the methodology for calculating these parameters for the 2027 benefit year. As such, these parameters are not included in this rulemaking. Instead, we published the 2027 benefit year parameters in guidance,¹⁴² using the methodology finalized in the 2025 Marketplace Integrity and Affordability final rule.

6. Multi-Year Terms for Catastrophic Plans To Improve Health (§§ 156.130(c) and 156.155(a)(6))

We propose to codify requirements under which issuers of catastrophic coverage may enroll individuals for multiple plan or policy year terms with periods of up to 10 years. We propose modifying the requirements for catastrophic plans in § 156.155 to specify that a catastrophic plan has a plan term of either 1 plan or policy year, or of multiple consecutive plan or policy years not to exceed 10 years.

We propose that catastrophic plans with terms of at least 2 plan or policy years may utilize value-based insurance designs to offer benefits for preventive

¹⁴⁰ See section 1311(d)(2)(B)(ii) of the Affordable Care Act for more information on offering SADP benefits.

¹⁴¹ Elani, H.W., Rahman, M.S., Wallace, J., Rosenthal, M.B., & Sommers, B.D. (2024). Availability Of Adult Dental Plans In The Affordable Care Act Marketplaces, 2016–23. *Health Affairs*, 43(11), 1587–1596. <https://doi.org/10.1377/hlthaff.2024.00307>.

¹⁴² Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year. <https://www.cms.gov/files/document/2027-papi-parameters-guidance-2026-01-29.pdf>.

services pursuant to section 2713(c) of the PHS Act, without the enrollee having to first satisfy their deductible or annual cost-sharing limitation. We request comment on the proposal at § 156.130, that issuers of multi-year catastrophic plans have the option to apply the annual limitation on cost sharing for each plan year of the contract on an annual basis, or, on average, over the life of the contract. For example, as an alternative to applying the annual limitation on cost sharing on an annual basis, an issuer could opt to offer a 5 year catastrophic plan that would apply the annual limitation as follows: the average over 5 years of the annual limitation on cost sharing in the plan equals the average over 5 years of the annual limitation on cost sharing as required by statute. Alternatively, the issuer could opt to vary the annual limitation on cost sharing in the plan by disease, for example, cancer, if that disease requires treatment that spans multiple years, so long as the average over all plan participants and over years of the annual limitation on cost sharing equals the average over 5 years of the annual limitation on cost sharing as required by statute. The value of varying the annual limitation on cost sharing in the plan over time in a long-term plan is that a higher annual limitation in early years may allow the plan to lower the limitation in later years to entice participants to remain in the plan for its duration, without altering the expected actuarial value of the plan over its duration as of the plan's start date.

Finally, as more fully discussed in section III.E.2 of this proposed rule, we propose to amend § 156.80(d)(2)(ii) to allow issuers of multi-year catastrophic plans to make a plan-level adjustment to the index rate. This proposal is intended to promote innovation in health coverage plan design that could exert downward pressure on premiums and costs, while increasing access to coverage and care and improving health outcomes.

We propose that an individual who satisfies the requirements for a catastrophic plan at the time of enrollment in the plan under section 1302(e)(2) of the Affordable Care Act at the time of enrollment in the multi-year plan. We seek comments on this proposal and how it would interact with other laws.

Given the large increases in premiums for health coverage in recent years, we are interested in offering additional alternatives for individuals to enroll in less expensive options. We believe that Congress' recent decision to designate all catastrophic and bronze plans as high-deductible plans, as well as our

recent broadening of the hardship exemption for individuals to qualify for catastrophic health plans,¹⁴³ is in keeping with that objective. We also believe that when individuals receive preventive services and effective disease management, those interventions can help reduce costs in the long run,¹⁴⁴ which in turn may ease pressure on premiums. However, issuers that do a particularly effective job of promoting these sorts of interventions often do not reap the long-term advantages of those reduced costs because they might retain those enrollees for only short durations and therefore cannot moderate premiums accordingly. This is because the single-year plan terms in the individual market promote churn where individuals cycle out of particular individual market plans, with enrollees often switching health insurance issuers on a frequent basis,¹⁴⁵ sometimes annually.¹⁴⁶ In such cases, an individual who receives such interventions while enrolled with a given issuer for 1 plan or policy year, and thereby may improve their health prospects for the future, is often not enrolled with that same issuer when those health benefits accrue. In this way, the incentives for individual market issuers differ from those for large employers, that often have an incentive to invest in the health of their long-term employees through wellness programs and offering of other workplace programs that promote physical fitness, smoking cessation, and other initiatives

aimed at reducing sick days and improving long term health outcomes.

In addition to incentivizing investments in health promoting activities, health insurance contract terms that exceed a year may decrease the administrative costs associated with marketing and enrollment and encourage alternative pricing structures where administrative efficiencies are reflected in lower premiums and enrollees in plans with multi-year terms are insulated from short-term premium spikes. From the perspective of the individual, remaining enrolled with the same plan or issuer for a longer period of time might also promote adherence to disease management programs, and thus promote better overall long-term health. Because of the potential positive impacts on enrollee health and plan affordability, we propose modifying the requirements for catastrophic plans in § 156.155(a)(6) to specify that a catastrophic plan has a term of either 1 plan or policy year, or of multiple consecutive plan or policy years not to exceed 10 years. If we should finalize the proposal to codify requirements for multi-year catastrophic plans, then, depending on issuer and enrollee reaction to and experience with such plans, we would consider expanding these or other similar requirements to multi-year plans of one or several metal levels.

We note that section 1302(e)(1)(B) of the Affordable Care Act specifies benefits that catastrophic health plans are required to provide pre-deductible, including three primary care visits per year and preventive services specified in section 2713 of the PHS Act. Section 2713(a) of the PHS Act requires applicable health plans to cover: (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by HRSA.

Section 2713(c) of the PHS Act allows the Secretary to develop guidelines to permit health plans to utilize value-

¹⁴³ See Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-sharing Reductions Due to Income, and Streamlining Exemption Pathways to Coverage, available at [guidance-on-hardship-exemptions.pdf](https://www.hhs.gov/guidance-on-hardship-exemptions.pdf).

¹⁴⁴ See Musich, S., Wang, S., Hawkins, K., and Klemes, A. (2016). The Impact of Personalized Preventive Care on Health Care Quality, Utilization, and Expenditures. *Population Health Management*. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC5296930/> and Maciosek, M.V., LaFrance, A.B., Dehmer, S.P., McGree, D.A., Flottemesch, T.J., Xu, Z. Solberg, L.I. (2017). Updated Priorities Among Effective Clinical Preventive Services. *Annals of Family Medicine*. Available at <https://pmc.ncbi.nlm.nih.gov/articles/PMC5217840/>.

¹⁴⁵ See Hill, S.C. and Jacobs, P.D. (2024). Changes in coverage stability and churning for private, individual insurance under the Affordable Care Act. *Health Affairs Scholar*. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC11747866/> and Fang, H., Frean, M., Sylwestrzak, G., and Ukert, B. (2022). Trends in Disenrollment and Reenrollment Within US Commercial Health Insurance Plans, 2006–2018. *JAMA Network Open*. Available at: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789399>.

¹⁴⁶ Wolf, E., Slosar, M., and Menashe, I. (2022). Assessment of Churn in Coverage Among California's Health Insurance Marketplace Enrollees. *JAMA Health Forum*. Available at <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2799211>.

based insurance design in the context of designing health coverage for preventive services. As described above, we believe that broadening plan terms beyond a single plan or policy year for catastrophic plans would increase the value provided to consumers in the form of better incentives for the issuer to invest in the long-term health of its enrollees. As such, we are clarifying under our authority at section 2713(c) of the PHS Act that catastrophic plans with a term of at least 2 plan or policy years may utilize a value-based insurance design in the context of designing health coverage for preventive services, such that benefits related to said design may be offered prior to satisfaction of the plan's deductible and prior to satisfying the plan's cost-sharing limitation, in addition to those benefits that can be offered prior to satisfaction of the plan's deductible and cost-sharing limitation enumerated in section 1302(e)(1) of the Affordable Care Act. We seek comment on the types of benefits plans could offer under this proposal, such as benefits that are designed to improve the long-term health of enrollees. We note that any such benefits must satisfy all applicable non-discrimination requirements. While this proposal is limited to catastrophic plans, we also seek comment on whether additional clarification or guidance specific to the group market is necessary.

We propose at § 156.130 that issuers of multi-year catastrophic plans have the option to apply the annual limitation on cost sharing for each plan year of the contract on an annual basis, or, on average, the life of the contract. For example, the limitation applicable to a specific year under each plan year of the coverage could be divided by 12 to determine the monthly limit on cost sharing under the plan.

Currently, enrollees can experience dramatic coverage changes when insurance contracts reset or change from one year to the next as deductibles and out-of-pocket limits reset. This can lead to significant shifts in cost sharing from month to month for the same services. Given that multi-year plans would not be subject to renewal at year's end (other than after the final year of the multi-year term), we believe it is appropriate to allow for a benefit structure that does not reset every 12 months. We believe that providing a consistent, predictable monthly out-of-pocket limit would reduce consumer confusion, improve financial planning, and bolster adherence to treatment plans.

Under the example above under which an issuer chooses to divide by 12

to determine the monthly limit on cost sharing, the monthly limitation on cost sharing during any plan or policy year contained in the multi-year plan, would reflect one-twelfth of the annual limitation for the plan or policy year for which the Federal annual limitation has been calculated, it is our view that this approach is consistent with how the annual limitation on cost sharing must be calculated by plans. Under this proposal to set requirements for catastrophic plans with multi-year terms, issuers would be able to choose the length of the multi-year term up to a maximum of 10 years, and could offer as many or as few such plans as desired, with different maximum terms. Issuers would not be required to offer a 1-year plan that is otherwise identical to each multi-year plan. Catastrophic plans with multi-year terms would continue to be subject to the Affordable Care Act guaranteed availability and guaranteed renewability requirements for individuals who are eligible for catastrophic plans under Federal law (as is the case for catastrophic plans with terms of 1 year). Individuals dropping coverage under a multi-year catastrophic plan, either at the end of the term or mid-term, would be treated the same as individuals dropping coverage under a 1-year policy either at the end of the year or mid-year, respectively, with respect to open enrollment and special enrollment periods. Additionally, other Federal requirements, including, but not limited to, the Mental Health Parity and Addiction Equity Act, The Women's Health and Cancer Rights Act, the Newborns' and Mothers' Health Protection Act, Michelle's Law, and the No Surprises Act, would continue to apply to such coverage.

Under current policy, an enrollee could terminate their enrollment in a multi-year catastrophic plan at any time and for any reason, without a penalty or being liable for the premium for the remainder of the multi-year term. An issuer could discontinue the product or exit the market under the same guaranteed renewability exceptions that apply generally under section 2703 of the PHS Act. That said, we understand the importance of certainty for issuers and enrollees in unlocking the aforementioned benefits of multi-year plans and the improvements in incentives they create. We seek comment on how Federal policies could promote continuous coverage in multi-year plans and defray the risk of termination by either the enrollee or issuer, including by promoting continuous coverage for individuals

who churn in and out of the individual market through the use of Individual Coverage Health Reimbursement Arrangements.

All multi-year catastrophic plans would be expected to disclose that the plan has a multi-year term, and the length of that term. To the extent multi-year catastrophic plans utilize the monthly method of applying the annual limitation on cost sharing discussed earlier in this preamble, plans would be expected to include that information in marketing and enrollment materials.

Under this proposal, issuers could apply the deductible that applies in the first year of coverage on an annual basis for each year within the coverage, or divide the annual deductible by 12, and apply it equally to each month of the policy throughout the entire term of coverage, similar to how a multi-year plan could choose to apply the annual limitation on cost sharing, as discussed in this section of the rule. For example, if the plan had an annual deductible of \$6,000, it could apply 1/12 of that deductible monthly (\$500 per month). We seek comment on if, and the degree to which, a plan could modify the amount of the annual deductible for each year of the multi-year policy.

We acknowledge that multi-year plans in individual health insurance markets represent a novel idea that could necessitate changes to other programs and processes that affect individual and group market plans. For example, we would need to consider how to treat multi-year catastrophic plans for purposes of the HHS-operated risk adjustment program, but in order to do that we would want to consider what the benefits and drawbacks are to each option.

Therefore, we seek comments on all aspects of this proposal, including whether there are any specific plan duration terms that would incentivize enrollees to adopt longer term, health-promoting habits. We also request comment on ways that plans with multi-year terms could be a more affordable option for consumers over single-year terms, including how premiums and rating practices for these plans might differ from other catastrophic plans that have a standard 1-year term; and whether plan terms of more than 10 years would better facilitate rating and promote lower premium products. We also seek comment on if and how any terms of coverage should be permitted to change over the course of the multi-year term, such as reduced deductibles or other cost-sharing, or reduced maximum cost-sharing requirements, and in what intervals could such changes be permitted.

We also request comment on whether any further modifications to HHS risk adjustment regulations under 45 CFR part 153 may be needed to align with any expected differences in rating practices and any resulting risk selection; whether we should use the same catastrophic HHS risk adjustment models regardless of whether the catastrophic plan is offered for a standard plan year or on a multi-year basis or whether we should have separate models or factors for these catastrophic plans (or enrollees in catastrophic plans) offered on a multi-year basis and, if so, what data, trending assumptions, and plan benefit design assumptions should be used for those models; whether we should calculate risk adjustment transfers for catastrophic plans offered for a standard plan year separately from risk adjustment transfers for catastrophic plans offered on a multi-year basis; and whether and how the State average premium term in the State payment transfer formula¹⁴⁷ should be modified to account for the influence of the length of the plan term in regards to the State average premium term of the formula, plan allowable rating factor, or for any other reason. We also request comment on whether and how plans with longer terms should be treated for MLR purposes, particularly whether the current MLR standard set forth in 45 CFR part 158 is appropriate for measuring revenue and claims experience of multi-year plans, and whether multi-year plans should be considered under the same book of business as plans with a traditional 1-year plan term for purposes of MLR. We also seek comment on what incentives or disincentives issuers would have to offer multi-year catastrophic plans, potential administrative barriers for issuers, and how long it would take issuers to develop and offer these plans. We seek comment on whether to require or permit, issuers to offer multi-year terms for individual market catastrophic and metal level plans, and if so, which ones and why. We request comment on potential interactions between this proposal and the health insurance market rules in 45 CFR parts 144 and 147, including rules for guaranteed availability and guaranteed renewability, fair health insurance premiums, specifically with respect to

premium variations based on age and restrictions to the 3:1 age rating, and uniform modifications to coverage; and whether more regulatory changes would be needed to effectuate this policy. Finally, we request comment on how this proposal would exist and interact with other laws related to tax policy such as health savings accounts and individual coverage health reimbursement arrangements, and any changes, either to this proposal or such other laws, that would resolve any such conflict between this proposal and those laws.

7. Cost Sharing for Bronze and Catastrophic Plans (§§ 156.136 and 156.155)

To address an issue that has arisen in the implementation of section 1302(c) through (e) of the Affordable Care Act, we propose changes to the permissible cost-sharing parameters for individual market bronze plans through new proposed § 156.136 and to the required cost-sharing parameters for catastrophic plans through revisions to § 156.155(a)(3).

Section 1301(a)(1)(B) of the Affordable Care Act directs all issuers of QHPs to cover the EHB package described in section 1302(a) of the Affordable Care Act, which includes coverage of the benefits described in section 1302(b) of the Affordable Care Act, adherence to the cost-sharing limits described in section 1302(c) of the Affordable Care Act, and meeting the AV levels established in section 1302(d) of the Affordable Care Act.

Section 2707(a) of the PHS Act, which is effective for plan or policy years beginning on or after January 1, 2014, extends the requirement to cover the EHB package to non-grandfathered individual and small group health coverage, irrespective of whether such coverage is offered through an Exchange. In addition, section 2707(b) of the PHS Act directs non-grandfathered group health plans to ensure that cost sharing under the plan does not exceed the limitations described in section 1302(c)(1) of the Affordable Care Act.

Section 2707(a) of the PHS Act and section 1302 of the Affordable Care Act 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 Affordable Care Act (except for catastrophic plans described in section 1302(e) of the Affordable Care Act). Section 1302(c) of the Affordable Care Act limits the annual cost sharing incurred under a health plan to the

maximum annual limitation on cost sharing. Section 1302(d)(2) of the Affordable Care Act 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) through (D) of the Affordable Care Act 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 Affordable Care Act 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 Affordable Care Act requires the Secretary to develop *de minimis* variations in AV calculations.

Section 1302(e) of the Affordable Care Act permits an individual market health plan not providing a bronze, silver, gold, or platinum level of coverage to be a catastrophic health plan that is treated as meeting the levels of coverage specified in section 1302(d)(1) of the Affordable Care Act for a plan year. A catastrophic plan may be offered only in the individual market and only to qualified individuals who have not attained age 30 before the beginning of the plan year, or to qualified individuals who are exempt from the requirement to maintain minimum essential coverage under section 5000A of the Internal Revenue Code by reason of a hardship exemption or an exemption described in section 5000A(e) of the Internal Revenue Code relating to the affordability of coverage. Catastrophic coverage must provide coverage for the EHB and must meet the statutory requirement to cover at least three primary care visits before the plan deductible is applied. In addition, catastrophic plans must comply with all other requirements applicable to QHPs except those specifically modified by section 1302(e) of the Affordable Care Act, and they must be offered through the Exchange in the same manner as other qualified health plans. We codified the requirements for catastrophic plans at § 156.155 in the Exchange Establishment Rule.

In the sections that follow, we provide an overview of how HHS has implemented the AV requirements of the Affordable Care Act, including a discussion of the major components of AV calculation. We go on to explain that we have discovered an inherent and unavoidable issue for implementation of the cost-sharing provisions of the EHB package in section 1302(c) through (e) of the Affordable Care Act that will eventually make issuer compliance with all these provisions mathematically

¹⁴⁷ For resources explaining the State payment transfer formula, see Pope, G.C., et al. (2014). Risk Transfer Formula for Individual and Small Group Markets Under the Affordable Care Act. *Medicare and Medicaid Research Review*, 4(3). Available at: https://www.cms.gov/mmrr/downloads/mmrr2014_004_03_a04.pdf. See also the 2014 Payment Notice (78 FR 15410, 15428 through 15434).

impossible. This issue has first become evident with respect to bronze and catastrophic plans, though without further changes, it will eventually impact silver plans and plans at higher metal tiers. To mitigate the worsening issue, we propose to create new optional cost-sharing parameters for bronze plans and to revise the cost-sharing requirements for catastrophic plans in the individual market only.

a. The Three Major Components of AV Calculation

AV is the anticipated covered medical spending for coverage of EHB¹⁴⁸ paid by a health plan (1) for a standard population, (2) computed in accordance with the plan's cost sharing (that is capped by the maximum annual limitation on cost sharing), and (3) divided by the total anticipated allowed charges for EHB coverage provided to the standard population. The denominator of this calculation is the average allowed cost of all services for the standard population in the year for a specified metal tier; the numerator is the share of average allowed cost covered by the health plan, using the cost-sharing parameters specified. These are the three major components of AV calculation, and year-over-year changes in each of them influence how AV calculation changes year-over-year.

AV Component #1: The Standard Population. In accordance with section 1302(d)(2)(A) of the Affordable Care Act, HHS develops and provides a standard population for the AV Calculator that resemble enrollees who are likely to be covered by individual and small group market health insurance in a particular year. The costs and utilization of this population are currently derived from the enrollee-level EDGE data. As the AV Calculator Methodology that HHS releases each year in connection with the AV

Calculator describes in detail,¹⁴⁹ we apply adjustments to the claims and enrollment data of the standard population, including weighting to account for the expected demographic distribution across individual and small group plans, and use it to create a series of continuance tables that underlie the AV Calculator. Our annual updates to the AV Calculator's standard population ensure accordance with generally accepted actuarial principles and methodologies. Generally, the claims and enrollment data indicate that the standard population is costlier to cover each year, which leads to a corresponding rise in AV each year. If we did not update the AV Calculator to account for changes in the standard population, the AV Calculator would not accurately account for the enrollees who are likely to be covered by individual and small group market health insurance in a particular year, and would be increasingly nonrepresentative of the people who enroll in metal-tier plans.

AV Component #2: The Maximum Annual Limitation on Cost Sharing. Section 1302(c) of the Affordable Care Act sets the maximum annual limitation on cost sharing¹⁵⁰ which limits an enrollee's overall financial responsibility by restricting the maximum out-of-pocket (MOOP) limit for a plan. For PY 2014, section 1302(c)(1)(A) of the Affordable Care Act sets this limit at the maximum cost-sharing limit for high-deductible health plans (HDHPs) under section 223(c)(2)(A)(ii) of the Internal Revenue

Code of 1986—that is, \$6,350 for a self-only plan. Section 1302(c)(1)(B) of the Affordable Care Act requires HHS to update the maximum annual limitation on cost sharing annually. For plan years after 2014, section 1302(c)(1)(B)(i) of the Affordable Care Act sets the limit for a self-only plan at the product of the 2014 value and the PAPI, 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 coverage for 2013.¹⁵¹ Under section 1302(c)(1)(B)(ii) of the Affordable Care Act, the maximum annual limitation on cost sharing for other plans, like coverage other than self-only, is twice the limit of a self-only plan. In accordance with § 156.130(e), in years where HHS is not making methodological changes, HHS will release the PAPI in guidance that will include the maximum annual limitation on cost sharing amount for the applicable benefit year.¹⁵² Using PAPI, the maximum annual limitation on cost sharing for self-only coverage has risen from \$6,350 in PY 2014 to \$12,000 in PY 2027 (see Table 8).

¹⁵¹ See section 1302(c)(4) of the Affordable Care Act.

¹⁵² In the 2025 Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability final rule (90 FR 27074, 27166 through 27168 (June 25, 2025)), HHS finalized a change to the methodology for calculating the premium adjustment percentage such that the average per capita premium will be based on the National Health Expenditure Accounts (NHEA) estimates of private health insurance (PHI) premiums (excluding Medigap and the medical portion of property and casualty insurance) for the 2026 benefit year and beyond. As discussed in this proposed rule, for the 2027 benefit year, HHS is not proposing changes to the methodology to calculate the premium adjustment percentage or related parameters. As such, for the 2027 benefit year, we released these parameters in guidance entitled “Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year.” Available at: <https://www.cms.gov/files/document/2027-papi-parameters-guidance-2026-01-29.pdf>.

¹⁴⁹ For an example of the methodology, see <https://www.cms.gov/files/document/updated-revised-final-2026-av-calculator-methodology-september-2025.pdf>.

¹⁵⁰ Cost sharing is defined at § 156.20 as any expenditure required by or on behalf of an enrollee with respect to EHB; the term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers that are not prohibited by the No Surprises Act, and spending for non-covered services.

¹⁴⁸ As defined in 45 CFR 156.110(a).

TABLE 8: Maximum Annual Limitations on Cost Sharing For Self-only Coverage By Year

Year	Maximum Annual Limitation on Cost Sharing, Self-Only	Percentage Increase from Previous Year
2014	\$6,350	N/A
2015	\$6,600	3.94%
2016	\$6,850	3.79%
2017	\$7,150	4.38%
2018	\$7,350	2.80%
2019	\$7,900	7.48%
2020	\$8,150	3.16%
2021	\$8,550	4.91%
2022	\$8,700	1.75%
2023	\$9,100	4.60%
2024	\$9,450	3.85%
2025	\$9,200	-2.65%
2026	\$10,600	15.22%
2027	\$12,000	13.21%

The maximum annual limitation on cost sharing impacts AV calculation since it changes the maximum amount that an enrollee may have to pay out-of-pocket each year. When the maximum annual limitation on cost sharing increases from year-to-year (which it typically does), it has the effect of decreasing year-over-year AVs. This is because plans can increase their MOOPs with a higher maximum annual limitation on cost sharing, which means enrollees typically need to pay more out-of-pocket for the EHB than they did in previous years, which would lower AV.

AV Component #3: EHB Costs. We also adjust the AV Calculator each year with an update to the cost of EHB that is provided to the AV Calculator's standard population, again to ensure accordance with generally accepted actuarial principles and methodologies and section 1302(d)(2)(A) of the Affordable Care Act. We project historical claims data for medical items and services and prescription drugs covered as EHB for the standard population for the next plan year. We

often refer to this projection as the “trend factor.” For years that we used a trend factor in the AV Calculator, we have set it for an increase of between 3.25 percent and 6.50 percent for medical costs and between 6.50 percent and 11.50 percent for prescription drug costs.¹⁵³ Table 9 sets forth the AV Calculator trend factors from 2014 to 2026.

¹⁵³ For PYs 2014–2017, we applied a single trend factor for medical and prescription drug costs combined. We began applying different trend factors for medical and prescription drug costs in 2018.

TABLE 9: AV Calculator Trend Factors By Year, Percent

AV Calculator	Medical Claims Trend Factor	Prescription Drug Claims Trend Factor
2014	6.50	
2015	0.00	
2016	6.50	
2017	6.50	
2018	3.25	11.50
2019	5.40	11.50
2020	6.10	9.80
2021	5.40	8.70
2022	0.00	0.00
2023	5.80	8.70
2024	5.40	8.20
2025	6.40	9.90
2026	6.40	10.10

We review a variety of data sources on medical services and prescription drug claims costs, including rate data from the Unified Rate Review Templates (URRTs) and National Health Expenditure data from the HHS Office of the Actuary, to develop and select the proposed adjustment to health care costs. This health care cost update also impacts AV calculation; as health care becomes more expensive, the generosity of a plan's AV increases as an enrollee needs to receive less medical care than in previous years to reach the maximum annual limitation on cost-sharing. If we did not apply this trend factor, the AV Calculator would not account for changes in the cost of health care and would be less and less accurate each year, inconsistent with section 1302(d)(1)(A)'s instruction to calculate AV based on the "actuarial value of the benefits provided under the plan."

b. The Rates of Change for the Three Major AV Components

Together, these three major components of AV calculation affect AV differently each year, depending on how the health of the standard population, the maximum annual limitation on cost sharing, and EHB costs all change, and at different rates. Ideally, the effect of a higher statutory maximum annual limitation on cost sharing each year would allow plans to exactly offset the year-over-year increase on AV created by the more expensive standard population and increased EHB costs

required by the statute. That would mean that the net impact of the three major factors on AV would be zero each year, and in turn any particular plan with the same cost-sharing structure would have the same AV year-over-year. We believe this is the actuarially preferred approach, because it would allow for relatively consistent cost sharing and benefits design year-over-year, which promotes consumer understanding. However, plans do not have the same AVs each year because the three factors change at different rates.

For nearly every year since 2014, the effect of updating the AV Calculator with the most recent data on the standard population and health care costs has led to a faster rise in AV with the same cost sharing structure than can be mitigated by the effect that a higher maximum annual limitation on cost sharing has on decreasing AV.¹⁵⁴ In

¹⁵⁴ There is one year that is an exception. The maximum annual limitation on cost sharing decreased for PY 2025 due to updated NHEA data from the CMS Office of the Actuary. In the NHEA Projections 2021–2030 data set available at the time of calculation of the PY 2024 maximum annual limitation on cost sharing, the estimated 2023 per capita employer-sponsored insurance (ESI) premiums value used in the premium adjustment percentage index calculation was \$7,292. In the NHEA Projections 2022–2031 data set available at the time of the calculation of the PY 2025 maximum annual limitation on cost sharing, the estimated 2024 per capita ESI premiums value used in the premium adjustment percentage index calculation was \$7,110, which was lower than the previously projected 2023 per capita ESI premiums from the previous data set. See Premium Adjustment

other words, the effects of updating the standard population and health care costs every year to maintain the accuracy of AV calculations typically results in AVs increasing year-over-year, and the effects of an increased maximum annual limitation on cost sharing make AVs decrease year-over-year, but not enough to offset the standard population and health care costs. This is the outcome of the PAPI—calculated from the percentage difference between the average per capita premium for health coverage for the preceding calendar year and the average per capita premium for health coverage for 2013—being outpaced by the increasing costs of the health care for the population enrolling in metal-tier plans. This means that we expect that a particular plan with the same cost-sharing structure has a *higher* AV year-over-year, even if nothing about the plan changes. We discussed this previously as long ago as 2016 in the

Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2025 Benefit Year (November 15, 2023) available at <https://www.cms.gov/files/document/2025-papi-parameters-guidance-2023-11-15.pdf>. See also, the Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2024 Benefit Year (December 12, 2022) available at: <https://www.cms.gov/files/document/2024-papi-parameters-guidance-2022-12-12.pdf>. The current NHEA projections are available at: <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected>.

2018 Payment Notice proposed rule¹⁵⁵ and most recently in the Marketplace Integrity and Affordability final rule.¹⁵⁶

This shift often forces issuers to change other parts of a plan's cost-sharing structure to (make the plan less generous to) conform to the relevant *de minimis* ranges that we permit for plans at \$ 156.140 in accordance with section 1302(d)(3) of the Affordable Care Act. Such changes are not actuarially sound, because the same plan, with the same cost-sharing structure, should have generally the same AV year-over-year. Over the years, as explained below, we have also modified the methodology by which issuers calculate AV, in an effort to mitigate some of these challenges. However, modifications made to ensure that plans at a certain metal tier can continue to exist do not carry the level of fidelity to AV calculation that may be justified by generally accepted actuarial

principles and methodologies, and we believe we have reached a point which further modifications would undermine the integrity of AV calculation and threaten our ability to implement section 1302(d) of the Affordable Care Act in such a manner.

The discrepancy in the rates of change of the three components have a magnified effect on the ability of issuers to design plans that conform to the *de minimis* ranges or that offer what issuers consider desirable; thus, issuers have narrower options to adjust cost sharing in their plan offerings each year. If current trends persist, eventually the maximum annual limitation on cost sharing will be too low to allow for an AV calculation for the most basic bronze plan design, with a deductible set to the maximum annual limitation on cost sharing, that is within widened *de minimis* ranges, even with the use of an

AV Calculator that caps claims. Thus, an actuarial issue exists in the implementation of the statutory text of section 1302(c) through (e) of the Affordable Care Act and the observed differences in the trend rates of the competing factors: PAPI (setting the maximum annual limitation on cost sharing and therefore plans' MOOP limit) and AV (which rises with increasing claims costs), discussed in greater detail in later lettered subsections.

Since we expanded the bronze *de minimis* range in 2018, we have seen a clear increase in the percentage of bronze plans at the upper end of the permissible *de minimis* range (+5 percent). In 2025, approximately 18 percent of FFE bronze plans were not in the expanded *de minimis* range, down from approximately 81 percent in 2018.

TABLE 10: Percentage of FFE Bronze Plans by AV Percentage, 2018-2025¹⁵⁷

AV	2018	2019	2020	2021	2022	2023	2024	2025
56.00 to <57.00%	9*	9*	0*	0*	0*	N/A	N/A	N/A
57.00 to <58.00%	1*	0*	5*	0*	0*	N/A	N/A	N/A
58.00 to <59.00%	6	11	2*	0*	0*	0*	0*	0*
59.00 to <60.00%	4	6	10	0*	0*	15	0*	8
60.00 to <61.00%	27	7	7	0*	0*	6	9	2
61.00 to <62.00%	34	36	15	20	17	6	3	8
62.00 to <63.00%	9	8	25	2	5	3	5	11
63.00 to <64.00%	2	8	10	10	8	12	9	46
64.00 to <65.00%	8	14	24	68	70	59	73	26

Today, bronze plans appear increasingly more as silver plans than bronze plans. As previously noted, over the years we have changed the methodology underlying the AV Calculator (for example, by imposing a spending cap) and expanded the *de*

minimis ranges (for example, by creating expanded bronze plans) in order to allow bronze plan viability. However, we believe that further changes to the AV Calculator methodology and *de minimis* ranges for the purpose of preserving bronze plans would near the

outer boundary of our statutory authority to address this issue under section 1302(d)(3) of the Affordable Care Act. When bronze plans have an AV between 62 and 65 percent, they are closer to the bottom of the silver *de minimis* range (66 percent) than they are

¹⁵⁵ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Proposed Rule, 81 FR 61456, 61510 (September 6, 2016).

¹⁵⁶ Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 FR 27075, 27175 (June 25, 2025).

¹⁵⁷ After the 2023 Payment Notice raised the lower bound of the permitted AV *de minimis* range from -4 percent to -2 percent, no bronze plans

could be certified as a QHP with an AV below 58 percent. In Table 10, where bronze plans' AVs are not permitted, they are marked "N/A". The asterisks are used to indicate when that AV percentage is nearly impossible to reach for a bronze plan through its cost sharing design. The non-zero numbers marked with an asterisk represent actual bronze plans that had an even lower AV calculated than for a theoretical bronze plan that only provides non-preventative benefit coverage after an enrollee has reached their MOOP,

with the MOOP set as equal to the given plan year's annual limitation on cost sharing. Bronze plans with AVs calculated as lower than this minimum-generosity design are no longer possible after an algorithm improvement in the 2021 AV Calculator, which ensured that plans using "copay with deductible" would no longer have an underestimated AV (due to previous AV Calculators overestimating enrollee spending during the plan's deductible phase).

to the bottom of the bronze *de minimis* range (56 percent or 58 percent, depending on the year). This clearly undermines the integrity of silver plan cost-sharing designs and makes it more difficult for consumers to distinguish between the two metal tiers.

However, the maximum annual limitation on cost sharing limits issuers' options in bronze plan design. We believe issuers may have designed competitive plans that would be attractive for bronze plan consumers but that are ineligible for sale because they

need to have a higher MOOP than is permissible under the maximum annual limitation on cost sharing. Specifically, the existing permissible MOOP leads to issuers offering higher deductible bronze plans over time because costs have risen faster than the permissible MOOP, requiring plans to raise cost-sharing below the permissible MOOP to meet the AV range for bronze plans. By 2024, the average deductible for bronze plans exceeded \$7,000. With a \$9,450 maximum annual limitation on cost sharing that year, these plans look

increasingly like catastrophic plans with a deductible that is almost set to the maximum annual limitation on cost sharing, and this includes expanded bronze plans that have an AV of up to 65 percent. The convergence of non-expanded bronze plans with catastrophic plan design is even more stark when viewing the median (or midpoint) of the deductibles and MOOPs of all the bronze plans offered on the FFEs alongside the maximum annual limitation on cost sharing over the last few years (Table 11).

TABLE 11: Median Deductible and Median MOOP of non-expanded FFE Bronze Plans, and the Maximum Annual Limitation on Cost Sharing, 2023-2026

	2023	2024	2025	2026
Median Deductible of Bronze (58%-62% AV) Plans	\$9,100	\$9,100	\$9,200	\$10,600
Median MOOP of Bronze (58%-62% AV) Plans	\$9,100	\$9,450	\$9,200	\$10,600
Maximum Annual Limitation on Cost Sharing	\$9,100	\$9,450	\$9,200	\$10,600

This convergence in the deductible and MOOP in these plan designs with the maximum annual limitation on cost sharing occurred at the same time the AV of bronze plans increased (Table 10). If issuers lowered deductibles in existing bronze plans but held their MOOP and average copayment rate between the deductible and MOOP constant, those plans would have higher AVs and risk appearing more like silver plans than bronze plans, or having to meet the requirements described at § 156.140(c) to be an expanded bronze plan. Issuers could feasibly lower the AV of their bronze plans by raising the deductible in those plans, but few offer such plans (Table 10).

Plans could increase their MOOP in order to offer plans with lower deductibles and copayment rates. Variation in MOOPs and deductibles across bronze plans in 2024 reveals that, for the median bronze plan a \$1 higher MOOP is associated with a 58 cent lower deductible. There is less response to the MOOP in higher metal tiers, consistent with the idea that the MOOP affects deductibles more at lower AV levels. However, as claims continue to rise at a rate greater than the growth in the statutory maximum annual limitation on cost sharing (due to rising faster than the index calculated based on how much premiums have increased), a higher MOOP may eventually be warranted to tamp down deductibles for plans seeking to maintain their AV compliance with higher metal tiers than bronze, as well. However, the deductible and MOOP of

most plan designs at the other metal tiers have not converged with the maximum annual limitation on cost sharing; in other words, silver plans and higher metal tier plans appear to still have appropriate flexibility in their cost sharing design, as observed by their wider ranges of deductibles, pre-deductible coverage, and MOOPs compared to non-expanded bronze plans (see Table 11).

Of the metal plans, bronze plans are most susceptible to increases in AV because they have the lowest AV (60 percent), and the highest allowable maximum annual limitation on cost sharing typically requires issuers to cover more than 60 percent of allowed claims. Issuers have fewer options to adjust the cost sharing for bronze plans compared to other metal level plans and, as noted previously, are increasingly designing them to have a deductible near or equal to the maximum annual limitation on cost sharing. To address this increase in AV for bronze plans in the short-term, we have already utilized the authority at section 1302(d)(3) of the Affordable Care Act to revise § 156.140(c) to expand the allowable *de minimis* range for bronze plans to a maximum of 65 percent AV, and refer to these plans as “expanded bronze” plans.¹⁵⁸

We began to reduce the distortion created by outliers with very high spending in the AV Calculator’s standard population beginning in 2021 by implementing a cap on enrollee spending at \$1,000,000. In later years, we capped enrollee spending at the 99.50th percentile of annual allowed amounts for all enrollees in the claims data. Without this cap, many, if not all, bronze plan designs would already be non-viable. For example, utilizing the 2027 version of the AV Calculator without the enrollment cap, we estimate that all bronze plan AVs would be 5 to 6 percentage points higher than with it. Based on internal analysis, all existing non-expanded bronze plans offered in the FFEs in PY 2026 would have an average AV of 65.1 percent if calculated using an AV Calculator that did not apply the enrollment cap. The simulated AV results range from 64.5 percent to 68.0 percent, which is much higher than the currently permitted maximum of 62 percent. We further estimated the effect on the other metal levels without the cap and found standard silver AVs would be 4 to 5 percentage points higher; gold plan AVs would be 1 to 2 percentage points higher; and platinum plan AVs would be up to 1 percent higher.

As AVs increase year-over-year, absent some other administrable regulatory solution, we may need to consider continuously expanding the cap on enrollee spending beyond the 99.50th percentile in order to preserve plan design viability, particularly for bronze plans. We know expanding this

¹⁵⁸ 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. (81 FR 94058).

cap is not a permanent solution. The AV Calculator becomes less accurate, and less representative of the standard population as more and more enrollees are excluded from it. Moreover, continued cap expansion does not align with the statutory requirements for determining the AV. While the initial cap may have reasonably been set from the Secretary's discretion to define a standard population, the continued expansion of cap clearly serves a separate purpose. However, without it, bronze plans will eventually become entirely non-viable, which is not a result that Congress could have intended. Thus, an issue exists in the implementation of sections 1302(c) through (e) of the Affordable Care Act and, to date, we have chosen to address it by applying flexibility in the determination of the AV. However, if current trends persist (and we have no reason to believe they will not), eventually the maximum annual limitation on cost sharing will be too low to allow for an AV calculation for a bronze plan design with a deductible set to the maximum annual limitation on cost sharing that is within widened *de minimis* ranges, even with an AV Calculator that uses a spending cap.

We are not aware of any administrable, actuarially sound regulatory alternatives that we might propose that could address these issues to preserve the integrity of AV calculations and the comparability between the levels of coverage. As discussed above, we can continue to expand the cap on enrollee spending beyond the 99.50th percentile as a temporary solution, but we hesitate to do so in order to preserve the integrity of AV calculations, as section 1302(d)(1)(A) of the Affordable Care Act directs the calculation of AV based on the "actuarial value of the benefits provided under the plan. We have also considered not trending the AV Calculator to account for changes in the standard population or for changes in EHB costs. This would make AV rise less quickly year-over-year. However, we believe doing so would render the AV Calculator wholly inaccurate actuarially. We have also considered proposing changes to EHB policy to reduce the scope of benefits that are covered as EHB to address this issue, but the calculation of AV does not so readily factor in the scope of covered benefits under the plan. We believe that changing the current EHB benchmark framework and potentially making significant changes to covered benefits is an extreme approach that would yield minor benefits, if any because AV is a

measurement of the cost sharing imposed by an issuer on whatever benefits the plan covers as EHB, and not a measurement of the EHB themselves. Additionally, section 1302(b)(2)(A) of the Affordable Care Act requires HHS to define the EHB to cover items and services covered within 10 specific categories of benefits such that their scope is equal to the scope of benefits provided under a typical employer plan; the statute does not create ability to define the EHB in order to accommodate AV calculations. In addition, we believe there are no changes to the PAPI methodology that would raise the annual limitation on cost sharing enough to preserve the viability of AV calculations, even in the short-term, though we solicit comment on whether there are any regulatory changes we might make to the PAPI that would address this AV issue.

We seek comment on other administrable regulatory alternatives that we might consider that could address these issues to preserve the integrity of AV calculations and the comparability between the levels of coverage long-term. However, at this time, we believe no administrable alternatives exist because the issue is one of innate mathematical incongruence, not methodological decisions. In the end, we believe the differing rates of changes between the three major factors of AV calculation pose an insurmountable regulatory problem created by the cost-sharing provisions of section 1302 of the Affordable Care Act.

c. Statutory Adherence

Below, we propose to revise the cost-sharing parameters for bronze plans and to revise the cost-sharing requirements for catastrophic plans, respectively, in order to adhere to the cost-sharing provisions of section 1302 of the Affordable Care Act, given this regulatory issue.

Consistent with longstanding principles of statutory interpretation, we seek to give effect to all provisions of the Affordable Care Act so that they operate together in a coherent structure.¹⁵⁹ The Supreme Court has recognized that agencies should adopt statutory interpretations that harmonize related provisions wherever possible and should implement statutes in a manner that advances the overall

statutory scheme.¹⁶⁰ However, where two statutory requirements cannot reasonably be satisfied simultaneously, an agency must act in a manner that best effectuates congressional intent and preserves the operability of the relevant statutory framework.¹⁶¹

We believe that maintaining the AV requirement for metal-level plans is the more specific and operational statutory instruction, and adherence to it best serves Congress' intent. The AV requirement applies only to a defined subset of plans offered in the individual and small group markets, and establish precise quantitative benchmarks that define the statutory coverage tiers themselves. By contrast, the maximum annual limitation on cost sharing applies broadly across all plan types and markets and functions as a general consumer protection ceiling rather than a plan-defining metric. In addition, compliance with the AV requirements necessitates detailed, plan-level calibration of cost-sharing parameters and is central to preserving Congress' deliberate creation of distinct metal-level coverage categories, whereas the maximum annual limitation on cost sharing operates as a uniform backstop that does not distinguish among plan types. Thus, we are prioritizing the highly specific statutory AV requirement over the generally applicable maximum annual limitation on cost-sharing.

Interpreting the AV requirement as the more specific statutory directive is consistent with how the Affordable Care Act, as originally passed, treated another conflict between cost-sharing limits and AV calculations. As originally passed, the Affordable Care Act included an annual limitation on deductibles for employer-sponsored plans under section 1302(c)(2) of the Affordable Care Act.¹⁶² Recognizing that this limitation would conflict with the AV, the statute provided that the limitation "shall be applied in such a manner so as to not affect the actuarial value of any health plan, including a plan in the bronze level."¹⁶³ Congress ultimately entirely abandoned any limitation on deductibles for employer-

¹⁶⁰ See *King v. Burwell*, 576 U.S. 473, 492 (2015) (recognizing that reviewing courts will exercise independent judgment in evaluating whether the agency has acted within its statutory authority and noting that the Affordable Care Act's statutory language must be read in context and in light of the statute's structure and purpose).

¹⁶¹ See *Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 412 (2024).

¹⁶² See Patient Protection and Affordable Care Act, Public Law 111–148 § 1302(c)(2), 124 Stat. 119, 166 (Mar. 23, 2010).

¹⁶³ *Id.* Section 1302(c)(2)(C) of the Affordable Care Act.

¹⁵⁹ See *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (explaining that statutes should be interpreted as a "symmetrical and coherent regulatory scheme"); *Gustafson v. Alloyd Co.*, 513 U.S. 561, 570 (1995) (statutory provisions should not be interpreted in a manner that renders any part "superfluous").

sponsored plans in 2014, while leaving in place the relevant AV requirements.¹⁶⁴ This statutory history suggests that Congress did not intend maximum annual cost-sharing requirements employer-sponsored plans to disrupt the AV calculation requirements.

For these reasons, we conclude that the proposals that follow represent a reasonable and legally permissible approach to implementing section 1302 that gives effect to Congress' core design of distinct coverage tiers while preserving the overall operability of the statutory framework. Accordingly, these proposals reflect our obligation to implement section 1302's interrelated provisions in a manner that is understandable and workable.

d. An Incremental Approach

Before turning to our proposals for bronze and catastrophic plans beginning with PY 2027, we note that any regulatory framework that permits plans to exceed the maximum annual limitation on cost sharing should be as limited as possible in order to still implement section 1302(c) through (e) of the Affordable Care Act so that these paragraphs operate together in as coherent a structure as Congress could have intended. Since the issue becomes more pronounced each year due to the growing disparity in the rates of change among the three major components of AV calculation, absent a statutory change, we believe we should implement regulatory solutions in a gradual, proportional manner.

To that end, we view the set of proposals that follow as only the beginning of necessary regulatory changes to the cost-sharing parameters for metal-tier and catastrophic plans. Catastrophic and bronze plans are the two plans most demonstrably and presently affected by this issue, and so we propose changes to the cost-sharing parameters for these plans first in the hopes of giving enrollees more PY 2027 options at lower premiums and with more attractive plan designs. Because we seek to minimize the extent that these plans may exceed the maximum annual limitation on cost sharing, we anticipate proposing future amendments to the applicable regulations through notice and comment rulemaking to address other metal tiers—at the point that the growing disparity in the rates of change among the three major components of AV begins to affect these higher tiers, and after sufficient research

into how to prevent unintended effects on the calculation of premium tax credits.

As demonstrated above, standard silver plans would already be non-viable if we had not already adjusted the standard population by capping enrollee spending at the 99.50th percentile of annual allowed amounts for all enrollees in the claims data. We considered proposing changes to the permissible cost-sharing parameters for silver plans in this rule but chose not to at this time. Rather, our intent in the future would be to propose changes to the cost-sharing parameters for silver plans, when necessary, through future notice and comment rulemaking. Second-lowest cost silver plans are used as the benchmark to determine premium tax credit amounts. Seeking changes to the permissible cost-sharing parameters for silver plans could have an outsized impact on the overall affordability of plans for subsidized enrollees, and we seek to minimize any destabilizing effects of this proposed policy by assuming such an incremental regulatory approach. For now, we will monitor and consider future incremental action we may take to change the cost-sharing parameters for the other metal tiers, and we invite comments about how we might calculate an appropriate threshold for flagging that the cost sharing incongruence is severely limiting silver plan design. We also seek comment on other implications that may exist for silver plans that do not exist for bronze and catastrophic plans.

e. Bronze Plan Cost-Sharing Parameters

To ensure that plans designated at the bronze metal level can continue to exist in the future and to also preserve a meaningful difference between the AVs of bronze and silver plans, which we believe was part of the congressional intent of having metal tiers, we propose to add new § 156.136 that states, for plan years beginning on or after January 1, 2027, if an issuer offers a bronze plan (as defined at § 156.140(b)(1)) in the individual market that complies with the cost-sharing requirements at § 156.130 and the levels of coverage requirements at § 156.140, it may also offer, within the same service area, bronze plans that utilize a cost-sharing design that exceeds the maximum annual limitation on cost sharing at § 156.130 by amounts in increments of 50 dollars in order to achieve an AV within the standard bronze *de minimis* variation at § 156.140(c), calculated as described in § 156.135.

We further propose, that, in order for an issuer to avail itself of the ability to

offer individual market bronze plans that utilize a cost-sharing design that exceeds the maximum annual limitation on cost sharing, the issuer must also offer at least one individual market bronze plan in the same service area that utilizes a cost-sharing design that does not exceed the maximum annual limitation on cost sharing at § 156.130 and complies with the levels of coverage requirements at § 156.140. This proposed flexibility is necessary to support the design and offering of bronze plans with AVs closer to the 60 percent intended by the Affordable Care Act. The MOOP for such individual market bronze plans must be in increments of 50 dollars. Under this proposal, we would not specify a strict dollar amount as the upper bound by which issuers could exceed the maximum annual limitation on cost sharing; rather, issuers would calculate this amount so that it fits within the narrower bronze *de minimis* range at § 156.140(c). We do not believe it is necessary set such an upper bound because plan MOOPs would still be restricted by the requirement that the plan's AV to comply with the levels of coverage requirements at § 156.140. However, we seek comment on whether we should set a strict dollar amount as the upper bound by which issuers could exceed the maximum annual limitation on cost sharing upon finalization of this rule, and if so, what the upper bound should be.

In addition, limiting this additional flexibility for bronze plans to issuers that also offer a bronze plan that complies with the existing cost-sharing requirements in the same service area ensures that, to the extent a bronze plan is available, there would be at least one in the service area that meets the maximum annual limitation on cost sharing. By allowing a wider range of possible cost-sharing designs at the bronze metal tier in the individual market, we create opportunities for issuers to offer plans that are appealing to more consumers with lower premiums and more pre-deductible coverage than would have been possible without this proposal.

We considered imposing no precondition that issuers offer a bronze plan within the same service area that utilizes a cost-sharing design that does not exceed the maximum annual limitation on cost sharing at § 156.130 in order to offer bronze plans that utilize a cost-sharing design that exceeds the statutory maximum annual limitation on cost sharing. However, we believe the precondition is necessary at this time because bronze plans are barely still viable in 2027 without the 99.50th

¹⁶⁴ See Protecting Access to Medicare Act of 2014, Public Law 113–93 § 213, 128 Stat. 1040, 1047 (April 1, 2014).

percentile cap (a bronze plan with a deductible equal to maximum annual limitation on cost sharing has an AV of 63.91 percent in 2027) and we believe consumers must retain access to bronze plans that do not exceed the maximum annual limitation on cost sharing so that we can best signal our good faith efforts to adhere to the statute.

If it is no longer possible to design a bronze plan with a MOOP set at or below the maximum annual limitation on cost sharing and a permissible bronze AV, then it would also no longer be possible to take advantage of this new proposed flexibility in bronze plans' allowed MOOP limit: as in, it would no longer be possible to additionally offer a non-expanded (standard) bronze plan with a higher MOOP limit. The proposed flexibility relies on the issuer already offering a bronze plan in the same service area which has a permissible bronze AV and complies with that plan year's maximum annual limitation on cost sharing as a prerequisite to setting a higher MOOP for additional bronze plans. If the market reaches this point, as we are warning in this rule—that a bronze plan with a MOOP set at the maximum annual limitation on cost sharing will be unable to fit within the bronze AV *de minimis* range according to that year's AV Calculator—we will need to propose a new approach to maintaining bronze plans' viability through future notice-and-comment rulemaking.

Thus, we intend to require such plans for as long as these bronze plan remain actuarially viable; however, pursuant to the overall incremental approach described earlier, we may revisit this precondition in future rulemaking as AVs continue to rise. Given these circumstances, we are considering and request comment on whether we should allow an adjustment to the result of the AV Calculator (which uses the 99.50th percentile cap) that approximates an AV calculation based on a standard population which includes those highest-cost enrollees (*i.e.*, approximates what the AV output would be from an AV Calculator which includes claims from the 0.50th highest percentile). We seek comment on how to better align with standard actuarial practice in our interpretation of the AV Calculator's outputs in light of the statutory incongruence described in this section, and how future AV Calculators might appropriately include more of these high-cost enrollees in its standard population without causing unnecessary disruption to existing plans that seek to remain in the same metal tier in the following plan year. Alternatively, we

seek comment on whether an issuer should be permitted to offer bronze plans which exceed the maximum annual limitation on cost sharing in order to achieve an AV between 58 and 62 percent only after a default adjustment to the 2027 AV Calculator's output for that plan design which approximates what the plan's AV would be if measured by an AV Calculator without a spending cap, and on whether a future release of the AV Calculator, such as the PY 2028 AV Calculator, could reduce or remove the spending cap.

We further propose that this flexibility would apply only in the individual market. Specifically, we believe that individual market consumers in particular would be interested in more plan choices offering lower deductibles and lower premiums. We believe that prospective consumers who do not qualify for APTCs may be deterred from enrolling in individual market plans due to the benefit design of current bronze plans. Providing additional plan design flexibility may encourage individual market enrollment and in turn promote a healthier risk pool by capturing currently uninsured people.

As already is the case, States that are the primary enforcers of AV standards would be responsible for ensuring that issuers that design bronze plans that exceed the maximum annual limitation on cost sharing do so to achieve an AV within the standard (non-expanded) bronze *de minimis* ranges at § 156.140(c). Title XXVII of the PHS Act contemplates that States will exercise primary enforcement authority over health insurance issuers in the group and individual markets to ensure compliance with health insurance market reforms, which include the EHB requirements in 45 CFR subpart B. Under this proposal, States that enforce Affordable Care Act insurance market requirements would retain their primary enforcement authority over the EHB, and may determine that a particular bronze plan design unnecessarily exceeds the maximum annual limitation on cost sharing. HHS would conduct such reviews of bronze plans offered in States where HHS directly enforces Affordable Care Act insurance market reform requirements.¹⁶⁵ We invite

¹⁶⁵ Pursuant to § 150.203, in the event that a State notifies HHS that it does not have statutory authority to enforce or that it is not otherwise enforcing one or more of the provisions of title XXVII of the PHS Act, or if HHS determines that the State is not substantially enforcing the requirements, HHS has the responsibility to enforce these provisions in the State. As of the date of this proposed rule, the following States have notified

comments about the enforcement of this proposed flexibility.

We seek comment on this proposal. Specifically, we seek comment on what, if any, additional requirements we should consider in order for issuers to avail themselves of the flexibility to exceed the maximum annual limitation on cost sharing. For example, we also considered whether to propose allowing bronze plans to exceed the maximum annual limitation on cost sharing only when bronze plans would otherwise be non-viable (that is, impossible to design). In addition, we are interested in comments discussing what additional consumer protections we can consider implementing to educate and notify consumers about individual market bronze plans that have a MOOP that does not exceed the maximum annual limitation on cost sharing. For example, we welcome comments on imposing disclosure requirements on any such bronze plan to explain the plan's higher MOOP in the Summary of Benefits and Coverage (SBC) and on an Exchange website, though we note that any such changes would be unlikely for PY 2027 due to time constraints preventing appropriate time to discuss and make a formal proposal in consultation with other Executive agencies including the Department of Treasury and Department of Labor. We seek comment on whether this policy should also apply to the small group market. We also seek comment on whether we should annually set a precise amount by which an issuer could utilize a plan design with cost sharing that exceeds the maximum annual limitation on cost sharing, or whether the proposed regulatory language is precise enough to limit the instances in which an issuer could offer such a plan. We seek comment on operational effects of this policy, such as whether these plans would be considered the same plan under § 157.106(e)(3)(iv), and what impact this would have on plan crosswalking. We seek comment on these additional requirements related to permitting a high MOOP for some bronze plans, or any others commenters may identify, that we might finalize in this rule.

As we contemplate how this policy could apply to plans at higher metal levels, we seek comment on what special considerations may exist for those plans, and particularly for silver plans in determining the second lowest cost silver plan. We also seek comment

HHS that they do not have the authority to enforce or are not otherwise enforcing the Affordable Care Act market reform provisions, including the EHB: Missouri, Oklahoma, Tennessee, Texas, and Wyoming.

on whether this flexibility should also apply to cost-sharing variants. Finally, we seek comment on whether we should propose changes to the bronze de minimis range and expanded bronze policy at § 156.140(c)(1).

f. Catastrophic Plan Cost-Sharing Requirements

Lastly, to best preserve a meaningful difference between the AVs of bronze and catastrophic plans, we propose to amend § 156.155(a)(3) to require catastrophic plans to provide no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount equal to 130 percent of the maximum annual limitation on cost sharing, rounded down to the next lowest multiple of 50 dollars, is reached.

The issue regarding the implementation of the maximum annual limitation on cost sharing and AV also impacts catastrophic plans. Issuers do not have flexibility in varying the cost sharing for catastrophic plans; the Affordable Care Act requires catastrophic plans to have a deductible and MOOP set to the maximum annual limitation on cost sharing and provide few specific benefits pre-deductible at section 1302(e)(1)(B). Because of this rigidity, catastrophic plans do not have prescribed AV requirements. Nevertheless, the perceived value of catastrophic plans is still affected by the conflict. We estimate that the year-over-year AVs for catastrophic plans are gradually rising, just like metal-tier plans. However, they are rising at an even faster rate than bronze plans.

An eligible consumer might prefer to select a bronze plan over a catastrophic plan if the catastrophic plan has a similar premium to the bronze plan and has a comparable AV to a bronze plan, but the bronze plan is able to provide more pre-deductible benefits and lower deductibles and MOOPs. This obvious choice is evident in enrollment data; enrollment in catastrophic plans on the FFEs has decreased every year since 2016 while bronze plan enrollment has increased. In 2016, nearly 100,000 people enrolled in catastrophic plans, but only about 20,000 people enrolled in catastrophic plans in 2025. Since we expanded the bronze de minimis ranges in 2018, enrollment in bronze plans has more than doubled from about 2.5 million to about 5.4 million in 2025. We believe the continuous rise in AVs for bronze plans and the decrease in enrollment for catastrophic plans may be causally connected, though we seek

comment on other potential reasons to explain this phenomenon.¹⁶⁶

We believe that catastrophic plans only appeal to consumers when there is a clear difference in the perceived value between catastrophic and bronze plans. When there is such a clear difference, the healthier consumers that are generally eligible and best suited to enroll in catastrophic plans are more motivated to select a catastrophic plan in lieu of a bronze plan. This is plainly what Congress intended.

Accordingly, we propose a revision to § 156.155 that would more clearly distinguish expanded catastrophic plans from bronze plans. We propose to require catastrophic plans to provide no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount equal to 130 percent of the maximum annual limitation on cost sharing, rounded down to the next lowest multiple of 50 dollars, is reached, beginning in 2027. For PY 2027, this amount would be $\$12,000 \times 1.3$, or \$15,400. We chose to propose multiplying the maximum annual limitation on cost sharing by a factor of 130 percent because we estimate this would lower the estimated AV for these catastrophic plans to 55 percent; by definition, increasing the cost sharing for which consumers are responsible in a plan design reduces some of the market pressure that drive increasing premiums. We believe this is a reasonable estimate for a theoretical AV of catastrophic plans, as it strikes a balance between comprehensiveness of coverage and premium affordability for healthier enrollees.

This higher cost-sharing limit for catastrophic plans would allow for a more meaningful difference between the cost sharing typically expected for catastrophic and bronze plans and would allow issuers to more aggressively price catastrophic rates lower so that cheaper catastrophic plans would appeal to the kinds of consumers that we believe should tend to be enrolled in catastrophic plans—especially the healthy, non-subsidized enrollees who may be disincentivized from enrolling in a QHP due to the rise in costs. However, we seek comment on

¹⁶⁶ For example, section 1302(c)(1) of the Affordable Care Act requires HHS to trend the maximum annual limitation on cost sharing forward in accordance with the premium adjustment percentage, while the IRS may only trend the maximum allowable MOOP for HDHPs forward to account for inflation (see section 223(c)(2)(A)(ii)(I) of the Code). This creates a discrepancy between the Affordable Care Act's maximum annual limitation on cost sharing and the maximum allowable HDHP MOOP, which could also explain the recent shift in bronze plans at the upper end of the permissible +5 range.

whether we should strive for a theoretical AV for catastrophic plans that is higher or lower than 55 percent, including whether we should phase in this multiplication factor over a number of plan years to ease the impact on catastrophic plan cost sharing, and how the availability of catastrophic plans at 130 percent of the maximum annual limitation on cost sharing would affect the landscape of plans available to consumers. We reserve the ability to finalize a different factor than 130 percent in the final rule after reviewing public comments. In addition, we solicit comments that address whether, in potentially finalizing this proposal, we should not require catastrophic plans to provide no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount equal to 130 percent of the maximum annual limitation on cost sharing. Alternatively, we solicit comments that address whether we should, in potentially finalizing this proposal, require issuers to offer, in the same service area, at least one catastrophic plan that provides no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount equal to 100 percent of the maximum annual limitation on cost sharing, as a precondition to being able to offer catastrophic plans that provide no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount equal to 130 percent of the maximum annual limitation on cost sharing. We also solicit comment on whether we should, in potentially finalizing this proposal, alternatively allow catastrophic plans to provide no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount that could be less than 130 percent of the maximum annual limitation on cost sharing (but not less than 100 percent). This proposed approach for catastrophic plans harmonizes plan and market outcomes with section 1302(c) through (e) of the Affordable Care Act to the greatest extent possible to preserve meaningful catastrophic plan availability without jeopardizing the integrity of the metal-tier framework that Congress envisioned. And, while raising the maximum annual limitation for catastrophic plans beyond what Congress specified is not an action we take lightly, we believe that, due to the mathematical irreconcilability created by current section 1302(c) through (e) of the Affordable Care Act, this proposal is necessary and most narrowly-tailored to ensure the coherent implementation of the Affordable Care Act's overall statutory scheme with as minimal

disruption to consumers as possible. Per the previous section, we also propose to allow issuers to offer catastrophic plans with a multi-year term: if finalized, all catastrophic plans that an issuer wishes to offer for PY 2027 would be required to use the higher annual limitation on cost sharing.

We also seek comment on whether there would be impacts to HHS risk adjustment as a result of requiring catastrophic plans to provide no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount equal to 130 percent of the maximum annual limitation on cost sharing, rounded down to the next lowest multiple of 50 dollars, is reached. Finally, we considered whether the guidance document on the “Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage”, or another regulatory vehicle, might be more appropriate for releasing this additional permitted MOOP limitation annually, and invite comment on where to release and seek comment on the updated MOOP limitations ahead of each plan year.

We seek comment on all aspects of these proposals, including revisions to § 156.130 to reflect the proposed exception to the annual limitation on cost sharing that we propose to add for bronze plans at § 156.136, the changes to cost-sharing requirements for catastrophic plans at § 156.155, and any proposed alternative requirements we might consider finalizing in this rule connected to these proposals.

Additionally, we seek comment on whether the methodology for estimating the PAPI should be revised to further reflect per capita claims cost growth in the individual health insurance market,¹⁶⁷ so that the annual adjustment to the maximum out-of-pocket limit better tracks the claims experience of the population in the individual market to which that limit applies. Because the premium adjustment percentage is also used to determine other parameters under the Affordable Care Act and the Internal Revenue Code and the annual limitation on cost sharing also impacts the large group and self-insured markets, we are particularly interested in comments addressing the potential

consequences of such a methodological change for other areas of policy in which the premium adjustment percentage is a factor.

8. Standardized Plan Options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv))

We propose to exercise our authority under sections 1311(c)(1) and 1321(a)(1)(B) of the Affordable Care Act to discontinue the full suite of standardized plan option policies effective beginning in PY 2027. Specifically, we propose to remove the following from our regulations: the definition of “standardized option” at § 155.20; all requirements pertaining to standardized plan options at § 156.201 (the requirements for FFE and SBE–FP QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one another at paragraph (c)); the differential display of standardized plan options on *HealthCare.gov* at § 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv). Finally, we propose to cease the annual design and publication of these plans in the applicable Payment Notice rulemaking for each plan year.

a. Regulatory History

Standardized options were first introduced in the 2017 Payment Notice at § 155.20 (81 FR 12289 through 12293). These standardized option plan designs were subsequently updated in the 2018 Payment Notice (81 FR 94107 through 94112). The 2018 Payment Notice (81 FR 94118) also introduced the authority for HHS to differentially display standardized options on *HealthCare.gov* at § 155.205(b)(1), which allowed consumers the ability to filter all available plan options to view only standardized options and receive an accompanying message explaining how standardized options differed from non-standardized options. The 2018 Payment Notice (81 FR 94118) also introduced standardized option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP at

§§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv).¹⁶⁸

Standardized options were then discontinued in the 2019 Payment Notice (83 FR 16974 through 16975). However, the discontinuance was challenged in the United States District Court for the District of Maryland. On March 4, 2021, the court decided *City of Columbus, et al. v. Cochran*.¹⁶⁹ The court reviewed nine separate policies HHS had issued in the 2019 Payment Notice, vacating four of them. The court vacated the policy finalized in the 2019 Payment Notice that ceased HHS’ practice of designating some plans in the FFEs and SBE–FPs as “standardized options,” a policy that the 2019 Payment Notice (83 FR 16974 through 16975) stated was intended to maximize innovation by issuers in designing and offering a wide range of plans to consumers.

As a result, in part 2 of the 2022 Payment Notice (86 FR 24264 through 24265), we announced our intent to engage in rulemaking under which we would propose to resume designation of standardized options and propose specific designs in more detail in PY 2023. Thus, in the 2023 Payment Notice (87 FR 27310 through 27322), we reintroduced standardized plan options to enhance the consumer experience, increase consumer understanding, simplify the plan selection process, and combat discriminatory benefit designs.¹⁷⁰ We required FFE and SBE–FP issuers offering QHPs in the individual market to offer these plans, but we exempted FFE and SBE–FP issuers offering QHPs in the small group market as well as issuers in State Exchanges from these requirements. We also exempted issuers of QHPs in FFEs and SBE–FPs that were already required to offer standardized plan options under State action taking place on or before January 1, 2020, such as issuers in the State of Oregon,¹⁷¹ from the requirement

¹⁶⁸ Under these requirements, when an internet website of a web-broker or issuer is used to complete the QHP selection, at a minimum the internet website must differentially display all standardized options prominently and in accordance with the requirements under § 155.205(b)(1) in a manner consistent with that adopted by HHS for display on the FFE website and with standards defined by HHS, unless HHS approves a deviation.

¹⁶⁹ *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021).

¹⁷⁰ Although the official nomenclature for these plans was “standardized options” in the 2017 through 2019 Payment Notices, when we resumed this policy in the 2023 Payment Notice and in all subsequent Payment Notices, the official nomenclature became “standardized plan options.”

¹⁷¹ See Or. Admin. R. 836–053–0009.

¹⁶⁷ In the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability (90 FR 27074), CMS finalized updates to the methodology for calculating the premium adjustment percentage to establish a premium growth measure that captures premium changes in both the individual and employer-sponsored insurance markets for the 2026 plan year and beyond.

to offer the standardized plan options specified by HHS in rulemaking.

In the 2023 Payment Notice (87 FR 27312), we finalized standardized plan options at the following metal levels: one bronze plan, one bronze plan that meets the requirement to have an AV up to 5 points above the 60 percent standard, as specified in § 156.140(c) (known as an expanded bronze plan), one standard silver plan, one version of each of the three income-based silver CSR plan variations, one gold plan, and one platinum plan. We did not finalize standardized plan options for the AI/AN CSR plan variations as provided for at § 156.420(b) given that the cost sharing parameters for these plan variations are already largely specified.

In the 2023 Payment Notice (87 FR 27312), we finalized two sets of standardized plan options to accommodate different States' cost sharing laws. Specifically, the first set of standardized plan options applied to all FFE and SBE-FP issuers, except issuers in Delaware, Louisiana, and Oregon. The second set of standardized plan options applied only to issuers in Delaware and Louisiana to accommodate these two States' specialty prescription drug cost sharing laws.

We designed these standardized plan options to resemble the most popular QHP offerings that millions of consumers were already enrolled in by taking the following steps: selecting the most popular cost sharing type for each benefit category; selecting enrollee-weighted median cost sharing values for each of these benefit categories based on PY 2022 cost sharing and enrollment data; modifying these plans to ensure they were able to comply with applicable State cost sharing laws; and decreasing the AVs for these plan designs to be at the floor of each AV *de minimis* range, primarily by increasing deductibles.

In the 2023 Payment Notice (87 FR 27313), we also resumed the differential display of standardized plan options on *HealthCare.gov* under the authority at § 155.205(b)(1), including those standardized plan options required under State action taking place on or before January 1, 2020. In addition, we resumed enforcing the standardized plan option differential display requirements for approved web-brokers and QHP issuers using a DE pathway to facilitate enrollment through an FFE or SBE-FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv).

As such, web brokers and QHP issuers were once more required to differentially display standardized plan options in accordance with § 155.205(b)(1) in a manner consistent

with how standardized plan options are displayed on *HealthCare.gov*, unless we approve a deviation. Any requests from web brokers and QHP issuers seeking approval of an alternate differentiation format are reviewed based on whether the same or a similar level of differentiation and clarity is provided under the requested deviation as is provided on *HealthCare.gov*.

In the 2024 Payment Notice (88 FR 25847 through 25855), we maintained a high degree of continuity with our approach to standardized plan options finalized in the 2023 Payment Notice. However, in contrast to the policy finalized in the 2023 Payment Notice, at § 156.201(b), we finalized for PY 2024 and subsequent plan years to no longer include a standardized plan option for the non-expanded bronze metal level—primarily due to AV constraints and the infeasibility of designing such a plan.

In the 2025 Payment Notice (89 FR 26357 through 26362) and in the 2026 Payment Notice (90 FR 4493 through 4500), we continued to maintain a high degree of continuity with the approach to standardized plan options finalized in the immediately preceding Payment Notices (that is, the 2024 and 2025 Payment Notices). In each rulemaking, we made only minor modifications to the plan designs to ensure they continued to have AVs within the permissible *de minimis* range for each metal level. Additionally, in the 2026 Payment Notice, we finalized a requirement for FFE and SBE-FP QHP issuers in the individual market offering multiple standardized plan options within the same product network type, metal level, and service area to meaningfully differentiate these plans from one another in terms of included benefits, provider networks, included prescription drugs, or a combination of some or all these factors at § 156.201(c).

We explained that this requirement was based in part on our experience with the meaningful difference standard, which was previously codified at § 156.298. The meaningful difference standard was introduced in the 2015 Payment Notice (79 FR 13813 through 13814), revised in the 2017 Payment Notice (81 FR 12312 and 12331), and subsequently discontinued and removed from our regulations in the 2019 Payment Notice (83 FR 17027). The meaningful difference standard was originally intended to enhance the consumer experience on *HealthCare.gov* by preventing duplicative plan offerings and limiting plan proliferation.

We refer readers to the preambles to the 2023, 2024, 2025, and 2026 Payment Notices discussing § 156.201 (87 FR 27310 through 27322, 88 FR 25847

through 25855, 89 FR 26357 through 26362, and 90 FR 4493 through 4500, respectively) for more detailed discussions regarding our approaches to standardized plan options in previous plan years. We also refer readers to the preambles to the 2015, 2017, and 2019 Payment Notices discussing § 156.298 (79 FR 13813 through 13814, 81 FR 12312 and 12331, and 83 FR 17027, respectively) for more detailed discussions regarding our approaches to the meaningful difference standard in previous plan years.

b. Current Proposal

We propose, effective beginning in PY 2027, that FFE and SBE-FP QHP issuers in the individual market would no longer be required to offer standardized plan options. Further, we would remove the following from our regulations: the definition of “standardized options” at § 155.20; all requirements pertaining to standardized plan options at § 156.201 (the requirements for FFE and SBE-FP QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one another at paragraph (c)); the authority to differentially display standardized plan options on *HealthCare.gov* at § 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE-FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv). Finally, we would cease the annual design and publication of these plans in the applicable Payment Notice for each plan year.

Nothing under this proposal would impact or preclude State-enacted standardized plan option requirements, including the requirement for issuers in the State of Oregon to offer such plans.¹⁷² Thus, under this proposal, Oregon issuers would continue to be subject to State requirements. However, standardized plan options offered under those requirements would no longer be differentially displayed on *HealthCare.gov*, and approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE-FP would no longer be required to differentially display those standardized plan options. We also note that nothing under this proposal would preclude State Exchanges from requiring their respective issuers to offer standardized plan options or from differentially

¹⁷² See Or. Admin. R. 836–053–0009.

displaying such plans on their respective enrollment platforms.

We also clarify that while we propose to discontinue the requirement for issuers to offer standardized plan options, the annual design and publication of these plans in the applicable Payment Notice each plan year, and the differential display of these plans on *HealthCare.gov* and the DE pathways, we are not proposing to require issuers to discontinue their existing standardized plan option offerings altogether. Instead, under this proposal, issuers would be permitted to choose whether to discontinue their existing standardized plan option offerings altogether or continue offering them with either the same or modified cost sharing, while we simultaneously discontinue the differential display of these plans and designation of these plans as standardized plan options.

Under this proposed approach, if issuers wished to discontinue their existing standardized plan option offerings altogether, they would be permitted to do so, and enrollees in these plans would be crosswalked to a different plan in accordance with the crosswalk hierarchy at § 155.335(j). Additionally, if issuers wished to continue offering these existing standardized plan options with the same cost sharing, they would also be permitted to do so, and enrollees in these plans would continue to be auto-reenrolled in these plans from one plan year to the next, absent selecting a different plan or discontinuing coverage. However, these plans would no longer be visually distinguished as standardized plan options on *HealthCare.gov* or the DE pathways. Finally, if issuers wished to continue offering these existing standardized plan options but also wished to modify these plans' cost sharing structures, they would be permitted to do so, but these issuers would continue to be subject to the requirements under the definition of "plan" at § 144.103 and to the uniform modification requirements at § 147.106.

c. Rationale for Proposal

We propose this approach for several reasons. To begin, when we reintroduced standardized plan options in the 2023 Payment Notice (87 FR 27316 through 27317), we noted that *City of Columbus* vacated the discontinuation of standardized plan options in the 2019 Payment Notice.¹⁷³ We then stated that several commenters explained that HHS was not legally obligated to resume standardized plan

options under this ruling. These commenters explained that the previous Administration simply provided insufficient justification for discontinuing standardized plan options, but that discontinuing them was not unlawful. These commenters suggested that instead of resuming standardized plan options, HHS should issue a new rule with a more thorough explanation than what was provided in the 2019 Payment Notice explaining why standardized plan options should remain discontinued.

In response to these comments, in the 2023 Payment Notice (87 FR 27316 through 27317), we acknowledged and agreed that *City of Columbus* did not require HHS to resume standardized plan options. However, we explained that this ruling caused us to reevaluate our previous decision to discontinue standardized plan options in the 2019 Payment Notice. We also explained that we believed it was appropriate to resume standardized plan options at that time since the contemporary market conditions differed significantly from the market conditions present when standardized plan options were discontinued in the 2019 Payment Notice—namely, the individual market was no longer considered to be at risk of destabilization.

In the 2023 Payment Notice (87 FR 27316 through 27317), we further explained that the stabilization of the individual market was demonstrated by the proliferation of plan offerings, increased issuer participation in the Exchanges, and record enrollment. We thus explained that resuming standardized plan options at that time could play a constructive role in enhancing the consumer experience, increasing consumer understanding, and simplifying the decision-making process for consumers on the Exchanges, despite the fact that *City of Columbus* did not legally obligate HHS to do so.

In the 2023 Payment Notice (87 FR 27316), we further explained that we believed standardized plan options could play an important role in that simplification by allowing consumers to compare offerings based on other meaningful features outside of cost sharing structures, such as premiums, networks, formularies, and quality ratings. We then explained that employing standardized plan option requirements at that time would allow consumers to more easily and more meaningfully differentiate between choices and select a plan that meets their unique health care needs.

Thus, issuers that offer QHPs through the FFEs and SBE-FPs have been

required to offer standardized plan options at every product network type, at every metal level (with the exception of the non-expanded bronze metal level since PY 2024), and throughout every service area they offer non-standardized plan options since PY 2023. As such, we have accumulated 4 plan years of experience (PY 2023 through PY 2026) administering these standardized plan option policies. This cumulative experience provides us with a comprehensive and nuanced perspective regarding weighing both the advantages and disadvantages of requiring FFE and SBE-FP QHP issuers to offer standardized plan options, whether this strategy aligns with our originally articulated objectives with standardized plan option policies, and whether this strategy has yielded the intended results.

Based on this experience, we have concluded that requiring FFE and SBE-FP QHP issuers to offer standardized plan options is an ineffective strategy in enhancing the consumer experience, increasing consumer understanding, and simplifying the plan selection process—the originally articulated objectives of employing our standardized plan option policies. This is primarily because requiring issuers to offer standardized plan options at every product network type, at every metal level, and throughout every service area that they offer non-standardized plan options led to an increase in the total number of QHPs that issuers offer through the FFEs and SBE-FPs in PY 2023 (the first year in which the requirement to offer these plans was introduced), which exacerbated plan proliferation—directly counteracting our originally articulated objectives.

In fact, the resumption of standardized plan options and the introduction of the requirement for FFE and SBE-FP QHP issuers to offer standardized plan options coincided with an increase in the weighted average number of total plans available per enrollee from 108 in PY 2022, the year before the introduction of the requirement to offer standardized plan options, to 114 in PY 2023, the year in which this requirement was introduced, with most of this increase in plans being comprised of standardized plan options. Furthermore, plan proliferation as measured by the weighted average number of total plans offered per issuer (which is derived by dividing the weighted average number of total plans available per enrollee by the weighted average number of total issuers per enrollee) increased from 16.9 in PY 2022 to 17.3 in PY 2023—meaning each issuer on average tended to offer a

¹⁷³ *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021).

higher number of plans after the imposition of the requirement to offer standardized plan options than the year before this requirement was made effective.¹⁷⁴

Furthermore, even with the introduction of the non-standardized plan option limit of four in PY 2024 and its reduction to two as well as the introduction of the exceptions process in PY 2025, the net impact of both the requirement to offer standardized plan options as well as the subsequent imposition of non-standardized plan option limits and exceptions on the weighted average number of total plans available per enrollee and the weighted average number of total plans offered per issuer (including both standardized and non-standardized plan options) was marginal—despite the substantially increased regulatory complexity and the associated burden of creating and submitting certification applications for new plans (standardized plan options) and correspondingly adjusting existing portfolios of plan offerings (non-standardized plan options).

Specifically, the weighted average number of total plans available per enrollee decreased from 114 in PY 2023 to 100 in PY 2024 and remained consistent at 100 in PY 2025. The weighted average number of total plans offered per issuer decreased from 17.3 in PY 2023 to 14.7 in PY 2024 and 13.7 in PY 2025. Thus, from PY 2022, before this suite of standardized plan option policies was introduced, there was a weighted average number of 108 total plans available per enrollee and a weighted average number of 16.9 total plans offered per issuer, whereas in PY 2025 (after several consecutive years imposing novel layers of requirements), these same measures were 100 and 13.7, respectively.

We do not believe that the marginal net reductions in the weighted average number of total plans available per enrollee and the weighted average number of total plans offered per issuer achieved by introducing this suite of standardized plan option and non-standardized plan option limit requirements warrant imposing additional burden on issuers or impeding issuer innovation in plan design choice—especially given that these marginal net reductions have likely been largely indiscernible to consumers during the plan selection process. This is especially true given that these metrics continue to remain

significantly elevated compared to only several plan years ago. For example, in PY 2020, the weighted average number of total plans available per enrollee was 39, and the weighted average number of total plans offered per issuer was 11.1. The impact of our non-standardized plan option limits and exceptions process policies on these metrics and plan proliferation are discussed in greater detail in section III.E.9 of this proposed rule.

The increase in the weighted average number of total plans available per enrollee from PY 2022 to PY 2023 (which arose primarily from the introduction of the requirement for issuers to offer standardized plan options), even taken altogether with the subsequent marginal net reductions in PY 2024 and PY 2025 (which arose primarily from the introduction of the non-standardized plan option limit of four in PY 2024 and the reduction of this limit to two as well as the introduction of the exceptions process in PY 2025), is particularly important.

We have utilized this metric, the weighted average number of total plans per enrollee, as opposed to the unweighted average number of total plans per enrollee, as the primary metric by which to evaluate plan choice overload because utilizing weighted averages takes into consideration the number of enrollees in a particular service area when calculating the average number of plans available to enrollees. As a result of weighting averages by enrollment, service areas with a higher number of enrollees have a greater impact on the overall average than service areas with a lower number of enrollees. Thus, weighting averages by enrollment allows a more representative metric to be calculated that more closely resembles the actual experience of enrollees.

Therefore, as measured by this metric, the weighted average number of total plans per enrollee, the plan proliferation that occurred subsequent to the introduction of the requirement for FFE and SBE-FP QHP issuers to offer standardized plan options in PY 2023 is inconsistent with our originally articulated objectives of enhancing the consumer experience, increasing consumer understanding, and simplifying the plan selection process for consumers on *HealthCare.gov*—even with the marginal net reductions that occurred subsequent to the introduction of non-standardized plan option limits and its reduction from four to two in PY 2024 and PY 2025, respectively. As we explained in the comment solicitation on choice architecture and preventing plan choice overload in the 2023

Payment Notice (87 FR 27345 through 27347), this is because increasing the total number of plans that consumers must compare and evaluate increases the risk of plan choice overload, suboptimal plan selection, and unexpected financial harm.

Based on our 4 plan years of experience (PY 2023 through PY 2026) administering this suite of standardized plan option and non-standardized plan option limits and exceptions policies, we have concluded that a marginal net reduction in the number of plan choices in the FFEs and SBE-FPs created by the approach of imposing requirements to offer standardized plan option and imposing non-standardized plan option limits and exceptions has significant disadvantages—namely, imposing additional burden and constraining issuer innovation and consumer choice.

We further note that the FFEs operate under constraints that differ substantially from other contexts in which standardized plan options have been implemented, such as in States with a State Exchange model type. In particular, there is a significant degree of heterogeneity on the FFEs (for example, in terms of consumer demographics, health care needs, and preferences) given that there are currently 28 States with an FFE model type, and it is impractical to design a standardized plan option offering that issuers must conform to regardless of the market dynamics in a given location. We further do not believe that it is feasible for HHS to more precisely tailor specific plan designs and requirements to the unique circumstances and market conditions in each State and update these plan designs on an annual basis. Finally, we do not believe that such an approach would be warranted in the first place given the limited efficacy that these policies have demonstrated in the last several years.

Relatedly, the strategy of requiring issuers to offer standardized plan options as well as differentially displaying these plans on *HealthCare.gov* and the DE pathways (which is discussed in greater detail later in this section) was intended to enhance plan comparability for consumers navigating the plan selection process. Theoretically, requiring issuers to offer plans with standardized cost sharing parameters would facilitate the plan selection process by reducing the number of factors that consumers must consider when evaluating all available plan options—since a certain subset of plans would have the same cost sharing parameters. As a result of having access to plans with standardized cost sharing parameters, consumers would

¹⁷⁴ “Plan Year 2025 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces.” October 25, 2024. <https://www.cms.gov/files/document/2025-qhp-premiums-choice-report.pdf>.

theoretically have the ability to shift their focus to other important plan attributes, such as premiums, benefit coverage, provider networks, formularies, and quality ratings, during the plan selection process.

However, based on our 4 plan years of experience (PY 2023 through PY 2026) administering these standardized and non-standardized plan option policies, we have found that in practice, given that standardized plan options continue to be offered alongside non-standardized plan options, whether a particular plan offering was a standardized or non-standardized plan option served as yet another variable that consumers must consider during the plan selection process, adding an additional layer of complication. Furthermore, in our experience, we have found when consumers are faced with a large number of heterogeneous plan options, they continue to rely primarily on premiums, networks, and issuer brand—meaning that standardizing cost sharing parameters by itself (especially when doing so only for a subset of all available plan options) fails to meaningfully reduce decision complexity for consumers.

We also considered more recent literature examining the effects of offering standardized plan options alongside non-standardized plan options. We highlight a 2024 study demonstrating that the introduction of “Simple Choice” plans in PY 2017 and PY 2018 was associated with a reduction in gross premiums.¹⁷⁵ Although we acknowledge that these findings contribute to a broader understanding of how plan standardization may influence issuer pricing behavior under certain market conditions, we emphasize that the authors caution against extrapolating these effects beyond the specific context in which they arose. In particular, the study period coincided with a period of pronounced market instability, characterized by significant issuer exits, rapidly increasing market concentration, and the defunding of cost-sharing reduction payments. The authors concluded that observed premium effects were likely attributable, in part, to issuer uncertainty during this volatile period and state that similar policies implemented in more stable environments would have likely yielded smaller effects.

The study further documented that premium impacts dissipated following

the discontinuation of the policy after PY 2018, with no evidence of persistent effects in subsequent years—suggesting that plan standardization, absent continued market disruption or policy-induced uncertainty, did not result in durable structural changes to issuer pricing behavior. We consider this lack of persistence particularly relevant when evaluating the continued necessity of standardized plan option requirements and associated non-standardized plan option limits within the current market context—especially with the increased burden, inhibition of issuer innovation, and constrained consumer choice associated with these policies.

Beyond this more recent literature, we note that for each plan year since these requirements were introduced in PY 2023, there has consistently been a comparatively low uptake of standardized plan options relative to corresponding non-standardized plan options. In fact, only 20 percent of total enrollment in the FFEs and SBE-FPs was in standardized plan options in PY 2023, 33 percent in PY 2024, and 33 percent in PY 2025, even with the reduction in non-standardized plan option offerings due to the introduction of the non-standardized plan option limit of four in PY 2024 and its reduction to two in PY 2025.¹⁷⁶

Relatedly, 25 percent of total plan offerings were standardized plan options in PY 2023, 28 percent in PY 2024, and 31 percent in PY 2025.¹⁷⁷ Thus, total enrollment in standardized plan options was lower compared to what would be expected based on the total proportion of plans that are standardized plan options in PY 2023 and only increased to be approximately equal with what would be expected as the non-standardized plan option limit was introduced in PY 2024 and reduced in PY 2025. The consistently low proportion of consumers enrolled in standardized plan options over the years suggests that these plans fail to appeal to consumers compared to corresponding non-standardized plan options—or at the very least that consumers are unable to perceive a meaningful difference between standardized and non-standardized plan options.

Moreover, even among active plan selections (which includes both consumers currently enrolled in a QHP

that are making a new plan selection as well as consumers who are enrolling in any QHP offered through an FFE or SBE-FP for the first time, but excludes consumers who are auto-reenrolled in their current QHP from one year to the next), only 18 percent of consumers in the FFEs and SBE-FPs actively selected standardized plan options in PY 2023, 26 percent in PY 2024, and 18 percent in PY 2025.¹⁷⁸ This comparatively lower than expected rate of active plan selections for standardized plan options further suggests that these plans have consistently failed to appeal to consumers—or at the very least that it is difficult for consumers to meaningfully distinguish standardized from non-standardized plan options or ascertain the benefits of enrolling in such plans.

We note that this consistently low uptake of standardized plan options by FFE and SBE-FP consumers for the last several plan years, as measured by both the proportion of total enrollment in as well as active selections of these plans, has occurred despite the fact that a full suite of differential display features visually distinguishes these plans from corresponding non-standardized plan options on both *HealthCare.gov* and the DE pathways, in accordance with the differential display requirements at §§ 155.205(b)(1), 155.220(c)(3)(i)(H), and 156.265(b)(3)(iv).

Under the present form of differential display on *HealthCare.gov* (and the corresponding forms of differential display on the DE pathways), standardized plan options are labelled “easy pricing” plans, and an accompanying icon visually distinguishes these plans from non-standardized plan options. Accompanying hover text also explains both the benefits and distinctive features of these plans and how these plans differ from non-standardized plan options. An additional “quick tip” feature provides greater detail regarding the benefits of standardized plan options—including that these plans contain pre-deductible coverage and that they are easier to compare because they have the same MOOP values, deductibles, and cost sharing within their respective health plan categories. Finally, consumers have the option to select a filter to view only standardized plan options among all available plan options—which excludes non-standardized plan options from the list of search results.

¹⁷⁵ Hopkins, B., and Lyons, S. (2024, December 13). “The Effect of Offering ‘Simple Choice’ Plans on Premiums in the Federally Facilitated ACA Marketplaces.” https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5084737.

¹⁷⁶ “Marketplace Open Enrollment Period Public Use Files.” <https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products>.

¹⁷⁷ “Plan Year 2025 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces.” October 25, 2024. <https://www.cms.gov/files/document/2025-qhp-premiums-choice-report.pdf>.

¹⁷⁸ “Marketplace Open Enrollment Period Public Use Files.” <https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products>.

Even with this full suite of differential display features that visually distinguishes standardized plan options from non-standardized plan options on *HealthCare.gov* and the DE pathways, non-standardized plan options are consistently the more popular option for consumers, with a greater proportion of total enrollment in and active plan selections of non-standardized plan options each plan year since these requirements were introduced in PY 2023. Without this full suite of differential display features that visually distinguishes standardized plan options from non-standardized plan options, standardized plan options would likely constitute an even lower proportion of both total enrollment and active plan selections, further suggesting that these plans have consistently failed to appeal to consumers compared to non-standardized plan options.

Furthermore, total enrollment in and active selections of standardized plan options would be conceivably lower without the progressively more stringent non-standardized plan option limits (since there would have been a greater number of non-standardized plan options for consumers to select from). Given the consistently low proportion of total enrollment in and active selections of standardized plan options each plan year since these requirements were introduced in PY 2023, we no longer believe that the benefits of requiring issuers to offer these plans outweighs the burden of requiring them doing so—especially since employing this strategy has failed to achieve our originally articulated objectives.

Specifically, the burden of requiring issuers to offer these plans includes creating new plans that have cost sharing parameters that conform with the designs specified by HHS in annual rulemaking, the burden for both issuers and HHS in certifying a greater number of plans during QHP certification each year (standardized plan options as well as non-standardized plan option limit exceptions process plans), and the burden on issuers correspondingly adjusting portfolios of plan offerings (non-standardized plan options).

In addition to enhancing the consumer experience, increasing consumer understanding, and simplifying the decision-making process for consumers purchasing coverage through the Exchanges, as we stated in the 2023 Payment Notice (87 FR 27311), another original objective of requiring FFE and SBE-FP QHP issuers to offer these standardized plan options was combatting discriminatory benefit designs. We attempted to achieve this

objective in our approach to the design of these plans.

In particular, each plan year since we introduced standardized plan options in PY 2023, in our design of these plans, we exempted the following frequently utilized benefit categories from the deductible at every metal level: primary care visits, specialist visits, mental health and substance use outpatient office visits, speech therapy, physical and occupational therapy, and generic drugs—with an increasing number of benefit categories being exempted from the deductible at higher metal levels. We adopted this approach since exempting benefits from the deductible reduces barriers to access for these services and makes it easier (that is, less expensive) for consumers to obtain these health care services. We also attempted to combat discriminatory designs by requiring flat copayments as the form of cost sharing instead of coinsurance rates for a greater number of benefit categories. We incorporated this plan design feature to enhance consumer certainty and reduce the risk of unexpected financial costs when obtaining health care.

We continue to recognize that subjecting additional benefit categories to the deductible and including coinsurance rates as the form of cost sharing instead of flat copayments may make it more difficult for consumers to obtain the corresponding health care services. However, we acknowledge that these design features (specifically, pre-deductible benefit coverage and flat copayments for the aforementioned benefit categories) are routinely included for the corresponding benefit categories in many non-standardized plan option offerings, and with similar cost sharing amounts. This is because, as we explained in the 2023 Payment Notice (87 FR 27319), we design these standardized plan options to mirror the most popular plan design features of QHPs offered through the FFEs and SBE-FPs in previous plan years.

More specifically, regarding the methodology we employ to design these plans, in the 2024 Payment Notice (88 FR 25848), we explained that we design these standardized plan options by selecting the most popular cost sharing type for each benefit category (which is a copayment or coinsurance rate that is either subject to or exempt from the deductible); selecting enrollee-weighted median cost sharing values for each of these benefit categories (as well as for the annual limitation on cost sharing and deductible values) based on refreshed cost sharing and enrollment data; modifying these plans to be able to accommodate State cost sharing laws;

and decreasing the AVs for these plan designs to be at the floor of each AV *de minimis* range, primarily by increasing deductibles.

Employing this methodology in the annual design of these standardized plan options has resulted in these plans being comparable in many respects to corresponding non-standardized plan options that millions of consumers are already enrolled in. This further means that pre-deductible benefit coverage and flat copayments as the form of cost sharing instead of coinsurance rates are design features that are not exclusive to standardized plan options. Instead, these plan design features largely reflect market consensus and do not substantially deviate from this consensus. The fact that these plan design features are already routinely included in many non-standardized plan options means that we could combat discriminatory plan designs (another originally articulated objective for reintroducing the requirement for issuers to offer standardized plan options) without subjecting both issuers and HHS to the increased burden of requiring issuers to offer and submit certification applications for these plans that largely reflect market consensus and existing offerings.

Furthermore, we believe that incorporating coinsurance rates as the form of cost sharing for particular benefits instead of flat copayments can serve an important role in plan design—by promoting greater engagement on behalf of consumers in evaluating health care options and by providing issuers additional levers to control costs, thereby helping to manage rising premiums. We believe incorporating coinsurance rates as the form of cost sharing promotes greater engagement on behalf of consumers by encouraging consumers to more comprehensively research the full costs for particular services from different providers. We thus believe that employing coinsurance rates instead of flat copayments as the form of cost sharing for particular benefits is not in itself necessarily discriminatory in nature and is an important factor in controlling costs and by extension counteracting increasing premiums.

Additionally, the combination of standardized plan option requirements as well as non-standardized plan option limits has increasingly constrained issuers' ability to offer a sufficiently broad range of plans for several plan years. This includes plans with tiered provider networks, plans with separate medical and drug deductibles (as opposed to integrated medical and drug deductibles), plans with separate

medical and drug MOOPs (as opposed to integrated medical and drug MOOPs), HSA-eligible high-deductible health plans (HDHPs), and plans with more than four tiers of prescription drug coverage. Issuers have not been able to offer plans with these design features as standardized plan options since doing so would deviate from the required cost sharing parameters specified by HHS in rulemaking. Thus, removing this suite of requirements would grant issuers additional flexibility to once more vary plans along these parameters, which would enhance both issuer innovation in plan design as well as the degree of consumer choice.

d. Plan Discontinuations

However, we recognize that some issuers and consumers may still find certain features of these plan designs valuable. This is why we are not proposing to require issuers to discontinue their standardized plan option offerings altogether. Instead, under this proposed approach, FFE and SBE-FP QHP issuers would be permitted to choose whether to discontinue these offerings altogether or to continue offering them with either the same or modified cost sharing, while we simultaneously discontinue the differential display of these plans on *HealthCare.gov* and the DE pathways.

Under our proposed approach, if issuers wished to discontinue their standardized plan option offerings altogether, they would be permitted to do so, and enrollees in these plans would be crosswalked to a different plan in accordance with the crosswalk hierarchy at § 155.335(j). Additionally, if issuers wished to continue offering these standardized plan options with the same cost sharing, they would also be permitted to do so, and enrollees in these plans would continue to be auto-reenrolled in these plans from one plan year to the next. However, these plans would no longer be visually distinguished as standardized plan options on *HealthCare.gov* or the DE pathways. Finally, if issuers wished to continue offering these standardized plan options but also wished to modify these plans' cost sharing structures, they would be permitted to do so, but these issuers would continue to be subject to the requirements under the definition of "plan" at § 144.103 and to the uniform modification requirements at § 147.106.

In most scenarios where an issuer modifies the cost sharing structure of one of its standardized plan option offerings, the newly modified plan that was formerly the standardized plan option would be considered a new plan and would therefore require a new plan

ID. In this scenario, enrollees would be crosswalked from the discontinued plan to another plan in accordance with the crosswalk hierarchy at § 155.335(j). These enrollees could be crosswalked into the newly modified plan that was formerly the standardized plan option, or an entirely different plan altogether, depending on the unique circumstances in each county.

However, under the definition of "plan" at § 144.103, a State may permit issuers to make greater changes to a plan's cost sharing while still permitting that plan to be considered the same plan—thus maintaining the same plan ID. Furthermore, under § 147.106(e)(3)(iv), as long as the variation in cost sharing is solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level (and other applicable requirements under § 147.106(e) are met), the modifications could be considered uniform (thus, a viable exception to guaranteed renewability).

In the scenario where an issuer modifies what was formerly a standardized plan option's cost sharing structure while maintaining the same plan ID, enrollees in the plan would be auto-reenrolled from one plan year to the next. In either case, whether the modification of a former standardized plan option's cost sharing results in that plan being considered the same or a different plan, enrollees would be crosswalked in accordance with the crosswalk hierarchy at § 155.335(j), and that plan would no longer be differentially displayed as a standardized plan option on *HealthCare.gov* or the DE pathways. Adopting this approach would effectively remove the standardization component of this suite of policies while minimizing the risk of disruption for consumers enrolled in and issuers of these plans.

Altogether, we believe that employing this suite of policies for the last several plan years has failed to achieve the originally articulated objectives of enhancing the consumer experience, increasing consumer understanding, and combatting discriminatory benefit designs. This failure is demonstrated by exacerbated plan proliferation in PY 2023 and the comparatively low uptake of these standardized plan options despite the full suite of differential display features that visually distinguishes these plans from corresponding non-standardized plan options. Finally, these standardized plan options reflect market consensus and incorporate the most popular plan design features of many existing non-standardized plan option offerings,

meaning these plan design features are not exclusive to standardized plan options.

Given that imposing these requirements has increased burden for both issuers and HHS (for example, by requiring issuers to create and submit certification applications for additional plans) and unnecessarily constrained issuers in plan design while failing to achieve our originally articulated objectives, we no longer believe that the advantages of employing this strategy outweigh the disadvantages of doing so. We therefore believe that discontinuing the full suite of standardized plan options policies (in conjunction with discontinuing non-standardized plan option limits and exceptions, discussed in section III.E.9 of this proposed rule) would reduce issuer and HHS burden and provide more flexibility for issuers to innovate in plan design.

Accordingly, this proposal would remove the following from our regulations effective beginning PY 2027: the definition of "standardized option" at § 155.20; all requirements pertaining to standardized plan options at § 156.201 (the requirements for FFE and SBE-FP QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one another at paragraph (c)); the differential display of standardized plan options on *HealthCare.gov* at § 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE-FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv). This proposal would also entail the cessation of the annual design and publication of these plans in the applicable Payment Notice rulemaking for each plan year.

We seek comment on this proposal. We also seek comment on potential regulatory alternatives that would allow us to achieve the same goals of simplifying the plan selection process and reducing burden without discontinuing this suite of policies in its entirety. In particular, we seek comment on continuing to require issuers to offer standardized plan options only at particular metal levels, such as the bronze and silver metal levels (instead of at every metal level at which they offer non-standardized plan options). We also seek comment on requiring issuers to offer standardized plan options only in certain service areas in which they offer a certain number of non-standardized plan options. We also seek comment on transitioning from

requiring issuers to offer these standardized plan options to once more allowing issuers to voluntarily offer them—as was the approach with the previous iteration of the policy—while we continue to maintain the differential display of these plans on *HealthCare.gov* and the DE pathways.

9. Non-Standardized Plan Option Limits (§ 156.202)

We propose to exercise our authority under sections 1311(c)(1) and 1321(a)(1)(B) of the Affordable Care Act to discontinue non-standardized plan option limits and exceptions at § 156.202 effective beginning in PY 2027. Section 1311(c)(1) of the Affordable Care Act directs the Secretary to establish criteria for the certification of health plans as QHPs. Section 1321(a)(1)(B) of the Affordable Care Act directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the Affordable Care Act, which includes section 1311, for, among other matters, the offering of QHPs through such Exchanges.

In the 2023 Payment Notice proposed rule (87 FR 27345 through 27347), we solicited comment on choice architecture and preventing plan choice overload. In this comment solicitation, we noted that although we continued to prioritize competition and choice on the FFEs and SBE-FPs, we were concerned about plan choice overload, which can result when consumers have too many choices in plan options. We referred to a 2016 report by the RAND Corporation reviewing over 100 studies which concluded that having too many health plan choices can lead to poor enrollment decisions due to the difficulty consumers face in processing complex health insurance coverage information.¹⁷⁹ We also referred to a study of consumer behavior in Medicare Part D, Medicare Advantage, and Medigap that demonstrated that a choice of 15 or fewer plans was associated with higher enrollment rates, while a choice of 30 or more plans led to a decline in enrollment rates.¹⁸⁰

With this concern in mind, in the 2023 Payment Notice proposed rule (87 FR 27345 through 27347), we explained that we were interested in exploring possible methods of improving choice

architecture and preventing plan choice overload. We expressed interest in exploring the feasibility and utility of limiting the number of non-standardized plan options that QHP issuers could offer through the FFEs and SBE-FPs as one option to reduce the risk of plan choice overload and to further streamline and optimize the plan selection process for consumers on the FFEs and SBE-FPs.

Accordingly, we sought comment on the impact of limiting the number of non-standardized plan options that issuers can offer through the FFEs and SBE-FPs, on effective methods to achieve the goal of reducing the risk of plan choice overload and to further streamline and optimize the plan selection process for consumers on the FFEs and SBE-FPs, the advantages and disadvantages of these methods, and if there were alternative methods not considered. We also sought comment on evidence-based approaches to enhancing choice architecture within the FFEs and SBE-FPs.

In response to this comment solicitation, in the 2023 Payment Notice (87 FR 27345 through 27347), we highlighted many commenters' specific recommendations regarding modifying choice architecture to enhance the consumer shopping experience. We also noted that several commenters supported limiting the number of QHPs that could be offered through the FFEs and SBE-FPs, explaining that adopting such an approach could lower costs for consumers, set standards for plan quality, and foster robust competition among issuers seeking entry into the FFEs and SBE-FPs. Conversely, we noted that several commenters opposed limiting the number of QHPs that could be offered through the FFEs and SBE-FPs, explaining that doing so would limit issuer flexibility to design plans based on consumer preferences and needs. We also noted that several commenters supported resuming an updated version of the meaningful difference standard, which was previously codified at § 156.298.

In the 2024 Payment Notice (88 FR 25855 through 25865), at § 156.202, we introduced limits on the number of non-standardized plan options that issuers of QHPs can offer through Exchanges on the Federal platform (including SBE-FPs) to four non-standardized plan options per product network type (as described in the definition of "product" at § 144.103), metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage, in any service area for PY 2024, and two for PY 2025 and subsequent plan years.

In the 2024 Payment Notice (88 FR 25856 through 25857), we explained that we introduced non-standardized plan option limits for several reasons. We explained that there had been a sizeable increase in the weighted average number of total QHPs on the FFEs and SBE-FPs available per enrollee and plans offered per issuer in recent years. We stated that with this continued plan proliferation, we believed that limiting the number of non-standardized plan options that FFE and SBE-FP issuers of QHPs could offer through the FFEs and SBE-FPs would greatly enhance the consumer experience on *HealthCare.gov*. We further explained that we made several enhancements to the consumer experience and choice architecture on *HealthCare.gov* in conjunction with introducing non-standardized plan option limits.

We explained that we believed that adopting both of these measures (in conjunction with requiring issuers to offer standardized plan options) would be the most effective method to streamline the plan selection process and to reduce the risk of plan choice overload for consumers on *HealthCare.gov*. We also explained that we believed that directly limiting the number of non-standardized plan options that issuers could offer through the FFEs and SBE-FPs was a more effective approach in reducing the risk of choice overload than reinstituting a revised version of the meaningful difference standard, which had previously demonstrated limited efficacy.

In the 2025 Payment Notice (89 FR 26362 through 26375), we introduced an exceptions process allowing issuers to offer additional non-standardized plan options exceeding the limit of two per product network type, metal level, inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage, and service area for PY 2025 and subsequent plan years, if issuers demonstrate that these additional non-standardized plans have specific design features that would substantially benefit consumers with chronic and high-cost conditions. As part of this exceptions process, each issuer must demonstrate how cost sharing pertaining to the treatment of the chronic and high-cost condition would be reduced by 25 percent or more relative to that issuer's other non-standardized plan option offerings in the same product network type, metal level, inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage, and service area.

¹⁷⁹ Taylor EA, Carman KG, Lopez A, Muchow AN, Roshan P, and Eibner C. Consumer Decision-making in the Health Care Marketplace. RAND Corporation. 2016.

¹⁸⁰ Chao Zhou and Yuting Zhang, "The Vast Majority of Medicare Part D Beneficiaries Still Don't Choose the Cheapest Plans That Meet Their Medication Needs." *Health Affairs*, 31, no. 10 (2012): 2259–2265.

In the 2025 Payment Notice (89 FR 26366), we explained that we introduced this exceptions process for several reasons. Specifically, we noted that several commenters explained that reducing the non-standardized plan option limit from four in PY 2024 to two in PY 2025 would cause FFE and SBE-FP issuers to discontinue non-standardized plans with lower enrollment, which would likely be plans with designs that are attractive to a smaller number of enrollees who have relatively less common and high-cost health care needs. Commenters further explained that many of the plans that would likely be discontinued would be those that benefit consumers with chronic and high-cost conditions. Commenters explained that permitting issuers to offer additional non-standardized plan options that would provide targeted coverage specifically for medically complex populations with chronic and high-cost conditions would allow for more targeted innovation by issuers while still achieving the reduction in plan proliferation HHS has sought.

Under our proposed approach in this rulemaking, issuers would no longer be subject to the non-standardized plan option limit of two per product network type, metal level, inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage, in any service area at § 156.202(a) through (c), for PY 2027 and subsequent years. Issuers would similarly no longer be required to utilize the non-standardized plan option limit exceptions process at § 156.202(d) through (e) to offer additional non-standardized plan options given that they would no longer be limited in the number of non-standardized plan options they may offer. We would correspondingly remove § 156.202 from our regulations.

Similar to our proposal to discontinue the requirement for issuers to offer standardized plan options (as well as the differential display of these plans) but not to require issuers to discontinue these existing offerings altogether, we propose to discontinue the non-standardized plan option limits and exceptions process but not require issuers to discontinue these existing offerings altogether. Instead, under this proposal, issuers would be permitted to choose whether to discontinue the chronic and high-cost condition plans originally offered through the non-standardized plan option limit exceptions process altogether or continue offering them with either the same or modified cost sharing.

Under this proposed approach, if issuers wished to discontinue the chronic and high-cost condition plans originally offered through the non-standardized plan option limit exceptions process altogether, they would be permitted to do so, and enrollees in these plans would be crosswalked to a different plan in accordance with the crosswalk hierarchy at § 155.335(j).

Additionally, if issuers wished to continue offering the chronic and high-cost condition plans originally offered through the exceptions process with the same cost sharing structures, they would also be permitted to do so, and enrollees in these plans would continue to be auto-reenrolled in these plans from one plan year to the next. Finally, if issuers wished to continue offering the chronic and high-cost condition plans originally offered through the exceptions process but also wished to modify these plans' cost sharing structures, they would be permitted to do so, but these issuers would continue to be subject to the requirements under the definition of "plan" at § 144.103 and to the uniform modification requirements at § 147.106.

In most scenarios where an issuer modifies the cost sharing structure of one of its chronic and high-cost condition plans originally offered through the exceptions process (or other non-standardized plan options not associated with the non-standardized plan option limit exceptions process that they currently offer subject to the existing non-standardized plan option limit), the newly modified plan that was formerly the exceptions process plan would be considered a new plan and would therefore require a new plan ID. In this scenario, enrollees would be crosswalked from the discontinued plan to another plan in accordance with the crosswalk hierarchy at § 155.335(j). These enrollees could be crosswalked into the newly modified plan that was formerly the exceptions process plan, or an entirely different plan altogether, depending on the unique circumstances in each county.

However, under the definition of "plan" at § 144.103, a State may permit issuers to make greater changes to a plan's cost sharing while still permitting that plan to be considered the same plan—thus maintaining the same plan ID. Furthermore, under § 147.106(e)(3)(iv), as long as the variation in cost sharing is solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level (and other applicable requirements under § 147.106(e) are met), the modifications could be

considered uniform (thus, a viable exception to guaranteed renewability).

In the scenario where an issuer modifies what was formerly an exceptions process plan's cost sharing structure while maintaining the same plan ID, enrollees in the plan would be auto-reenrolled from one plan year to the next. In either case, whether the modification of a former exceptions process plan's cost sharing results in that plan being considered the same or a different plan, enrollees would be crosswalked in accordance with the crosswalk hierarchy at § 155.335(j), including reenrollment, if applicable.

We propose this approach for several reasons. As discussed earlier in this section and in the section of this proposed rule addressing proposed updates to § 156.201, for the last several plan years, we have employed a multi-faceted strategy in an attempt to streamline the consumer experience. This strategy entailed requiring issuers to offer standardized plan options, requiring these plans to meaningfully differ from one another, differentially displaying these plans, making additional enhancements to choice architecture on *HealthCare.gov*, limiting the number of non-standardized plan options that issuers can offer through the FFEs and SBE-FPs, and permitting issuers to offer additional non-standardized plan options beyond this limit if issuers demonstrate that these plans would substantially benefit consumers with chronic and high-cost conditions.

As we noted in the preamble section of this proposed rule addressing the proposed removal of § 156.201, we have accumulated 4 plan years of experience (PY 2023 through PY 2026) administering this strategy. This cumulative experience provides us with a comprehensive and nuanced perspective regarding weighing both the advantages and disadvantages of employing this strategy, whether this strategy has aligned with our originally articulated objectives, and whether this strategy has yielded the intended results.

Similar to our view on the ineffectiveness of employing standardized plan option requirements, based on this experience, we have concluded that imposing non-standardized plan option limits and permitting exceptions to this limit for chronic and high-cost condition plans is an ineffective strategy in counteracting plan proliferation and enhancing the consumer experience on *HealthCare.gov*, the originally articulated objectives of employing our

non-standardized plan option limits and related exceptions process policies.

This is because requiring issuers to offer additional plans in the form of standardized plan options increased the weighted average number of total plans available per enrollee from 108 in PY 2022, the year before the introduction of the requirement to offer standardized plan options, to 114 in PY 2023, the year in which this requirement was introduced, with most of this increase in plans being comprised of standardized plan options. Furthermore, plan proliferation as measured by the weighted average number of total plans offered per issuer (which is derived by dividing the weighted average number of total plans available per enrollee by the weighted average number of total issuers per enrollee) increased from 16.9 in PY 2022 to 17.3 in PY 2023—meaning each issuer on average tended to offer a higher number of plans after the imposition of the requirement to offer standardized plan options than the year before this requirement was made effective.¹⁸¹

Furthermore, even with the introduction of the non-standardized plan option limit of four in PY 2024 and its reduction to two as well as the introduction of the exceptions process in PY 2025, the net impact of both the requirement to offer standardized plan options as well as the subsequent imposition of non-standardized plan option limits and exceptions on the weighted average number of total plans available per enrollee and the weighted average number of total plans offered per issuer (including both standardized and non-standardized plan options) was marginal—despite the substantially increased regulatory complexity and the associated burden of creating and submitting certification applications for new plans (standardized plan options) and correspondingly adjusting existing portfolios of plan offerings (non-standardized plan options).

Specifically, the weighted average number of total plans available per enrollee was reduced from 114 in PY 2023 to 100 in PY 2024 (when the non-standardized plan option limit of four was introduced) and remained constant at 100 in PY 2025 (when the limit was reduced to two and the non-standardized plan option limit exceptions process was introduced). Relatedly, the weighted average number of total plans offered per issuer decreased from 17.3 in PY 2023 to 14.7

in PY 2024 and 13.7 in PY 2025. Thus, in PY 2022, the year before this suite of policies was introduced, there was a weighted average number of 108 total plans available per enrollee and a weighted average number of 16.9 total plans offered per issuer, whereas in PY 2025 (after several consecutive years of imposing new layers of requirement), these same measures were 100 and 13.7, respectively.

We do not believe that the marginal net reductions in the weighted average number of total plans available per enrollee and the weighted average number of total plans offered per issuer achieved by introducing this suite of standardized plan option and non-standardized plan option limit and exceptions requirements warrant imposing additional burden, impeding issuer innovation in plan design, and constraining consumer choice—especially given that these reductions are largely indiscernible to consumers during the plan selection process. This is especially true given that these metrics continue to remain significantly elevated compared to only several plan years ago. Specifically, in PY 2020, the weighted average number of total plans available per enrollee was 39, and the weighted average number of total plans offered per issuer was 11.1.

Thus, the primary metric by which we have evaluated plan proliferation (the weighted average number of total QHPs available per enrollee in the FFEs and SBE-FPs) has remained relatively constant despite the imposition of multiple layers of requirements from PY 2023 to PY 2025 (specifically, the requirement to offer standardized plan options in PY 2023, non-standardized plan option limits in PY 2024, and the reduction of this limit and the introduction of the exceptions process in PY 2025). Further, the imposition of these requirements substantially increased burden for both issuers and HHS (that is, the burden associated with issuers creating and submitting certification applications for additional plans that would otherwise not be created and offered and HHS reviewing and certifying these additional plans). This suite of policies creates additional fixed costs for issuers, introducing market inefficiencies. Finally, the imposition of these requirements caused a significant degree of market disruption—as reflected by the substantial number of plan discontinuations and the high number of enrollees impacted by these discontinuations, as is discussed in greater detail later in this section.

We refer readers to the section III.E.8 of this proposed rule addressing the

proposal to discontinue standardized plan options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv)) for a detailed discussion of relevant literature we also considered in our approach to the proposal to discontinue non-standardized plan option limits and exceptions.

Relatedly, the strategy of requiring issuers to offer standardized plan options, differentially displaying these plans on *HealthCare.gov* and the DE pathways, and limiting the number of non-standardized plan options that issuers can offer was intended to enhance plan comparability for consumers navigating the plan selection process. Theoretically, requiring issuers to offer plans with standardized cost sharing parameters would facilitate the plan selection process by reducing the number of factors that consumers must consider when evaluating all available plan options—since a certain subset of plans would have the same cost sharing parameters. As a result of having access to plans with standardized cost sharing parameters, consumers would theoretically have the ability to shift their focus to other important plan attributes, such as premiums, benefit coverage, provider networks, formularies, and quality ratings, during the plan selection process.

However, in practice, given that standardized plan options continue to be offered alongside non-standardized plan options, whether a particular plan option was a standardized or non-standardized plan option served as yet another variable that consumers must consider during the plan selection process. Furthermore, in our experience, we have found when consumers are faced with a large number of heterogeneous plan options, they continue to rely primarily on premiums, networks, and issuer brand—meaning that standardizing cost sharing parameters alone (especially when doing so only for a subset of all available plan options) fails to meaningfully reduce decision complexity for consumers.

In addition, we believe the fact that the consistently high proportion of total FFE and SBE-FP enrollment in as well as active selections (which includes both consumers currently enrolled in a QHP who are making a new plan selection as well as consumers who are enrolling in any QHP offered through the FFEs and SBE-FPs for the first time, but excludes consumers who are auto-reenrolled in their current QHP from one year to the next) of non-standardized plan options reflects the

¹⁸¹ “Plan Year 2025 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces.” October 25, 2024. <https://www.cms.gov/files/document/2025-qhp-premiums-choice-report.pdf>.

fact that consumers value the full range of choice within these plan offerings.

Specifically, 80 percent of all consumers in the FFEs and SBE-FPs were enrolled in non-standardized plan options in PY 2023, 67 percent in PY 2024, and 67 percent in PY 2025. Furthermore, non-standardized plan options constituted 82 percent of FFE and SBE-FP active selections in PY 2023, 74 percent in PY 2024, and 82 percent in PY 2025.¹⁸² Relatedly, 75 percent of total plan offerings were non-standardized plan options in PY 2023, 72 percent in PY 2024, and 69 percent in PY 2025.¹⁸³ Thus, total enrollment in non-standardized plan options was higher compared to what would be expected based on the total proportion of plans that were non-standardized plan options in PY 2023 and within the expected range of deviation for PY 2024 and PY 2025. Furthermore, active plan selections for non-standardized plan options were higher compared to what would be expected based on the total proportion of plans that were non-standardized plan options in PY 2023, PY 2024, and PY 2025.

The consistently low proportion of consumers enrolled in standardized plan options over the years suggests that these plans fail to appeal to consumers compared to corresponding non-standardized plan options—or at the very least that consumers are unable to perceive a significant difference between standardized and non-standardized plan options. This is despite the full suite of differential display features for standardized plan options on *HealthCare.gov* and the DE pathways that visually distinguish standardized plan options from non-standardized plan options and effectively steer consumers into standardized plan options and away from corresponding non-standardized plan options in accordance with §§ 155.205(b)(1), 155.220(c)(3)(i)(H), and 156.265(b)(3)(iv).

Without this full suite of differential display features that visually distinguishes standardized plan options from non-standardized plan options, the proportion of FFE and SBE-FP total enrollment in and active selections of non-standardized plan options would likely be considerably higher. We believe consumers' demonstrated preference for non-standardized plan options (as measured by both total

enrollment and active plan selections) is in large part due to the fact that there is a greater degree of choice and variety in these plan offerings compared to standardized plan options.

Indeed, as we stated in the 2024 Payment Notice (88 FR 25860), many commenters who opposed imposing non-standardized plan option limits emphasized the importance of permitting issuers to maintain a diverse range of plan offerings as a mechanism to maximize the degree of consumer choice. These commenters specifically explained that imposing non-standardized plan option limits would force issuers to drastically reduce the unique plan designs they have thoughtfully developed to best serve their members' health care needs, which would in turn force consumers into a "one-size fits all" benefit offering.

Relatedly, the combination of standardized plan option requirements as well as non-standardized plan option limits has increasingly constrained issuers' ability to offer a sufficiently broad range of plans for several plan years. This includes plans with tiered provider networks, plans with separate medical and drug deductibles (as opposed to integrated medical and drug deductibles), plans with separate medical and drug MOOPs (as opposed to integrated medical and drug MOOPs), HSA-eligible high-deductible health plans (HDHPs), and plans with more than four tiers of prescription drug coverage.

Issuers have been constrained by these requirements since they have been forced to discontinue offerings to comply with the non-standardized plan option limit. The plans that issuers have discontinued have generally been those with lower enrollment—which has often been plans with the aforementioned design features. Thus, removing this suite of requirements would grant issuers additional flexibility to once more vary plans along these parameters, which would enhance consumer choice. Removing this suite of requirements would also simultaneously reduce the issuer burden associated with creating and submitting additional QHP certification applications as well as HHS burden in reviewing and approving these applications.

Regarding market disruption that arose from issuers discontinuing plans to conform to the non-standardized plan option limit, we acknowledge that there is a baseline rate of routine plan discontinuations on the FFEs and SBE-FPs that occur for a range of reasons unrelated to the imposition of new requirements. For example, in the FFEs and SBE-FPs from PY 2020 to PY 2021,

17 percent of plan-county combinations were discontinued, affecting 10 percent of enrollees.¹⁸⁴ Additionally, in the FFEs and SBE-FPs from PY 2021 to PY 2022, 22 percent of plan-county combinations were discontinued, affecting 13 percent of enrollees. Thus, based on measures from the 2 plan years immediately preceding the introduction of the standardized plan option requirements in PY 2023, the baseline rate of routine plan-county discontinuations in the FFEs and SBE-FPs ranged from 17 to 22 percent, while the corresponding baseline rate of enrollees impacted by these discontinuations ranged from 10 to 13 percent.

However, from PY 2022 to PY 2023, when the requirement for FFE and SBE-FP QHP issuers to offer standardized plan options was introduced, 35 percent of plan-county combinations in the FFEs and SBE-FPs were discontinued, affecting 19 percent of enrollees. From PY 2023 to PY 2024, when the non-standardized plan option limit of four was introduced, 24 percent of plan-county combinations in the FFEs and SBE-FPs were discontinued, affecting 17 percent of enrollees. Finally, from PY 2024 to PY 2025, when the non-standardized plan option limit was reduced from four to two, 24 percent of plan-county combinations in the FFEs and SBE-FPs were discontinued, affecting 15 percent of enrollees on the FFEs and SBE-FPs.

Thus, employing these standardized plan option, non-standardized plan option limit, and non-standardized plan option limit exceptions process policies coincided with an increase in plan-county discontinuations of 18 percent and an increase in enrollees affected by these discontinuations of 9 percent compared to the years immediately preceding the introduction of these requirements (specifically between PY 2020 and 2021 and when the requirement to offer standardized plan options was introduced from PY 2022 to PY 2023). Ultimately, requiring issuers to discontinue other existing plans (to comply with the new non-standardized plan option limits) increased plan-county discontinuations and the number of enrollees affected by these discontinuations.

¹⁸⁴ Plan-county combinations are the count of unique plan ID and FIPS code combinations. This measure was used because a single plan may be available in multiple counties, and specific limits on non-standardized plan options may have different impacts on one county where there are four plans of the same product network type and metal level versus another county where there are only two plans of the same product network type and metal level, for example.

¹⁸² "Marketplace Open Enrollment Period Public Use Files." <https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products>.

¹⁸³ "Plan Year 2025 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces." October 25, 2024. <https://www.cms.gov/files/document/2025-qhp-premiums-choice-report.pdf>.

We acknowledge that some portion of these plan discontinuations and the subsequent number of enrollees affected by these discontinuations is attributable to the narrowing of the AV *de minimis* ranges per §§ 156.140, 156.200, and 156.400 in PY 2023 (such as the narrowing the AV *de minimis* range for on-Exchange silver offerings from 66 percent through 72 percent to 70 percent through 72 percent—which required issuers to either discontinue or modify offerings within the 66 percent through 70 percent range to have an AV within the 70 through 72 percent range). However, the rates of plan-county discontinuations and the subsequent number of enrollees impacted by these discontinuations continued to remain elevated in PY 2024 and PY 2025 (as the non-standardized plan option limit was introduced and subsequently reduced) compared to baseline rates of plan-county discontinuations and the number of enrollees affected by these discontinuations in PY 2020 through PY 2022—implying that a substantial portion of these discontinuations was also attributable to the imposition of the requirement to offer standardized plan options as well as the introduction of the non-standardized plan option limit.

Given this accumulation of data, we no longer believe that the advantages of imposing non-standardized plan option limits and exceptions (namely, a marginal net reduction in plan proliferation) outweigh the disadvantages of imposing these requirements (namely, increased burden, increased regulatory complexity, market disruption, inhibition of issuer innovation in plan design, and constrained consumer choice).

Altogether, we propose to discontinue non-standardized plan option limits under § 156.202(a) through (c) and the corresponding exceptions process under § 156.202(d) through (e), since we have concluded that adopting these measures (in conjunction with requiring issuers to offer standardized plan options) is an ineffective method of achieving our originally articulated objectives of employing this suite of policies to streamline the plan selection process, counteract plan proliferation, and reduce the risk of plan choice overload for consumers on *HealthCare.gov*. Furthermore, discontinuing these policies would decrease regulatory complexity, issuer burden, and the market disruption caused by plan discontinuations arising from the non-standardized plan option limit. Finally, discontinuing these policies would enhance consumer choice by supporting

issuers' ability to innovate in plan designs.

We seek comment on this proposal.

10. Deferral of Network Adequacy Reviews to States With an Effective Provider Access Review Program (§§ 156.230 and 155.1050)

We propose to exercise our authority under sections 1311(c)(1)(B) and 1321(a)(1)(B) of the Affordable Care Act to defer reviews of network adequacy to FFE States, including States performing plan management, provided the State elects to conduct such reviews, and demonstrates sufficient authority and the technical capacity to conduct network adequacy reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program under proposed § 155.1050(d)(2) through (d)(4). We propose to revise § 156.230 to clarify that HHS would continue to conduct network adequacy reviews using standards described at § 156.230(a)(2) through (a)(4) for QHP issuers that use a provider network in FFE States that do not elect to conduct their own provider access reviews, or that HHS has determined do not satisfy applicable criteria to be considered to have an Effective Provider Access Review Program, as described at proposed § 155.1050(d).

Section 1311(c)(1)(B) of the Affordable Care Act requires the Secretary to establish minimum criteria for provider network adequacy that a health plan must meet to be certified as a QHP. Section 1321(a)(1)(B) of the Affordable Care Act directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the Affordable Care Act, which includes section 1311, for, among other matters, the offering of QHPs through such Exchanges.

In the Exchange Establishment Rule (77 FR 18418), we set forth minimum network adequacy standards that plans must satisfy to be certified as QHPs at § 156.230. The Exchange Establishment Rule (77 FR 18409 through 18420) provided that an issuer of a QHP that uses a provider network must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible to enrollees without unreasonable delay. In the 2016 Payment Notice (80 FR 10830 through 10833), we revised § 156.230(a) to clarify that network adequacy requirements only apply to QHPs that use a provider network, defining such networks as networks comprised only of

providers that are contracted as in-network. For PYs 2015 through 2017, the FFEs conducted network adequacy reviews of proposed QHPs for compliance with network adequacy time and distance standards.

The 2017 Market Stabilization final rule (82 FR 18346) initially deferred reviews of network adequacy for QHPs to States that HHS determined to have a sufficient network adequacy review process, an approach that was reiterated in the 2019 Payment Notice (83 FR 16930). Specifically, we deferred these reviews to States that possessed sufficient authority to enforce network adequacy standards that were at least equal to the reasonable access standard defined in § 156.230 and that had the means to assess the adequacy of plans' provider networks. In States without the authority or means to conduct network adequacy reviews, we relied on an issuer's accreditation (commercial, Medicaid, or Exchange) from an HHS-recognized accrediting entity—specifically, either The National Committee for Quality Assurance (NCQA), URAC, or Accreditation Association for Ambulatory Health Care (AAAHC). Any unaccredited issuers were required to submit an access plan to demonstrate that the proposed QHP's provider network met the requirement in § 156.230(a)(2) to demonstrate that an issuer had standards and procedures in place to maintain an adequate provider network consistent with the National Association of Insurance Commissioners' (NAIC's) Health Benefit Plan Network Access and Adequacy Model Act. To provide additional support to States, we further coordinated with States to monitor network adequacy through consumer complaint tracking and resolution.

On March 4, 2021, the United States District Court for the District of Maryland issued its decision in *City of Columbus v. Cochran*, which addressed a challenge to the policy of outsourcing network adequacy reviews.¹⁸⁵ The court specifically vacated the portion of the 2019 Payment Notice's deferral of network adequacy reviews of QHPs offered through the FFEs to States with the authority and means to conduct sufficient network adequacy reviews, first finalized in rulemaking in the Market Stabilization final rule (83 FR 17024 through 17026). While the decision held that our policy of deferring network adequacy reviews to the States was not contrary to law, the court vacated the policy as an arbitrary and capricious agency action, holding

¹⁸⁵ *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021).

that HHS did not meaningfully respond to comments and evidence in the record.

Comments and evidence in question centered around assessment of States' ability to meaningfully conduct network adequacy reviews, and the use of accreditation as a basis for determining QHP issuers' satisfaction of provider network adequacy standards. Commenters stated that States' and accrediting entities' review processes do not do enough to ensure enrollees have adequate access to necessary care. In particular, the decision raised concerns about HHS' position that States' network adequacy review procedures are adequate simply because States have State-specific regulations without explaining what these entail or why they are comparable to review under Federal standards. The court also raised concerns about comments stating that State review procedures are often not adequate, have no quantitative standards for network adequacy in place, and, in many States, are complaint driven rather than preemptive, as well as comments that in some States, requirements only apply to certain types of plan designs. Comments expressing concern about relying on accreditation as a determination of network adequacy standard satisfaction stated that accreditation standards are not public, accreditors do not have regulatory authority over plans, and accreditors are not in a position to monitor network adequacy via consumer complaints or other means.

In the 2023 Payment Notice (87 FR 27322), we finalized that we would evaluate the adequacy of QHP provider networks offered through the FFEs, or of plans seeking certification as FFE QHPs, except for FFEs in States performing plan management (that is, Michigan, New Hampshire, South Dakota, and West Virginia) beginning with the 2023 QHP certification cycle. Additionally, in the 2023 Payment Notice (87 FR 27322), we adopted time and distance standards at § 156.230(a)(2) to assess whether plans seeking to be certified as QHPs in all FFE States meet network adequacy time and distance requirements.

In the 2024 Payment Notice (88 FR 25740), we revised network adequacy standards at § 156.230(a)(2) to establish appointment wait time standards starting in PY 2025. We also required all individual market QHPs, including individual market SADPs, and all SHOP QHPs, including SHOP SADPs, across all Exchanges to use a network of providers that complies with the network adequacy standards, and removed the exception that these requirements do not apply to plans that

do not use a provider network. A limited exception was finalized at § 156.230(a)(4) for certain SADP issuers that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers.

In the 2025 Payment Notice (89 FR 26218), we finalized § 155.1050(a)(2)(i)(A) to require that State Exchanges and SBE-FPs establish and impose quantitative time and distance network adequacy standards for QHPs that are at least as stringent as standards for QHPs participating on the FFEs under § 156.230. We also finalized § 155.1050(a)(2)(i)(B) which required that, for plan years beginning on or after January 1, 2026, State Exchanges and SBE-FPs conduct quantitative network adequacy reviews to evaluate a plan's compliance with network adequacy standards under § 156.230(a)(1)(ii), (a)(1)(iii), and (a)(2)(i)(A) prior to certifying any plan as a QHP, while providing QHP certification applicants the flexibilities described under § 156.230(a)(2)(ii) and (a)(3) and (4).

To implement the requirements for FFEs that were in place from PY 2023 and beyond as outlined above, we published in the 2023 Final Letter to Issuers in the Federally-facilitated Exchanges¹⁸⁶ a list of provider types and facility types, developed consistent with industry standards, alongside the time and distance standard for each provider or facility specialty type for each county type designation which are based on population size and density parameters (Large Metro, Metro, Micro, Rural, and Counties with Extreme Access Considerations). All FFE issuers were required to submit a Network Adequacy (NA) template during the QHP Certification period which is populated with their in-network provider and facility information (for example, NPI, specialty type, address(s) of their practice(s)). We used that information to conduct geocoding analyses for compliance with network adequacy standards.¹⁸⁷ This is an iterative process during QHP certification, with issuers informed of their review results and encouraged to contract with more providers to meet the standards if appropriate. Though there was no requirement for issuers to contract with a third-party vendor to

assist with populating network adequacy templates, we are aware of some issuers that opt to outsource this work to vendors that have access to their claims data to assist in populating the template with providers with which the issuer is actively contracted.

Additionally, beginning January 1, 2025, QHP issuers in the FFEs were required to meet appointment wait time standards established in the 2023 Letter to Issuers.¹⁸⁸ The 2025 Final Letter to Issuers on the Federally-facilitated Exchanges established the requirement for QHP issuers to contract with a third-party entity to administer secret shopper surveys on a sample of in-network providers to determine their level of compliance with appointment wait time standards for two provider types;¹⁸⁹ specifically, the requirement that enrollees would be able to schedule an appointment at least 90% of the time within 15 business days for routine primary care, within 10 business days for behavioral health providers, and within 30 business days for routine specialty providers. We use the final Network Adequacy templates submitted by FFE issuers during QHP certification to generate the Provider Population Files for QHP issuers and their third-party entity to develop the Appointment Wait Time Secret Shopper Survey Samples as outlined in the Appointment Wait Time Secret Shopper Survey Technical Guidance.

The preceding years of conducting reviews of QHP issuer provider network adequacy, including analyzing issuer submitted data and through discussions with States, issuers, and other various interested parties around diverse market conditions, have demonstrated that a one-size-fits all approach to provider network adequacy review is not satisfactory. For example, issuers have highlighted to us persistent challenges in locating and contracting with enough providers of various specialties (for example, allergy and immunology, behavioral health, gastroenterology) in remote or difficult to access areas of a State. States have brought to our attention various geographic constraints that impact QHP issuers' ability to satisfy time and distance requirements and have made suggestions to assess a QHP issuer's ability to meet a time or a distance standard individually, rather

¹⁸⁶ "2023 Final Letter to Issuers in the Federally-facilitated Exchanges", April 28, 2022. Available at <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf>.

¹⁸⁷ Geocoding is the process of converting provider street addresses, into geographic coordinates (latitude and longitude), enabling them to be used in the calculation of time and distance analysis.

¹⁸⁸ "2023 Final Letter to Issuers in the Federally-facilitated Exchanges", April 28, 2022. Available at <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf>.

¹⁸⁹ "2025 Final Letter to Issuers in the Federally-facilitated Exchanges", April 10, 2024. Available at <https://www.cms.gov/files/document/2025-letter-to-issuers.pdf>.

than requiring it to meet a standard that assesses time and distance together, which may be insurmountable due to a topographical constraint such as a body of water or navigating roads in mountainous terrain.¹⁹⁰

Partnerships with States performing plan management, who have elected to conduct their own network adequacy reviews, have also highlighted for us how States may innovate in their approach to conducting network adequacy reviews that are sensitive to conditions and capacity in the State. For example, we are aware of States performing plan management that assess network adequacy based on access to services rather than provider types. Deferring network adequacy reviews to FFE States that demonstrate sufficient authority and the technical capacity by satisfying the criteria to demonstrate they have an Effective Provider Access Review Program would empower these States to similarly innovate and mold their network adequacy standards to the needs of consumers in their individual States. For example, a State may find it is in the interest of their consumers to assess network adequacy using a time or a distance standard individually rather than assessing whether a QHP issuer meets a time and distance standard, make adjustments to time and distance standards that account for more remote areas or more urban areas, assess network adequacy in different ways such as through provider-enrollee ratios, expand or change the provider types they assess, and implement other innovative, State-specific approaches to identify and address the systemic issues that result in many issuers being unable to meet the network adequacy standards described at § 156.230(a)(2). A State, with its more intimate knowledge of its own demographics, topography, quantity, and density of providers, is often best positioned to evaluate local provider networks and market conditions and tailor network adequacy standards in a more nuanced way than Federal requirements.

¹⁹⁰ CMS currently uses a calculation for network adequacy that factors in both time and distance. Time and distance is especially critical in large metro areas where there is a standard of 15 miles/30 minutes as an example. There may be many providers available within 15 miles, but the time to travel would far exceed 30 minutes due to slower travel speeds in urban areas. The “and” condition makes it necessary for a provider location to be available within both the mileage and the time criteria. We are aware of State Exchanges and SBE-FP States that have implemented an “or” condition, particularly in rural areas where topographical limitations may make it feasible to meet a time requirement or a distance requirement without a need to meet both to ensure reasonable access to all services by enrollees without unreasonable delay.

Thus, in recognition of the crucial role States have in developing and enforcing network adequacy standards and because we believe that States are often best positioned to evaluate local provider networks and market conditions, we propose at § 155.1050(d), for PY 2027 and beyond, to allow FFE States, including States that perform plan management, that elect to do so, to conduct reviews for provider access for issuers’ plans that use and do not use a provider network, provided that we determine the State has sufficient authority and the technical capacity to conduct the reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program as described at proposed § 155.1050(d)(2) through (d)(4). Concurrently, we propose, for plan years beginning on or after January 1, 2027, to amend § 156.230, including (1) revising the section heading to state, “Provider access standards for network plans”; (2) revising § 156.230(a)(1) to remove the requirement that a QHP must use a provider network and clarify that the standards described in § 156.230(a)(1)(i), (ii), and (iii) apply to a QHP that uses a network of providers; (3) revising § 156.230(a)(2)(i) and (ii) to clarify that requirements for issuers of QHPs to meet time and distance standards and appointment wait time standards at § 156.230(a)(2) only apply to States that do not elect to conduct their own provider access reviews or States that we have determined do not do not satisfy the criteria to be considered to have an Effective Provider Access Review Program as described at proposed § 155.1050(d) and explained further in this section; (4) revising the exception at § 156.230(a)(3) to clarify that it applies only when HHS is conducting network adequacy reviews; and (5) revising § 156.230(a)(4) to conform with proposed revisions to § 156.230(a)(1).

Additionally, in recognition of the traditional role that all State Exchanges and SBE-FPs have in developing and enforcing network adequacy standards and to align with proposed changes for FFE States detailed in section III.D.18 of this proposed rule, we propose to remove the requirements under § 155.1050(a)(2)(i) and (ii) for State Exchanges and SBE-FPs to establish and impose quantitative time and distance network adequacy standards for QHPs that are at least as stringent as standards for QHPs participating on the FFEs under § 156.230 and to no longer require State Exchanges and SBE-FPs to conduct quantitative network adequacy reviews to evaluate a plan’s compliance

with network adequacy standards under § 156.230(a)(1)(ii), (a)(1)(iii), and (a)(2)(i)(A) prior to certifying any plan as a QHP. Instead, we propose to restore § 155.1050(a)(2) to a pre-PY 2025 policy and require that State Exchanges and SBE-FPs must ensure that each QHP provides sufficient access to providers in a manner that meets applicable standards specified in § 156.230(a)(1)(ii) and (iii) for network plans, or proposed § 156.236(a) for non-network plans, as applicable. This proposal is discussed in more detail in section III.D.18 of this proposed rule.

In addition, we also now believe that there are alternative administrable regulatory standards that can ensure satisfaction of provider sufficiency requirements by QHPs that do not use traditional contracted networks of providers and that, especially in light of efforts to improve health care price transparency, an expanded definition of how to achieve sufficient access to providers would allow for innovations in plan design. Our proposal to allow for QHP certification of plans without a provider network is described in detail in section III.E.12 of this proposed rule.

Our proposed revisions to §§ 156.230(a)(2)(i) and (ii) and (a)(3) reflect our proposed change in policy at § 155.1050(d) to defer network adequacy reviews to FFE States that elect to perform such reviews, and that demonstrate they have sufficient authority and the technical capacity to conduct these reviews by satisfying the criteria to be considered to have an Effective Provider Access Review Program as described at § 155.1050(d)(2) through (d)(4), while also retaining Federal standards for HHS to utilize in conducting network adequacy reviews, including time and distance and appointment wait time standards, in States that do not elect to conduct such reviews or do not demonstrate they have sufficient authority and the technical capacity to conduct these reviews by satisfying the criteria to be considered to have an Effective Provider Access Review Program.

Network adequacy analyses are often highly data-intensive. Because the FFE has economies of scale in the collection and analysis of various forms of network adequacy data, including time and distance data and appointment wait time data, under our proposal, we would continue collecting this data from all FFE issuers, either to use to conduct Federal network adequacy reviews in FFE States that do not elect to do so or do not demonstrate they have sufficient authority and the technical capacity to conduct these reviews by satisfying the criteria to be

considered to have an Effective Provider Access Review Program as described at § 155.1050(d)(2) through (d)(4), or with a view to make it available in a standardized format to States that are determined to have an Effective Provider Access Review Program, to assist them in their network adequacy analysis. We have extensive tools to standardize data, including a network adequacy template, other supporting document templates, manual data validation resources, and FAQs. The continuation of the aforementioned activities would support consumer protection as HHS would maintain an ability to utilize the collected data to research and address consumer or other complaints, provide continuity for States that may need time to expand their technical capacity and seek to rely on our infrastructure, and prevent any gaps in awareness as FFE States expand and fortify their own reviews. This aspect of our proposal primarily seeks to support States that do not presently have sufficient authority or the technical capacity to conduct reviews and States that demonstrate sufficient authority and the technical capacity but seek to capitalize on HHS' data collection and analysis to supplement their provider access review programs. We believe this approach appropriately balances State and Federal responsibilities as it seeks to empower States that elect to conduct network adequacy reviews but also utilizes Federal systems to provide support to States, maximizing consumer protection and taking advantage of State expertise in developing and enforcing provider network adequacy requirements.

We would consider a State to have sufficient authority and the technical capacity to conduct network adequacy reviews if the State meets criteria set forth at proposed § 155.1050(d)(2) through (4) (discussed at section III.D.18. of this proposed rule). The proposal also clarifies that if States are not determined to have an Effective Provider Access Review Program, then HHS would continue to perform provider access certification reviews consistent with § 156.230(a)(1) through (a)(4) for network plans and proposed § 156.236 for non-network plans.

As proposed at § 155.1050(d)(2), an FFE State with an Effective Provider Access Review Program would be required to ensure that a QHP issuer that uses a network of providers ensures that its network of providers, as available to all enrollees, includes ECPs in accordance with § 156.235, and maintains a network that is sufficient in number and types of providers, including providers that specialize in

mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay, and is consistent with the rules for network plans of section 2702(c) of the PHS Act. We propose at § 155.1050(d)(3) that an FFE State with an Effective Provider Access Review Program must ensure that a QHP issuer that does not use a network of providers (a non-network plan) provides access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full, including ECPs and providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay.

Under our proposal at § 155.1050(d)(4), a State operating an FFE that elects to conduct its own provider access reviews would be considered to have an Effective Provider Access Review Program by satisfying the following requirements:

(1) The FFE State has established provider access standards that are set forth in State statute or regulation which are consistent with provider access standards as set forth in § 156.230(a)(1)(ii) and (iii), and reports to HHS whether the State has delegated authority to some entity other than the State Department of Insurance to perform any or all provider access review activities;

(2) The FFE State's provider access review process includes reporting systems for State-required provider access metrics and documentation of methodology and the State provides descriptions of all data collection systems, resources, templates, and methodologies used by the State or the State's delegated entity to collect and review provider access data; and the State receives from issuers data and documentation in connection with provider access standards that are sufficient to conduct the examination;

(3) The FFE State's provider access review process includes procedures to ensure full and ongoing compliance with State provider access standards and enforcement frameworks applicable to issuers that fail to meet provider access standards so that those issuers come into compliance with State provider access standards, including standardized processes to assess efforts the issuer is pursuing to come into compliance with State provider access standards, and implementing any justification and exception processes for issuers that have not yet or cannot meet provider access requirements;

(4) The FFE State establishes and maintains clear procedures and timeline

requirements for regular provider access reviews, including processes that ensure reviews occur prior to each plan year's QHP certification cycle;

(5) The FFE State has a process for monitoring and addressing consumer-related provider access complaints to ensure sufficient access to providers consistent with section 1311(c)(1)(B) of the Affordable Care Act and as set forth in State statute; and

(6) The FFE State has a process to collect and review information sufficient to show that non-network plans provide access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full.

We propose at § 155.1050(d)(5) that we would determine whether a State has an Effective Provider Access Review Program based on information available to us that demonstrates whether the program meets the criteria described at proposed § 155.1050(d)(4). We propose at § 155.1050(d)(6) that we may also grant an exception to these criteria if we determine that making such an exception is in the interests of qualified individuals in the State or States in which such Exchange operates. We also propose at § 155.1050(d)(7) that we would notify the FFE State electing to conduct provider access certification reviews of our decision in writing regarding whether the State is determined to have an Effective Provider Access Review Program and can therefore conduct its own provider access certification reviews. We propose that we would also reserve the right at any time to evaluate whether, and to what extent, a State's circumstances have changed such that it has established, or no longer has, an Effective Provider Access Review Program under § 155.1050(d). We propose that these evaluations may result in HHS assuming provider access review responsibilities or transitioning such responsibilities back to the State.

We also propose that a State would need to demonstrate that it meets applicable criteria for both network plans and non-network plans under § 155.1050(d), if they decide to certify such plans, in order to receive the designation to have an Effective Provider Access Review Program. This would mean that a State would not be permitted to elect to conduct provider access certification reviews for only network plans and not non-network plans, if they certify such plans, or vice versa. We believe this is important, as some QHP issuers may choose to offer both network and non-network plans and centralizing reviews to a single entity, whether the FFE State or HHS,

for the same issuer, would reduce administrative inefficiencies that may result if the FFE State and HHS have to coordinate provider access certification review results across a range of network and non-network plans. We also believe that review authority being limited to a single entity, either the FFE State or HHS, would allow both network and non-network plans to undergo consistent, standardized reviews conducted by the same reviewing entity. We believe this would ensure similar requirements and methodologies would be applied fairly across network and non-network plans and reduce potential differences in provider access review results. Overall, just as with network plans, non-network plans would be required to ensure sufficient access to a range of providers in a manner consistent with section 1311(c)(1)(B) of the Affordable Care Act.

Rather than specifying the detailed methodology and standards States would be expected to use to determine sufficient access to providers, the proposed factors focus on processes to ensure a State has sufficient authority and the technical capacity to conduct network adequacy reviews. The approach, as set forth at proposed § 155.1050(d), would provide for more than a perfunctory review of authority, but rather would thoroughly investigate States' ability to ensure provider access sufficiency in line with § 156.230(a)(1)(ii) and (iii). This proposed approach would allow States more flexibility in defining network adequacy standards that reflect their local markets, provider availability, geographic considerations, and demographics. We would evaluate if the network adequacy review program in the State has established network adequacy standards that are set forth in State statute and regulation that are consistent with those set forth in § 156.230(a)(1)(ii) and (iii).

The first proposed criterion for evaluation requires that the State has established provider access standards that are set forth in State statute or regulation, which are consistent with provider access standards as set forth in § 156.230(a)(1)(ii) and (iii) and reports to HHS whether the State has delegated authority to some entity other than the State Department of Insurance to perform any or all provider access review activities. This criterion would be crucial as it addresses whether or not the State has sufficient authority to conduct provider access reviews. It would also be important for a State to report to us whether the State has delegated authority to some other entity to perform provider access review

activities so we understand how the State is handling provider access review data and to whom it entrusts such data.

The second proposed criterion states that the State's provider access review process includes reporting systems for State required provider access metrics and documentation of methodology and the State provides descriptions of all data collection systems, resources, templates, and methodologies used by the State, or the State's delegated entity, to collect and review provider access data; and the State receives from issuers data and documentation in connection with provider access standards that are sufficient to conduct the examination. This information would be important for us to understand processes a State has in place to appropriately assess provider access. Under our proposal, we would evaluate whether the State's provider access data, documentation, and analysis practices are sufficient to ensure it can conduct provider access reviews.

The third proposed criterion provides that the State's provider access review process includes procedures to ensure full and ongoing compliance with State provider access standards and enforcement frameworks applicable to issuers that fail to meet provider access standards so that those issuers come into compliance with State provider access standards, including standardized processes to assess efforts the issuer is pursuing to come into compliance with State provider access standards, and implementing any justification and exception processes for issuers that have not yet or cannot meet provider access requirements. This information would be important for reasons similar to the previously discussed proposed factor. Ensuring that adequate compliance processes exist would bolster the robustness of any network adequacy review to ensure sufficient provider access.

The fourth proposed criterion requires that the State establish and maintain clear procedures and timeline requirements for regular provider access reviews, including processes that ensure reviews occur prior to each plan year's QHP certification cycle. We believe that it would be important for States to have clearly established procedures for network adequacy review that are not reactive but are preemptive to ensure that plans being offered on an Exchange provide sufficient access to providers and so that consumers shopping for a plan have that guarantee.

The fifth proposed criterion requires the State to have a process for monitoring and addressing consumer-related provider access complaints to

ensure sufficient access to providers consistent with section 1311(c)(1)(B) of the Affordable Care Act and as set forth in State statute. This criterion would be important because provider access can change often during the year. For plans using a provider network, contracts may be executed or terminated throughout a plan year for various reasons. Also, any inaccuracies or out-of-date information contained in provider directories can create confusion or be misleading to consumers. Additionally, consumers may have trouble actually making appointments with network providers due to lack of availability of appointments. For plans without a provider network, we anticipate that providers that accept a benefit amount as payment in full may also change frequently depending on market conditions, negotiations, and competition.

The sixth proposed criterion requires the State to have a process to collect and review information capable of demonstrating whether non-network plans provide access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full. This criterion would be important to ensure that, should a State offer non-network plans, these plans also ensure sufficient access to providers.

While these proposed criteria for assessing whether a State has an Effective Provider Access Review Program are comprehensive, we believe this approach would provide ample flexibility to States to determine the best methodology to assess network adequacy within the State. We anticipate each State's approach would be dependent on available resources (for example, technical infrastructure, budget, staffing), topographical considerations, and population needs unique to each State, and we propose to empower States to utilize these factors to evaluate overall State processes that ensure sufficient consumer protection. This proposed approach would not simply 'rubber stamp' approval for a State to conduct provider access reviews upon a perfunctory review of authority but would thoroughly investigate States' processes to ensure provider access sufficiency in line with § 156.230(a)(1) as proposed in this rule. Our proposal also does not dictate the precise network adequacy review methodology which may reasonably differ from State to State.

Under our proposed approach, we would seek to work in partnership with States and would provide numerous resources to States to utilize as they see fit to further develop and enhance their

network adequacy review capabilities. For example, we would offer extensive resources originally developed for Federal network adequacy review during the annual QHP certification cycle as States may work to further develop network adequacy standards and review methods that best suit the conditions of their distinct consumer populations and needs. These tools, including a network adequacy template, other supporting document templates, manual data validation resources, and FAQs, could provide support to interested States as States continue to develop and implement processes to standardize any issuer-submitted data during their reviews, leveraging HHS' extensive experience in identifying efficient data formats and validation processes. This comprehensive support system would be available to States as States continue to develop and implement individualized network adequacy standards and review processes that are most appropriate and protective for their own consumers.

In summary, we propose, for plan years beginning on or after January 1, 2027, to amend § 156.230, including (1) revising the section heading to state, "Provider access standards for network plans"; (2) revising § 156.230(a)(1) to remove the requirement that a QHP must use a provider network and clarify that the standards described in § 156.230(a)(1)(i), (ii), and (iii) apply to a QHP that uses a network of providers; (3) revising § 156.230(a)(2)(i) and (ii) to clarify that requirements to meet time and distance standards and appointment wait time standards at § 156.230(a)(2) only apply to States that we have determined do not satisfy the criteria to be considered to have an Effective Provider Access Review Program or that do not elect to conduct their own provider access reviews of issuers as described at proposed new § 155.1050(d); (4) revising exceptions to the aforementioned requirements at § 156.230(a)(3), to apply only when HHS is conducting network adequacy reviews; and (5) revising § 156.230(a)(4) to conform with revisions to § 156.230(a)(1). Through these proposed changes, we would defer provider access reviews, for network and non-network plans, to FFE States, including States performing plan management, provided the State elects to conduct such reviews, and demonstrates it has sufficient authority and the technical capacity to conduct network adequacy reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review

Program, as detailed at proposed § 155.1050(d)(2) through (4).

We seek comment on these proposals.

11. Essential Community Provider Standards for Network Plans (§ 156.235) and Implementation of the Effective Essential Community Provider Review Program (§ 155.1051)

For PY 2027 and subsequent plan years, we propose changes to QHP certification requirements with respect to essential community providers (ECPs) included within a network plan issuer's provider network. First, we propose to reduce the minimum percentage requirement (also referred to as the "ECP thresholds" or "ECP threshold requirements") from 35 to 20 percent. (The minimum percentage requirement specifies a minimum percentage of participating ECPs that must be included within a network plan issuer's provider network based on the total available ECPs within the issuer's service area). Second, we propose to change the narrative justification regulation text at § 156.235(a)(3) and (b)(3) to be consistent with systems changes and existing issuer ECP data submission requirements as part of ECP certification reviews. Third, as further discussed in this section, we propose at new § 155.1051 to allow FFE States, including States performing plan management, to elect to conduct their own ECP certification reviews of QHP issuers' plans provided that the State has sufficient authority and the technical capacity to conduct these reviews by satisfying applicable criteria established by HHS to be considered an Effective Essential Community Provider (ECP) Review Program.

Section 1311(c)(1)(C) of the Affordable Care Act directs the Secretary to establish by regulation certification criteria for QHPs, including criteria that require QHP issuers to include ECPs within health insurance plan networks. ECPs include providers that serve predominantly low-income and medically underserved individuals, such as health care providers described in section 340B(a)(4) of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Act. We first implemented the above statutory provisions of the Affordable Care Act and codified ECP standards at § 156.235 in the Exchange Establishment Rule (77 FR 18310). These standards help ensure medical QHPs and SADP issuers include in their provider networks a sufficient number and geographic distribution of ECPs, where available, as a requirement to receive certification as a QHP.

a. Reduction of the Minimum Percentage (or Threshold) Requirement From 35 to 20 Percent

Sections 156.235(a)(2)(i) and (b)(2)(i) stipulate that a plan applying for QHP certification to be offered through an FFE has a sufficient number and geographic distribution of ECPs if it demonstrates, among other criteria, that its provider network includes as participating providers at least a minimum percentage, as specified by HHS, of available ECPs in each plan's service area collectively across all ECP categories defined under § 156.235(a)(2)(ii)(B). As stated in § 156.235(a)(2)(i) and (b)(2)(i), for purposes of satisfying this minimum percentage requirement, also known as the ECP threshold requirement, multiple providers at a single location count as a single ECP toward both the available ECPs in the plan's service area and the contracted ECPs included in the issuer's network for calculating the threshold.

The minimum percentage requirements have been modified over the years (for example, 20 percent, 30 percent, 35 percent) to accomplish different policy and operational priorities, such as to reduce regulatory burden (82 FR 18373, 83 FR 17025), to align with market conditions (82 FR 18373, 83 FR 17025), to expand access to care for consumers (87 FR 27336, 88 FR 25882), and to promote broader networks (87 FR 27336, 88 FR 25882). For example, for QHP certification for PY 2018, we reduced the minimum percentage requirement from 30 to 20 percent to substantially reduce the regulatory burden on issuers (due to issuers needing to submit less data on provider contracts with ECPs to demonstrate satisfaction of the ECP Standard under § 156.235), while still requiring issuers to include a sufficient number and geographic distribution of ECPs in their networks (82 FR 18373). These minimum percentage requirements have been set at 35 percent since PY 2023 (87 FR 27336). In the 2024 Payment Notice (88 FR 25882), we also began to apply these minimum percentage requirements separately to two existing types of ECP categories that comprise more than 60 percent of all facilities on the HHS ECP List, Federally Qualified Health Centers (FQHCs) and family planning providers, in accordance with revisions to § 156.235(a)(2)(i) and (b)(2)(i).¹⁹¹

¹⁹¹ Revisions made to § 156.235(a)(2)(i) and (b)(2)(i) implemented separate minimum percentage requirements for the FQHC and family planning provider categories by specifying that a plan applying for QHP certification to be offered through

At a high level, to meet the ECP threshold requirements under § 156.235, issuers have been required to contract with at least 35 percent of available ECPs in each plan's service area to participate in the plan's network (that is, the overall ECP threshold requirement), and separately, at least 35 percent of available FQHCs that qualify as ECPs in the plan's service area (that is, the FQHC threshold requirement), and at least 35 percent of available family planning providers that qualify as ECPs in the service area (that is, the family planning provider threshold requirement).

To reduce administrative burden for QHP issuers, we propose to reduce the overall threshold, FQHC threshold, and family planning provider threshold requirements from 35 to 20 percent for both medical QHP and SADP issuers in FFE States, including States performing plan management, for the upcoming PY 2027 and thereafter. We would consider medical QHP and SADP issuers to have satisfied the overall threshold requirement if these issuers contract with at least 20 percent of available ECPs in each plan's service area collectively across all ECP categories defined under § 156.235(a)(2)(ii)(B) to participate in the plan's provider network. Additionally, medical QHP issuers would be considered to have satisfied the separate FQHC and family planning provider threshold requirements by contracting with at least 20 percent of available FQHCs that qualify as ECPs in the plan's service area and at least 20 percent of available family planning providers that qualify as ECPs in the plan's service area, respectively. SADP issuers would be considered to have satisfied the separate FQHC threshold requirement by contracting with at least 20 percent of FQHCs offering dental services in the plan's service area. The calculation methodology for determining if an issuer meets the threshold requirements would be consistent with previous years.¹⁹² We note that while we propose

to lower the threshold requirements for each of these three thresholds, we recognize that issuers have the flexibility to continue to choose to exceed the proposed minimum percentage requirement within their provider networks. Each plan year, ECP certification data consistently indicate that the majority of issuers on the FFE, including States performing plan management, exceed each of the minimum percentage requirements,¹⁹³ and in prior years when the minimum percentage requirement was reduced (for example, from 30 to 20 percent during PY 2018), many FFE issuers continued to choose to exceed minimum percentage requirements.

We believe that reducing the overall threshold, FQHC threshold, and family planning provider threshold requirements from 35 to 20 percent would provide additional flexibility for QHP issuers to build provider networks that comply with the ECP Standard under § 156.235. We believe that reverting to the previous 20 percent minimum percentage that issuers were accustomed to at the establishment of the FFE in PY 2014 and during PYs 2018 through 2022 would minimize disruptions for issuers in adjusting to meet the threshold requirements. In the past, several commenters on the Market Stabilization final rule (82 FR 18373) had supported our proposals to decrease ECP threshold requirements, stating that the lower threshold requirement would reduce the administrative burden on issuers, especially for those issuers in rural areas or States with few ECPs. We welcome comments on if the proposed threshold percentage would still enable enrollees to access ECPs in rural areas and would not impose barriers to entry for issuers in rural areas by discouraging issuers from expanding into such areas. Similarly, we expect these proposed changes would continue to reduce the regulatory and administrative burden on QHP issuers, such as by reducing the amount of resources expended to secure and negotiate additional provider contracts and potential compliance related costs associated with submitting additional ECP data on provider contracts to meet the ECP standard under § 156.235. This may provide

issuers with more resources and flexibilities while still ensuring that a meaningful number of ECPs are included within an issuer's provider network consistent with the requirements of section 1311(c)(1)(C) of the Affordable Care Act. Though, we solicit comment on whether there is an alternative threshold percentage that is more effective and appropriate, including threshold percentages that may be targeted to specific geographic areas where issuers may require additional flexibilities to meet threshold requirements, and a percentage that strikes the appropriate balance between issuer flexibility and enrollee access. Furthermore, we understand that network participation negotiations are an important tool that issuers use to manage costs; therefore, fewer provider contracts needed to comply with threshold requirements may free up financial resources that issuers may leverage for other activities, such as innovating plan offerings to meet the diverse needs of consumers or passing on savings to consumers through lower premium rates that may especially benefit low-income and underserved populations.

Lastly, we continue to recognize concerns shared previously by commenters related to potential access to care barriers when reducing ECP threshold requirements in the past (82 FR 18373). When ECP threshold requirements were set at or reduced to 20 percent in previous years (PY 2014, PYs 2018 through 2022), we expanded efforts to ensure continued access to care to ECPs within an issuer's provider network. We continuously monitored potential issues raised by consumers and escalated any ECP access concerns identified through monitoring efforts by performing direct outreach to QHP issuers, as appropriate, including as part of post-certification monitoring and compliance efforts. Similarly, we would continue to monitor potential issues and undertake efforts to ensure consumers maintain adequate access to ECPs, and we would address any concerns through future guidance and/or possible rulemaking, as appropriate.

b. Modifications to Narrative Justification Requirements at §§ 156.235(a)(3) and 156.235(b)(3)

Additionally, we propose to change the narrative justification regulation text at § 156.235(a)(3) and (b)(3) to be consistent with system changes, current HHS operational processes, and existing issuer ECP data submission requirements as part of ECP certification

an FFE must include as participating providers within their provider network at least a minimum percentage of available ECPs in each plan's service area *within certain ECP categories*, as specified by HHS. HHS applied this requirement to the FQHC and family planning provider categories.

¹⁹² For calculating an issuer's satisfaction of the threshold requirements, we consider the number of in-network ECPs with which an issuer designates a contract is executed within their QHP certification application. The number of in-network contracted ECPs includes any qualified ECPs located within the plan's service area. The number of in-network contracted ECPs is the numerator in the threshold requirement calculation, and this number is divided by all available and qualified ECPs located within the plan's network service area in the denominator to create a threshold percentage. For the family

planning provider and FQHC threshold requirements, we only count family planning providers and FQHCs in the calculation methodology within the numerator and denominator and not other ECP categories.

¹⁹³ For PY 2026, the average threshold percentage for all FFE QHP issuers, including issuers in States performing plan management, for the overall ECP threshold requirement was 71 percent, 85 percent for the family planning provider threshold requirement, and 79 percent for the FQHC threshold requirement.

reviews.¹⁹⁴ The regulations at § 156.235(a)(3) and (b)(3) currently state that if a plan applying for QHP certification is to be offered through an FFE does not satisfy the ECP standard (under § 156.235(a)(2) for the General ECP Standard and § 156.235(b)(2) for the Alternate ECP Standard), the issuer must include as part of its QHP application a narrative justification describing how the plan's provider network provides an adequate level of service for low-income enrollees or individuals residing in Health Professional Shortage Areas within the plan's service area and how the plan's provider network will be strengthened toward satisfaction of the ECP standard prior to the start of the benefit year.

However, since beginning to collect this narrative justification information in PY 2014, we have instituted multiple refinements and modernizations to this process in recent years, including through innovations and standardizations to ECP data collection by implementing the ECP User Interface (UI)¹⁹⁵ in the Marketplace Plan Management System (MPMS). MPMS allows us to collect the same type of information previously obtained from the narrative justification without having to actually require issuers to fill out the narrative justification. We have integrated the ECP data collection into MPMS such that issuers can easily submit their ECP data, including justification related information previously collected through written narratives and pre-populated Excel templates, without having to again explain or describe how the plan's provider network provides an adequate level of ECPs prior to the start of the benefit year.

Due to these technical enhancements, along with other process efficiencies and resources provided to issuers (for example, Final Plan Year ECP Lists, outreach activities, and change reports), we have been able to efficiently obtain

relevant quality data to adequately perform ECP certification reviews while reducing the time and resources required by issuers to submit supporting information, including the narrative justifications required by § 156.235(a)(3) and (b)(3). The ECP data obtained by issuers during the QHP certification process details which qualified ECPs have contracts executed with the issuer within each of the issuer's provider networks and service areas, which allows us to calculate an issuer's satisfaction of the ECP standard. This ECP data also identifies opportunities to alleviate gaps in an issuer's network and service area to ensure reasonable and timely access to ECPs by identifying additional ECPs an issuer may contract with to meet the ECP standard, while also highlighting different contract negotiation statuses that may explain why an issuer has not yet executed a contract with a specific provider.

Therefore, we propose to modify and simplify this regulatory language at § 156.235(a)(3) and (b)(3) to remove the narrative justification and description requirement so that the regulatory language simply requires that an issuer include as part of its QHP application the status of contract offers to qualified ECPs available in the network plan's service area. As stated above, we believe that continuing to collect contract negotiation status data from issuers is essential for performing ECP certification reviews. Not only does this data allow us to monitor an issuer's progress toward contracting with a specific ECP and learn the rationale for why an issuer has yet to offer a contract with a specific ECP, the type of contract negotiation status an issuer selects for an ECP also determines whether the issuer will receive credit for that ECP toward satisfaction of the threshold, category per county, and Indian health care requirements under the ECP Standard. For example, if an issuer designates that an ECP rejected their contract offer in MPMS as part of their QHP application, the issuer will receive credit towards their efforts to offer a contract despite it being rejected as part of the calculations for the category per county and Indian health care requirements under § 156.235(a)(2)(ii), but will not receive credit as part of the calculations for the threshold requirements under § 156.235(a)(2)(i) and (b)(2)(i), which require that contract offers be fully executed with an ECP in order to receive credit. Overall, collecting these contract statuses within the ECP UI in MPMS has allowed us to conduct ECP certification reviews that are as fulsome as certification reviews

informed by narrative justifications, since the same information previously collected through narrative justifications is still received within MPMS but submitted by issuers in a simplified format through pre-populated contract status options that reduces issuer burden without written narratives required.

Moreover, this data had previously been collected through ECP narrative justifications, but the ECP UI enhancement now allows us to gather this information from issuers in a simplified and standardized format through various pre-populated fields, which eliminates the need for issuers to provide open-ended written descriptions that may be more time consuming for issuers that are continuing to work toward satisfaction of the ECP standard. In the ECP UI, this data is mainly collected from the status of contract negotiations. For example, the issuer could designate in its QHP application the contract negotiation status with an ECP for its networks by selecting if a contract was executed, a contract offer was made and awaiting a response, or a contract was not offered due to no response following issuer outreach, as some of the available standardized options.¹⁹⁶ To reflect collecting this type of information as part of ECP certification reviews, we propose to revise the regulations at § 156.235(a)(3) and (b)(3) to state that a network plan applying for QHP certification to be offered through a FFE must include as part of its QHP application the status of contract offers to qualified ECPs available in the network plan's service area. We note that since issuers have already been including this information as part of their QHP applications since PY 2025, there would be no substantive operational changes as a result of this proposal to the ECP data submission process as part of QHP certification.

Additionally, we note that issuers are not required to designate the contract negotiation status for all available ECPs within their service area in their QHP application. We understand that the total number of ECPs for which a

¹⁹⁴ QHP certification and ECP Data Collection to Support QHP Certification are already assessed and encompassed by the currently approved information collections (*Continuation of Data Collection to Support QHP Certification and other Financial Management and Exchange Operations* (OMB Control Number 0938–1187 (CMS–10433)/Expiration date: June 30, 2025) and *Essential Community Provider/Network Adequacy (ECP/NA) Data Collection to Support QHP Certification* (OMB Control Number. 0938–1415 (CMS–10803)/Expiration date: December 31, 2027)).

¹⁹⁵ The ECP UI is the web-based interface of the ECP section of the Marketplace Plan Management System (MPMS) Module, which is a sub-system of the Health Insurance and Oversight System, where QHP issuers demonstrate that they have a sufficient number and geographic distribution of ECPs. Medical QHP and SADP issuers submit provider data in each network associated with a QHP and/or SADP into the ECP UI.

¹⁹⁶ Options for contract negotiation statuses are as follows: Contract Executed; Contract Offer Made-Awaiting Response; Pre-Contract Negotiations in Progress (Contract Offer Not Made Yet); Offer Rejected; Contract Not Offered Due to No Response Following Issuer Outreach; Facility Closed; Facility Does Not Contract And Has No Interest To Contract With Commercial Insurance; Facility Does Not Provide Medical Services; Facility Does Not Provide Dental Services; Provider is in an Exclusivity Contract That Prohibits Us From Contracting With Them; Provider is Not Licensed, Accredited, or Certified by the State; Provider Has Relocated Outside Service Area Preventing Us From Contracting With Them.

contract negotiation status is selected within each network and service area is variable among issuers for multiple factors, including the size of the issuer's service area, the number of qualified ECPs available in the service area, the number of ECPs the issuer has contacted and/or engaged in contract discussions with, resources required by the issuer to initiate contract discussions with all qualified ECPs in their service area, if an issuer finds evidence that an ECP may no longer be eligible to qualify as an ECP, and the number of ECPs an issuer must contract with to achieve each of the requirements of the ECP Standard. For these reasons, we propose to additionally clarify at § 156.235(a)(3) and (b)(3) that a network plan does not need to report on the status of contract negotiations for all available ECPs in their service area, but must at least report on the status of contract offers for all ECPs which the issuer has either included in its network plan or offered a contract to be included in its network plan within each service area.

c. Implementation of an Effective Essential Community Provider (ECP) Review Program (§ 155.1051)

To align with proposals in sections III.D.18 and III.E.10. of this proposed rule that would provide FFE States with additional flexibilities to conduct their own network adequacy reviews of QHP issuers operating in their States as long as they have sufficient authority and the technical capacity to conduct these reviews by satisfying applicable criteria established by HHS to be considered an Effective Provider Access Review Program, we propose to adopt new flexibilities for FFE States to conduct ECP certification reviews of QHP issuers' plans in their States provided that the State is determined by HHS to have an Effective ECP Review Program, as discussed later in this section. In proposing flexibilities for FFE States to conduct ECP certification reviews, we propose to exercise our authority under section 1311(c)(1)(C) of the Affordable Care Act, which provides the Secretary authority to establish QHP certification criteria related to ECPs, and our authority under section 1321(a)(1)(B) of the Affordable Care Act, which grants HHS general rulemaking authority to promulgate regulations related to offering QHPs through the Exchanges.

Thus, beginning with PY 2027, we propose to provide the opportunity for FFE States, including States performing plan management, to elect to conduct their own ECP certification reviews of QHP issuers' plans provided that the State demonstrates it has sufficient authority and the technical capacity to

conduct these reviews by satisfying the applicable criteria established by HHS to have an Effective ECP Review Program in order to ensure reasonable and timely access to ECPs for low-income, medically underserved individuals. This proposal is set forth at new § 155.1051.

Over the years, we have deferred network adequacy reviews of QHPs to FFE States that were determined to have a sufficient network adequacy review process (82 FR 18346, 83 FR 16930). In determining whether it was appropriate to defer network adequacy reviews to FFE States, we considered a States' legal authority to enforce network adequacy standards and conduct network adequacy reviews, the means to conduct assessments on the adequacy of plans' provider networks, and the ability of States to enforce minimum access standards established by HHS (for example, reasonable access standards defined under § 156.230). In contrast, we have not historically deferred ECP certification reviews wholly to FFE States, in part due to the complexity of conducting ECP certification reviews, which require sufficient technical capacity and resources that may not be readily available to States. However, given the prior experience of many FFE States in reviewing issuer submitted network adequacy data and some FFE States in reviewing ECP data (for example, States performing plan management), we believe it is appropriate to reconsider a FFE State's desire, legal authority, and technical capability to effectively conduct ECP certification reviews. We note that some States performing plan management have experience conducting ECP certification reviews prior to PY 2026 due to previous data integration and system limitations that prevented HHS from being able to conduct these reviews before we implemented the ECP UI in MPMS, which eventually allowed us to effectively conduct these reviews for issuers operating in States performing plan management.

We recognize that States possess unique knowledge on local factors related to ECP reviews, such as on market conditions, geographic constraints, areas in the State with limited economic resources, provider shortages, workforce issues, and population demographics. The States' unique knowledge of these various local factors, in particular, could strengthen ECP certification reviews, which often involve identifying low-income areas and geographic areas with health professional shortages. A State's local knowledge of low-income areas and geographic areas with health

professional shortages within the State could effectively help locate facilities in these areas that may qualify as ECPs to both measure access to ECPs across the State and for possible inclusion of these ECPs within an issuer's network towards satisfaction of the ECP standard under § 156.235. Lastly, a State's unique knowledge of local factors may allow States to innovate their approach to conduct ECP certification reviews that are more sensitive and tailored to local conditions and provider capacity in the State. For example, a State may choose to implement additional or alternative access standards for mental health facilities, a type of ECP, and consider these standards during ECP certification reviews if the State is experiencing many Mental Health Professional Shortage Areas that necessitate tailored approaches to ensure consumers have increased access to mental health facilities within their networks.

Additionally, we believe that several States already have robust ECP requirements in place, including quantitative measures to oversee the number or percentage of ECPs included in an issuer's network operating in their State. For example, a Government Accountability Office (GAO) report in 2022 found evidence that approximately 19 States reported having a quantitative standard for ECPs when reviewing individual and group plans.¹⁹⁷ The example given in the report of a quantitative standard is that multiple States require that 35 percent of ECPs in a service area must be included in the plan's network, which is consistent with the current federal ECP threshold requirement. Furthermore, we have developed and expanded resources over the years that have familiarized some States with our ECP certification review process and methodologies, including various ECP review tools and templates, the Final Plan Year ECP List which captures qualified ECPs in each State, sub-regulatory guidance published on the QHP certification website (for example, Frequently Asked Questions, QHP Application Materials for the ECP section), and webinars and office hours with States. We discovered through stakeholder engagement and communications throughout the years that some States utilize the aforementioned ECP certification resources as a foundation for their State ECP List and/or State ECP requirements.

Lastly, we note that States have expressed interest in the past for us to

¹⁹⁷ GAO. (2022, December). Private Health Insurance: State and Federal Oversight of Provider Networks Varies. Available at <https://www.gao.gov/assets/gao-23-105642.pdf>.

grant them with additional flexibility to conduct reviews of ECP data. For example, in response to our proposal in the 2026 Payment Notice proposed rule (90 FR 4506) to allow HHS to conduct ECP certification reviews of QHP issuers in States performing plan management, one State that operates a State Exchange expressed that each State's market demands tailored approaches to meet their unique needs, which may be more effectively addressed through State-level decision making and reviews of issuer-submitted ECP data.

For all these reasons, we believe that FFE States may have the legal authority, technical capacity, expertise, and interest to conduct their own ECP certification reviews. Thus, beginning PY 2027 and thereafter, we propose to allow FFE States, including States performing plan management, to elect to perform their own State reviews of issuer-submitted ECP data provided the State demonstrates sufficient authority and technical capacity by meeting the applicable criteria, as determined by HHS, to have an Effective ECP Review Program. An FFE State would be granted an Effective ECP Review Program designation if we determine it meets all applicable requirements described for this program under proposed § 155.1051. We believe that establishing applicable requirements under proposed § 155.1051 for FFE States to demonstrate they have an Effective ECP Review Program is necessary to ensure States have the authority and technical capacity to conduct these ECP certification reviews in a way that continues to ensure consumers have adequate access to ECPs through their plans. If we determine that an FFE State does not have an Effective ECP Review Program, then we would continue to perform ECP certification reviews consistent with § 156.235 for network plans.

We continue to believe that HHS should continue to primarily conduct ECP certification reviews as the default approach for issuers' plans applying for certification to be offered as QHPs through an FFE, including States performing plan management, except if an FFE State elects to conduct ECP certification reviews and is determined to have sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective ECP Review Program. We believe that Federal ECP certification reviews are highly valuable for several reasons.

First, ECPs serve predominately low-income, medically underserved individuals, and these populations often

experience higher rates of illness and are less equipped to field high out-of-pocket costs; additionally, the services furnished by ECP facilities are often more highly specialized with greater levels of acuity and expense,¹⁹⁸ such as cancer care at Free-Standing Cancer Centers, Black Lung Disease treatment at Black Lung Clinics, tuberculosis treatment at Tuberculosis Clinics, hemophilia treatment at Hemophilia Treatment Centers, HIV/AIDs treatment with Ryan White Providers, and more. Altogether, centralized Federal ECP certification reviews are continuously valuable to perform complex analyses that aim to protect these more vulnerable populations and decrease potential disparities in access across States.

Second, while we are aware of many States that have qualitative and/or quantitative network adequacy regulatory standards that are comparable to standards under § 156.230 (including on time and distance and appointment wait time requirements) and experience conducting such reviews, less is known about to what extent States may have different and separate requirements for ECPs, integrate ECP and network adequacy requirements together under one standard, or do not have standalone ECP requirements at all. For this reason, we believe HHS retaining primary responsibility over conducting ECP certification reviews as the default approach is appropriate, at least until we learn additional information from FFE States on their ECP requirements as part of the Effective ECP Review Program determination process. To broaden knowledge on this issue, we solicit comments on different ways that FFE States, including States performing plan management, currently implement State-specific requirements for ECP standards and how these requirements may be comparable to or different from

ECP requirements implemented at § 156.235.

Third, through stakeholder engagement throughout the years, we are also aware that some State Departments of Insurance may have limited resources and bandwidth to conduct ECP certification reviews, which are highly complex and data intensive. In the past, these State Departments of Insurance have expressed support of HHS conducting ECP certification reviews due to State resource limitations. We have expanded our data collection capabilities and means to efficiently and adequately conduct ECP certification reviews over the years, such as through the development of the ECP List¹⁹⁹ and ECP data collection in MPMS. The ECP List has helped us identify the exact geographic location and distribution of ECPs to highlight specific ECPs that may be available within an issuer's service area and available for contracting with the issuer to satisfy ECP requirements under § 156.235. And, it simultaneously ensures that the full range of different ECP categories defined in section 340B(a)(4) of the PHS Act and, for network plans, providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act are adequately represented and available to consumers in an issuer's network. This ECP List has been embedded within the ECP UI in MPMS, so that QHP issuers can select specific ECPs from this list that are contracted with the issuer and included in their network within a particular service area, which allows us to calculate an issuer's satisfaction toward the ECP threshold, ECP category per county, and ECP Indian health care requirements. Based on our experience conducting ECP certification reviews, we maintain that having adequate and accurate data on available ECPs in a geographic area, sufficient tools to collect and calculate issuer submitted ECP data, and sound methodologies to quantitatively assess this data to determine reasonable and timely access to ECPs in accordance with section 1311(c)(1)(C) of the Affordable Care Act is crucial for any FFE State to demonstrate the technical capacity to conduct their own ECP certification reviews. Outside of a couple of State Exchanges that have reached out annually to inquire about our ECP List and a couple of States that have shared that they keep their own State-specific list of available ECPs, it is unknown how many States can develop

¹⁹⁸ Edward J, Wiggins A, Young MH, Rayens MK. Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform. *Health Lit Res Pract*. 2019 Nov 5;3(4):e250–e258. doi: 10.3928/24748307–20190923–01. Available at <https://pmc.ncbi.nlm.nih.gov/articles/PMC6831506/>. Karen Pollitz, Kaye Pestaina, Alex Montero, Lunna Lopes, Isabelle Valdes, Ashley Kirzinger, and Mollyann Brodie. KFF. (2023, June 15). KFF Survey of Consumer Experiences with Health Insurance. Available at <https://www.kff.org/mental-health/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/>. OASH, Health People 2023, Literature Review. Available at <https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty#:~:text=Unmet%20social%20needs%2C%20environmental%20factors,for%20people%20with%20lower%20incomes.&text=For%20example%2C%20people%20with%20limit>.

¹⁹⁹ HHS has developed and regularly maintained an ECP List since 2015, which provides a large national snapshot of the universe of qualified ECPs across all States and by various category types.

and maintain a similar State-specific list of qualified ECPs or utilize HHS' ECP List that can be applied to conduct their own ECP certification reviews of issuer-submitted ECP data. It is also unknown what tools States may currently utilize to collect issuer submitted ECP data and methodologies States apply to assess this data to demonstrate reasonable and timely access to ECPs. For these reasons, too, we believe it is appropriate that HHS retain primary responsibility over conducting ECP certification reviews as the default approach, at least until we learn additional information from FFE States as part of the Effective ECP Review Program determination process. This additional information would include whether FFE States have a process to identify qualified ECPs "where available" that may be included within a network plan's provider network, tools to collect issuer-submitted ECP data, and methodologies to assess the adequacy of an issuer's network of ECPs. Additionally, to broaden our knowledge in this area, we seek comment to learn which States have their own ECP List or other related process to identify qualified ECPs that may be utilized for certification purposes.

Accordingly, we propose to set forth the criteria for an Effective ECP Review Program by adding § 155.1051 to part 155, subpart K. Under § 155.1051(a), we propose that FFE States may elect to conduct their own ECP certification reviews of issuers' plans applying for certification to be offered as QHPs through an FFE, including States performing plan management, provided that the State demonstrates sufficient authority and technical capacity to conduct these reviews by satisfying the applicable criteria in proposed § 155.1051. If FFE States do not satisfy the criteria established in proposed § 155.1051, then we would continue to perform ECP certification reviews consistent with § 156.235 for network plans.

In alignment with the proposal in section III.E.12 of this proposed rule to allow plans that do not use a network (non-network plans) to receive QHP certification, including by demonstrating that these plans ensure a sufficient choice of ECPs consistent with section 1311(c)(1)(B) of the Affordable Care Act, we would also provide additional flexibilities to FFE States to conduct ECP certification reviews of non-network plans if they are determined to have an Effective ECP Review Program. Similar to the approach for network plans, we would perform ECP certification reviews for non-network plans under proposed

§ 156.236 if FFE States do not satisfy criteria for having an Effective ECP Review Program. An FFE State would need to demonstrate that it meets applicable criteria for both network plans and non-network plans (under proposed § 155.1051(b) through (c)), and the sufficient authority and technical capacity to conduct reviews of such plans (as assessed under proposed § 155.1051(e)), if they decide to certify non-network plans, in order to receive a designation as having an Effective ECP Review Program. This would mean an FFE State would not be permitted to elect to conduct ECP certification reviews for only network plans and not non-network plans, if they certify non-network plans, or vice versa. However, if an FFE State notifies us that they do not intend to certify non-network plans within their State and consequently do not offer these plans to consumers on the FFEs operating in their State altogether (regardless of if the State or HHS would conduct ECP certification reviews), then we would continue to review whether an FFE State meets all applicable criteria for only network plans during the Effective ECP Review Program determination process. For additional details regarding the criteria for the Effective ECP Review Program under proposed § 155.1051 and how these criteria would pertain to reviews of non-network plans in FFE States electing to conduct ECP certification reviews, please see the discussion under sections III.D.19 and III.E.12.e of this proposed rule.

Furthermore, to ensure that issuers in FFE States continue to meet ECP requirements promulgated under section 1311(c)(1)(C) of the Affordable Care Act, and consistent with § 156.235 for network plans, we propose in § 155.1051(b) that FFE States with an Effective ECP Review Program must ensure that a QHP issuer with a provider network includes in its provider network a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the Exchange's network adequacy standards. Furthermore, we continue to believe that to protect low-income, medically underserved populations, and to ensure that enrollees in all FFEs have a minimum standard for consumer protections on reasonable access to providers and that disparities in access are minimized across FFE States, issuers

in FFE States with an Effective ECP Review Programs must continue to demonstrate that they meet State requirements to ensure reasonable and timely access to ECPs that are consistent with requirements of the ECP Standard under § 156.235. Thus, we propose in § 155.1051(c) that FFE States with an Effective ECP Review Program must have established ECP requirements that are set forth in State statute or regulation. FFE States must demonstrate that these established ECP requirements ensure that issuers with a provider network in their State meet all of the following requirements that promote a sufficient number and geographic distribution of ECPs: the minimum percentage requirements under § 156.235(a)(2)(i), the Indian health care provider requirement under § 156.235(a)(2)(ii)(A), and the category per county requirements for each of the eight ECP category types described under § 156.235(a)(2)(ii)(B). In this manner, we believe that FFE States having ECP requirements consistent with the three aforementioned requirements would help maintain access to ECPs.

However, we recognize that FFE States may have alternative, distinct ECP requirements to ensure a sufficient number and geographic distribution of ECPs are included within an issuer's network to address various local conditions unique to each State. For example, some FFE States may have time and distance requirements that issuers must satisfy for enrollees to access certain types of ECPs; some FFE States may have different minimum percentage requirements than those described under § 156.235(a)(2)(i),²⁰⁰ such as minimum percentages for rural health providers, mental health facilities, or other types of ECP facilities; some FFE States may have ECP facility to enrollee ratio requirements, which may require an issuer to contract with a certain number or categories of ECPs based on the number of enrollees enrolled in their plan (for example, 1 FQHC per 1,000 enrollees). We acknowledge that there could be numerous quantitative and qualitative methods beyond these aforementioned examples that States may use to analyze access to ECPs, which may especially be influenced by factors unique to each State. For these reasons, FFE States with alternative ECP requirements would be required to demonstrate how these requirements would promote a

²⁰⁰ Current ECP minimum percentage requirements include an Overall ECP Threshold, FQHC Threshold, and Family Planning Provider Threshold.

sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to ECPs, and an adequate level of service for low-income enrollees or individuals residing in Health Professional Shortage Areas under § 155.1051(d). To assess an FFE State's satisfaction of the requirements in proposed § 155.1051(d), we would require FFE States to submit a written description of their alternative ECP requirements, an explanation of how the State collects ECP data from issuers to measure compliance with the alternative ECP requirement, and a detailed explanation of how the State uses this ECP data to analyze access to ECPs within an issuer's network.

In addition, for an FFE State to conduct ECP certification reviews, under our proposal, the FFE State would need to first express its interest to HHS and submit an attestation for having an Effective ECP Review Program. An FFE State would have the choice to submit an attestation for an Effective ECP Review Program, Effective Provider Access Review Program (described in section III.E.10 of this proposed rule), or both. This means that an FFE State can elect to conduct their own ECP certification reviews, provider access certification reviews, or both reviews provided the State demonstrates that it has sufficient authority and the technical capacity by satisfying the applicable criteria for the applicable review program depending on which review(s) it wishes to conduct. We propose that if an FFE State does not directly communicate to HHS its interest in conducting its own ECP certification reviews, then we will assume the FFE State prefers that we continue conducting these reviews. FFE States with an interest in conducting their own ECP certification reviews would need to submit their attestation that the State has an Effective ECP Review Program prior to the start of the QHP certification cycle for the first plan year it wishes to assume responsibility to conduct ECP certification reviews. We would review information submitted by the FFE State to ensure the State has the authority and technical capacity to conduct effective, timely reviews of ECP data submitted by an issuer prior to each plan year's QHP certification cycle. In our review, we would consider whether the FFE State receives adequate issuer data and documentation sufficient to conduct an examination of ECP requirements described in § 156.235 for network plans. For additional details regarding the proposed criteria for the Effective ECP Review Program under proposed

§ 155.1051 and how these criteria would pertain to reviews of non-network plans in FFE States electing to conduct ECP certification reviews, we refer readers to the discussion under sections III.D.19 and III.E.12.e of this proposed rule. We propose in § 155.1051(e)(1) through (10) that we would consider the following factors in our review to determine if a FFE State has an Effective ECP Review Program:²⁰¹

(1) The State's legal authority to review whether plans applying for QHP certification meet ECP requirements, including relevant State regulations and statutes;

(2) Evidence that the State's requirements are consistent with ECP requirements under proposed § 155.1051(c)(1) through (c)(3) that promote a sufficient number and geographic distribution of ECPs, or the State's explanation of how its alternative ECP requirements promote a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to ECPs;

(3) A description of the State's definition of an ECP, if different from the definition under § 156.235(c), including relevant categories and eligibility criteria that the State uses to determine whether a facility qualifies as an ECP;

(4) Whether the State utilizes the Federal ECP List or has a process it uses to identify qualified ECPs that may be included within a network plan's provider network;

(5) Whether the State utilizes the Federal ECP List or has a process it uses to identify qualified ECPs that may accept a non-network plan's benefit amount as payment in full;

(6) A description of data collection systems, resources, templates, or methodologies used by the State to collect and review ECP data;

(7) Whether the State generally collects information from QHP issuers regarding the status of contract offers for network plans or offers of benefit amounts as payment in full to an ECP for non-network plans;

(8) Whether the State has delegated authority to some other entity other than the State Department of Insurance to perform ECP any or all review activities;

(9) Whether the State has compliance reviews, follow-up procedures, and enforcement frameworks applicable to issuers that demonstrate inadequate networks of ECPs so that those issuers come into compliance with State ECP requirements, including standardized

processes to assess efforts the issuer is pursuing to come into compliance with State ECP requirements and any justification and exception processes for issuers that have not yet or cannot meet ECP requirements;

(10) Whether the State has a process for monitoring and addressing consumer-related complaints regarding access to ECPs to ensure sufficient access to ECPs consistent with section 1311(c)(1)(C) of the Affordable Care Act and set forth in State statute; and

The first proposed factor under § 155.1051(e)(1) requires that the FFE State has established ECP requirements that are set forth in State statute or regulation. This factor is crucial since it identifies whether the FFE State has sufficient legal authority to promulgate regulations to establish ECP requirements, and that it has the authority to conduct ECP certification reviews to ensure QHP issuers meet such requirements.

The second proposed factor under § 155.1051(e)(2) requires evidence that the FFE State's ECP requirements are consistent with ECP requirements under proposed § 155.1051(c)(1) through (c)(3) that promote a sufficient number and geographic distribution of ECPs, or the FFE State provides a rationale to describe how its alternative State ECP requirements promote a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to ECPs. This factor is important to ensure that an FFE State's requirements are consistent with those under § 156.235 for network plans and under proposed § 156.236 for non-network plans, so that these requirements continue to maintain access to ECPs especially if they differ from those ECP requirements under § 156.235 and proposed § 156.236.

The third factor under § 155.1051(e)(3) considers the FFE State's definition of an ECP, if different from the definition under § 156.235(c), and relevant categories and eligibility criteria that the FFE State uses to determine whether a facility qualifies as an ECP. This factor acknowledges that FFE States may have different categories of ECPs compared to those described under § 156.235(c), including that some FFE States may have chosen to expand the categories of facilities that may qualify to be an ECP in the State. An understanding of the FFE State's definition of an ECP is necessary to ensure the State satisfies statutory requirements under section 1311(c)(1)(C) of the Affordable Care Act which requires the Secretary to promulgate regulations to ensure QHPs include within their networks certain

²⁰¹ Please see the discussion regarding factors (5), (7), and (11) in section III.E.12.e of this proposed rule.

categories of ECPs, such as those specified in section 340B(a)(4) of the PHS Act and entities described in section 1927(c)(1)(D)(i)(IV) of the Act.

The fourth and fifth factors under § 155.1051(e)(4) and (e)(5) evaluate a FFE State's process to identify qualified ECPs that may be included within a network plan's provider network, or qualified ECPs that accept a non-network plan's benefit amount as payment in full, respectively; or whether it utilizes the Federal ECP List to identify qualified ECPs. As stated in the discussions above, we believe it is critical for the FFE State to have a process to identify qualified ECPs, "where available." Understanding whether the FFE State utilizes the Federal ECP List or has its own process to identify qualified ECPs is crucial to evaluate the FFE State's satisfaction of the requirements under section 1311(c)(1)(C) of the Affordable Care Act which requires the Secretary to promulgate regulations to ensure QHP issuers include within health insurance plan networks those ECPs, "where available" that serve predominately low-income, medically underserved individuals. An FFE State implementing a process to identify qualified ECPs, or even the FFE State's utilization of the Federal ECP list, would allow the State to identify the exact geographic location and distribution of ECPs to highlight specific ECPs that may be available within an issuer's service area and available for contracting with the issuer to satisfy ECP requirements. And, if the FFE State identifies the category of services an ECP provides when identifying the qualified ECP, it can simultaneously ensure that the full range of different ECP categories defined in section 340B(a)(4) of the PHS Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act are adequately represented and available to consumers in an issuer's network.

The sixth factor under § 155.1051(e)(6) considers if the FFE State has data collection systems, resources, templates, or methodologies to collect and review ECP data. This information would be important for HHS to understand processes a FFE State has in place to efficiently collect large, complex amounts of an issuer's ECP data and their ability to meaningfully leverage that data to apply assessment methodologies to measure access to ECPs across the State. This information would offer additional evidence to demonstrate an FFE State's technical capacity by indicating the different documentation, resources, and expertise it has developed to have the

means to conduct an effective, timely examination of ECP data.

The seventh factor under § 155.1051(e)(7) considers if the FFE State collects information from QHP issuers regarding the status of contract offers for network plans or offers of benefit amounts as payment in full to an ECP for non-network plans. We believe this type of ECP data is important for an FFE State to collect from QHP issuers during its assessment of the adequacy of an issuer's network of ECPs or during its assessment to ensure access to a sufficient choice of ECPs that would accept a non-network plan's benefit amount in full. An FFE State collecting this type of data would demonstrate that it has the technical capacity to validate a QHP issuer's progress towards contracting with ECPs, which allows the FFE State to track an issuer's effort in pursuing to build a sufficient network of ECPs so that consumers in network plans have reasonable and timely access to a broad range of ECPs. Similarly, an FFE State collecting data from QHP issuers with non-network plans regarding the status of offering benefit amounts as payment in full to ECPs would allow the State to assess the issuer's commitment to facilitating access to a sufficient number of ECPs that an enrollee can access in their service area without needing to pay charges in excess of the benefit amount for an array of services. These contract statuses would serve as important metrics during an FFE State's assessment of ensuring access to ECPs, where available, including by allowing States to measure an issuer's compliance with the minimum threshold percentage, category per county, and Indian health care requirements under proposed § 156.236(b)(1) through (b)(3), which would be evaluated based on measurements of contracts offered or executed, and benefit amounts as payment in full that were offered to or accepted by an ECP.

The eighth factor under § 155.1051(e)(8) considers whether the FFE State has delegated authority to some other entity other than the State Department of Insurance to perform any or all ECP review activities. It would be important for a FFE State to report to us any delegated authority to other entities to perform ECP review activities, so we understand how the FFE State is handling ECP review data and to whom it entrusts such data. In addition, it is important to review whether entities conducting such reviews have sufficient expertise to competently handle ECP reviews and that these entities would be able to conduct ECP reviews in such a

way that would allow the FFE State to still satisfy all applicable criteria in proposed § 155.1051 as part of having an Effective ECP Review Program.

The ninth factor under § 155.1051(e)(9) considers whether the FFE State has compliance reviews, follow-up procedures, and enforcement frameworks applicable to issuers that demonstrate inadequate networks of ECPs or inadequate access to ECPs that accept benefit amounts as payment in full, so that those issuers come into compliance with State ECP requirements. This factor would also consider whether the FFE State has standardized processes to assess efforts the issuer is pursuing to come into compliance with State ECP requirements and any justification and exception processes for issuers that have not yet or cannot meet ECP requirements. We believe that the existence of these processes is critical for an FFE State to demonstrate sufficient enforcement authority, while maintaining the ability to evaluate the integrity and outcome of ECP certification reviews, which aims to ensure that low-income, medically underserved populations traditionally served by ECPs have sufficient access to these ECPs through their plans, where available. Overall, these processes would ensure an FFE State has the ability to require that QHP issuers continue to meet state ECP requirements and comply with ECP statutory requirements under section 1311(c)(1)(C) of the Affordable Care Act.

The tenth factor under § 155.1051(e)(10) considers whether the FFE State has a process for monitoring and addressing consumer-related complaints regarding access to ECPs to ensure sufficient access to ECPs consistent with section 1311(c)(1)(C) of the Affordable Care Act and as set forth in State statute. This factor is important since it would indicate the FFE State has a process to continuously monitor access to ECPs and ensure that State ECP requirements aimed to promote access to ECPs have their intended effect among consumers. Access to ECPs can change during the year for a multitude of factors, including due to facility closures, network terminations, changes in services offered by ECPs, financial stability and funding reductions, staffing shortages, etc. For plans using a provider network, contracts may be executed or terminated throughout a plan year for various reasons. Also, any inaccuracies or out-of-date information contained in provider directories can create confusion or be misleading to consumers. Additionally, consumers

may have trouble making appointments with network providers due to lack of availability of appointments. For plans without a provider network, we anticipate that ECPs that accept a benefit amount as payment in full could change depending on market conditions, negotiations, and competition, or that consumers may require additional assistance in understanding how to utilize plan benefit amounts to meet their health care needs in such a way that does not increase out-of-pocket costs beyond the plan's benefit amount.

Lastly, in § 155.1051(f), we propose that we would notify the FFE State electing to conduct ECP certification reviews of our decision in writing prior to the start of the QHP certification cycle whether the FFE State is determined to have an Effective ECP Review Program and can therefore conduct its own ECP certification reviews for the plan year. In subsequent years and prior to the start of the QHP certification cycle each year, we would reach out to FFE States with an Effective ECP Review Program designation to confirm if the FFE States wish to continue conducting their own ECP certification reviews for the upcoming plan year and to verify if any circumstances have changed that may affect an FFE State's authority and technical capacity to continue conducting effective, timely reviews of ECP data. We propose that we would reserve the right to evaluate the FFE State at any time whether, and to what extent, the FFE State's circumstances has changed such that it has begun to or has ceased to satisfy the criteria established by HHS under proposed § 155.1051, and consequently no longer has an Effective ECP Review Program. We often complete an annual environmental scan of State authorities to maintain situational awareness of changing authorities across FFE States, and the same would apply to this proposal to ensure FFE States with an Effective ECP Review Program continue to satisfy all applicable Federal requirements.

Additionally, we clarify that we would be available to provide technical assistance to FFE States on any issues related to the Effective ECP Review Program. We remain open to assisting FFE States at any point of the process, from electing to conduct their own ECP certification reviews to performing ECP certification reviews as an Effective ECP Review Program State, to ensure an FFE State's ECP requirements and certification review process continue to protect access to ECPs for low-income, medically underserved populations. We

would also continue to make ECP resources publicly available, including for those FFE States that are determined to have an Effective ECP Review Program and wish to utilize these resources as part of their ECP certification reviews. These resources include the Final Plan Year ECP List and Rolling Draft ECP List, medical QHP and SADP ECP tools, the Available ECP Write-in List, the Plan Validation workspace in MPMS, and guidance on the QHP certification website.²⁰² We believe these supporting documents and tools are widely used across many States and among many issuers, serving as important resources for both identifying ECPs nationally to potentially include in a plan's network and assisting issuers in meeting ECP requirements.

In addition to the aforementioned resources and technical assistance that we would provide to FFE States, we would continue collecting ECP data from FFE issuers in FFE States with an Effective ECP Review Program, similar to the proposed approach for network adequacy in section III.E.10 of this proposed rule. We believe this data would provide additional insight to assess how QHP issuers are performing across the FFE, including in FFE States with an Effective ECP Review Program, to consistently compare issuer performance. Collecting this data would also provide us with the ability to continue to monitor consumer access to ECPs across the FFE. The data would also be available in a standardized format to FFE States with an Effective ECP Review Program, which could be utilized to inform their ECP certification reviews and to perform additional analyses to analyze access to ECPs across the State. We believe this proposed approach would support FFE States in their capacity to conduct these complex ECP reviews.

We seek comment on these proposals.

12. QHP Certification of Non-Network Plans (§§ 155.1050, 155.1051, 156.230, 156.235, 156.236, 156.275, and 156.810)

In this proposed rule, we propose a number of revisions to parts 155 and 156 to allow plans that do not use a network (non-network plans) to receive QHP certification beginning with PY 2027 by demonstrating that they ensure a sufficient choice of providers in a manner consistent with section 1311(c)(1)(B) and (C) of the Affordable Care Act. In addition, to ensure that

²⁰² These resources may be found at <https://www.qhpcertification.cms.gov/QHP/applicationmaterials/Essential-Community-Providers>.

non-network plans are subject to similar requirements as network plans, we propose that (1) FFE States that elect to conduct provider access certification reviews and are determined by HHS to have an Effective Provider Access Review Program under proposed § 155.1050(d) would be permitted to perform provider access reviews of non-network plans if the State satisfies all applicable criteria under § 155.1050(d); and (2) FFE States that elect to conduct ECP certification reviews and are determined by HHS to have an Effective ECP Review Program under proposed § 155.1051 would be permitted to perform ECP certification reviews of non-network plans if the State satisfies all applicable criteria under § 155.1051. For additional detail on how the Effective Provider Access Review Program and Effective ECP Review Program proposals would apply to FFE States conducting reviews of non-network plans, please reference these discussions in section III.E.12.d and section III.E.12.e of this proposed rule.

a. Previous Rulemaking Related to Non-Network Plans

Together, section 1311(c)(1), 1311(c)(1)(B), and 1311(c)(1)(C) of the Affordable Care Act directs HHS to establish by regulation certification criteria for QHPs, which include (but are not limited to) criteria that require QHPs to ensure a sufficient choice of providers, provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers, and include within health insurance plan networks those ECPs, where available, that serve predominantly low-income, medically underserved individuals. We have historically implemented these provisions through our network adequacy and ECP requirements for network plans at § 156.230 and § 156.235, respectively.²⁰³

In the Exchange Establishment Rule (77 FR 18310), we finalized the minimum network adequacy criteria that plans, including medical plans and SADPs, must meet to be certified as QHPs at § 156.230. In the 2016 Payment Notice (80 FR 10749), we revised § 156.230(a) to specify that network adequacy requirements apply only to QHPs that use a provider network (network plans) to deliver services to enrollees and that a provider network includes only providers that are contracted as in-network. We also revised § 156.235(a) to state that the ECP criteria apply only to QHPs that use a provider network. In part 1 of the 2022

²⁰³ See 45 CFR 156.230 and 156.235.

Payment Notice (86 FR 6138), we added section (f) to § 156.230 to clarify that a plan for which an issuer seeks QHP certification or any certified QHP that does not use a provider network (or non-network plan) is not required to comply with the network adequacy standards at paragraphs (a) through (e) of § 156.230 to qualify for certification as a QHP. Unlike network-based plans, non-network health plans do not rely on a contracted set of providers that agree in advance to specific terms and negotiated payment rates, nor do they condition or differentiate benefits to enrollees based on whether the issuer has a network participating agreement with a provider that furnishes covered services. Instead, these plans set specific benefit amounts for covered services and communicate those benefit amounts to enrollees who may then seek covered services from any provider. The plan may determine the benefit amount based on an established methodology such as a percentage of a publicly available benchmark, a reference-based pricing structure, or another reimbursement standard (that is, Medicare or private payor rates, etc.).

In the 2024 Payment Notice (88 FR 25872 through 25879), we exercised the authority delegated to us by section 1311(c)(1) of the Affordable Care Act to establish criteria for the certification of health plans as QHPs in order to revise §§ 156.230 and 156.235 to require all individual market QHPs and SADPs and all SHOP QHPs across all Exchanges to utilize a network of providers that complies with the standards described in §§ 156.230 and 156.235. In doing so, we acknowledged that we had previously stated that “nothing in [the Affordable Care Act] requires a QHP issuer to use a provider network” because there is no explicit standalone network requirement (88 FR 25872 (quoting 84 FR 6154)). But we still expressed concerns over whether a plan without a network would be able to comply with Affordable Care Act section 1311(c)(1)(C)’s requirement that plans “shall, at minimum . . . include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals,” which we read to imply that access to ECPs would be provided “within health insurance networks” (88 FR at 25873). We also solicited comment on alternative administrable regulatory standards under which non-network plans could “ensure a sufficient choice of providers” consistent with section 1311(c)(1)(B) of the Affordable Care Act. At the time,

neither commenters to the 2024 Payment Notice nor HHS had enough information to devise such an administrable regulatory standard to enable non-network plans to demonstrate a sufficient choice of providers to receive QHP certification. On these bases, in the 2024 Payment Notice (88 FR 25876), we finalized the requirement that all QHPs (except certain SADPs)²⁰⁴ must use a network of providers. As a result of this, non-network plans are currently unable to meet all of the minimum certification criteria at § 155.1000(c), which means Exchanges cannot currently certify non-network plans as QHPs and consumers cannot enroll in non-network plans through the Exchanges.

b. The Basis for Reconsidering Our Existing Prohibition on Non-Network Plans as QHPs

As a preliminary matter, we first explain why we are revisiting our existing blanket prohibition of non-network plans as QHPs, including our approach to ensure non-network plans meet requirements to ensure a sufficient choice of providers in a manner consistent with section 1311(c)(1)(B) and (C) of the Affordable Care Act. One justification for revisiting our existing prohibition of non-network plans as QHPs is that circumstances have changed: when we finalized our blanket prohibition of non-network plans as QHPs, we had not developed an effective, administrable approach at the time we adopted the prohibition through which we could adequately measure whether non-network plans could ensure a “sufficient choice of providers” under section 1311(c)(1)(B) of the Affordable Care Act, or include ECPs through their plans, where available, under section 1311(c)(1)(C) of the Affordable Care Act. We continue to believe that consumers shopping on the Exchanges must be assured of the ability of every QHP to provide a sufficient choice of providers under section 1311(c)(1)(B) of the Affordable Care Act, and that a non-network plan should not be given a “pass” on demonstrating that it provides access to a sufficient choice of providers because it does not utilize a provider network. As described further below and in the next subpart, we now propose a new approach to measuring a non-network plan’s compliance with section 1311(c)(1)(B) and (C) of the Affordable Care Act, which addresses our prior concerns. In doing so, we also revisit our original interpretation of section 1311(c)(1)(C) of the Affordable Care Act, including how

our proposed approach would mitigate prior concerns over non-network plans being able to provide access to ECPs in a manner consistent with this provision.

First, we acknowledge that provider networks serve as a critical cost control tool, which has downstream impacts on a consumer’s out-of-pocket costs that are important to consider when devising an alternative regulatory standard to continue to ensure broader access to care. Insurers with a provider network often have different cost-sharing requirements depending on if an enrollee sees a provider that is in-network versus out-of-network. A traditional network plan typically contracts with a certain number of providers (but rarely all) in each area who agree to accept the plan’s negotiated rates as payment in full for covered services, ensuring that enrollees have reasonable access to a certain number of providers who will render services at specified costs; and often, these specified costs are lower if an enrollee sees an in-network provider since enrollees often have to pay more when seeking care from providers with whom the issuer did not contract.

In contrast, a non-network plan sets specified benefit amounts for covered services and communicates those benefit amounts to its enrollees in advance. Non-network plan enrollees use this benefit amount as a reference price for how much they should expect to pay for the receipt of covered services under the plan. With it, they can choose any provider for their care and compare and negotiate prices among available providers to find a provider who will accept the plan’s benefit amount as payment in full, such that the provider will not balance bill the enrollee for additional amounts beyond the plan’s benefit amount. This interaction between the enrollee and provider before services are rendered could limit the enrollee from incurring additional unforeseen out-of-pocket costs, particularly if the enrollee decides to pursue care with the provider at a cost below or equal to the plan’s benefit amount. Thus, both plan models are capable of providing a pathway for enrollees to limit out-of-pocket costs. Non-network plans are capable of providing an opportunity for individual enrollees to participate in efforts to lower their health care costs through individualized price comparisons and negotiations, while network plans rely heavily on health insurers to do so.

However, while enrollees in a non-network plan can receive some benefit for covered services from virtually any provider, there is no guarantee that the plan’s benefit amounts are actually

²⁰⁴ See 45 CFR 156.230(a)(4).

sufficient to cover the provider's full charges, and there is no requirement imposed by the non-network plan on providers to accept the plan's benefit amount as payment in full. As a result, if or when these benefit amounts are too low, non-network plans can leave enrollees with additional out-of-pocket costs that make certain providers, as a practical matter, unavailable. That can be problematic for services that an enrollee could not have reasonably anticipated needing to negotiate for in advance. And, it can have a particular impact on low-income, medically underserved populations who may face disproportionate challenges in paying for large out-of-pocket costs.

Furthermore, if a non-network plan's benefit amount for a covered service is so low that virtually no providers in a particular area accept the benefit amount as payment in full, the non-network plan cannot credibly claim to provide a sufficient choice of providers of those services, and the non-network plan does not provide access to a sufficient choice of providers under section 1311(c)(1)(B) of the Affordable Care Act. Conversely, if the benefit amount is sufficient such that many providers in the area accept the benefit amount as payment in full, enrollees may choose between providers in their area who will accept the non-network plan's benefit amount as payment in full without incurring additional out-of-pocket costs. In this case, a non-network plan may be able to provide access to a sufficient choice of providers for those services. In other words, the set of providers in the applicable area that would accept the plan's benefit amount as payment in full is like a network plan's network. So long as that set of providers is adequate, a non-network plan can comply with requirements to ensure a sufficient choice of providers, and we describe our proposed method to measure that compliance in the next section.

As we stated in the discussions above, we raised concerns in the 2024 Payment Notice regarding the ability of a non-network plan to comply with section 1311(c)(1)(C) of the Affordable Care Act, due to our understanding that access to ECPs should be provided "within health insurance networks." We inferred from Affordable Care Act section 1311(c)(1)(C)'s use of the word "network" that the statute meant that Exchanges could certify, as QHPs, only plans that have a contractual network of providers, not inclusive of non-network plans. Though, we recognize that the term "network" is never defined in the statute. And, as we have consistently noted, Congress never imposed a

standalone requirement that QHPs structure their plans via contracts with providers nor was Congress specific on the requirements needed to constitute a network. We now interpret the statute to offer broad flexibility governing the status of a contractual relationship between a plan and provider as a precondition to constitute a network under section 1311(c)(1)(C) of the Affordable Care Act. In this regard, we believe that so long as non-network plans provide sufficient access to ECPs, where available, that serve predominately low-income, medically underserved individuals, a non-network plan could comply with requirements under section 1311(c)(1)(C) of the Affordable Care Act. This may be accomplished through a non-network plan demonstrating access to ECPs within their service area that would accept the plan's benefit amount as payment in full.

Furthermore, we have evaluated traditional networks to ensure enrollees have access to a sufficient choice of providers, consistent with section 1311(c)(1)(B) of the Affordable Care Act, and to promote access to ECPs, where available, for low-income, medically underserved individuals, consistent with section 1311(c)(1)(C) of the Affordable Care Act. To that effect, networks facilitate a multitude of different relationships between providers, insurers, and enrollees to ensure sufficient access to care, which can still be maintained through non-network plans through their greater focus on enrollees more directly participating in lowering the price of their care. Specifically, a non-network plan's "network" consists of the providers in the applicable area that would accept the plan's benefit amount as payment in full. By establishing payment amounts that providers can choose to accept as payment in full, non-network plans are capable of creating a *de facto* network of providers or suppliers even without formal contractual relationships. Thus, a non-network plan can comply with section 1311(c)(1)(C) of the Affordable Care Act by ensuring that a sufficient number of ECPs accept the plan's benefit amounts as payment in full. However, a non-network plan would not satisfy that requirement if its benefit amount is so low that many ECPs would not accept the benefit amount as payment in full from enrollees, because section 1311(c)(1)(C) of the Affordable Care Act would still require an Exchange to consider the practical availability of services from ECPs before certifying a QHP, including ECPs, where available.

It would not be sufficient for an Exchange to simply conclude that a non-network plan provides access to providers in a manner consistent with section 1311(c)(1)(B) and (C) of the Affordable Care Act because the plan provides some benefit amount for covered services rendered by any provider. Thus, the availability of providers in a particular area that accept the benefit amount as payment in full is important to constitute a sufficient choice of providers consistent with section 1311(c)(1)(B) and (C) of the Affordable Care Act.

Moreover, there are additional reasons for our reconsideration of our blanket prohibition of non-network plans as QHPs. Specifically, recent efforts to improve health price transparency and its implementation across the health care system present an opportunity to reshape how health care services are delivered, and when enrollees have easier access to health care pricing information, market forces can and often do drive down costs through increased competition among providers.²⁰⁵ Because enrollees directly negotiate the cost of care in non-network plans, non-network plans can more naturally leverage price transparency principles compared to network plans. By incentivizing patient involvement in health cost comparison, these plans have potential to reduce overall health care costs by empowering their enrollees to shop for and potentially negotiate lower prices. Such efforts could lead to a more efficient market where network formation becomes less critical for ensuring affordable health care access. Because providers are not bound by pre-negotiated network agreements, enrollees in such plans may face different pricing dynamics than in network-based plans, including the need to compare costs more proactively and, in some cases, negotiate payment amounts directly with providers. This model places greater emphasis on enrollee engagement and transparency but can also offer increased flexibility and broader provider choice while maintaining predictable plan liability through the use of clear and consistently applied reimbursement formulas.

²⁰⁵ For example, see CMS. Hospital Price Transparency. Available at <https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency>. See also, The White House. (2025, February 25). Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information. Available at <https://www.whitehouse.gov/presidential-actions/2025/02/making-america-healthy-again-by-empowering-patients-with-clear-accurate-and-actionable-healthcare-pricing-information/>.

Overall, non-network plans have great potential to reduce overall health care costs. First, they can empower enrollees to use price information on benefit amounts, when available, to shop for lower prices and negotiate directly with providers, fostering increased competition and potentially driving down prices across the market. When enrollees have access to accurate, timely health care pricing information, they can make informed decisions about their health care spending and actively seek the best value for medically necessary services. We anticipate that this consumer-driven approach would create a more competitive marketplace where providers would need to consider their pricing strategies more carefully to attract and retain patients. Additionally, as more enrollees engage in shopping and direct price negotiations, providers may be incentivized to proactively offer more competitive rates to maintain their market share, potentially leading to broader market-wide price reductions that benefit many enrollees.

Second, non-network plans eliminate substantial administrative overhead associated with traditional network management, which in turn can result in lower premiums. The administrative cost savings are realized through four key areas: (1) the elimination of provider contract management costs (including legal fees, staff, and provider relationship development and maintenance); (2) the removal of provider credentialing expenses and directory maintenance; (3) reduction in claims processing complexity and network-specific prior authorization requirements; and (4) streamlined organizational structure with resources redirected to consumer support tools and education.

c. Proposed Alternative Regulatory Standard for Non-Network Plans (§ 156.236)

Based on these legal principles, we propose the following regulatory standards for non-network plans to demonstrate that they provide access to a sufficient choice of providers (including ECPs) to ensure compliance with section 1311(c)(1)(B) and, as relevant, section 1311(c)(1)(C) of the Affordable Care Act. First, we propose to add a new section to part 156, § 156.236, that contains the provider access sufficiency standards (including ECP access) specific to non-network plans, and to revise §§ 156.230 and 156.235 to make clear that those sections address the provider access sufficiency standards (including ECP access) for network plans.

We propose to add § 156.236(a) to state that a non-network QHP must ensure access to a range of providers that accept the non-network plan's benefit amount as payment in full, including ECPs and providers that specialize in mental health and substance use disorder services, to ensure that services will be accessible without unreasonable delay. Additionally, as discussed in sections III.D.18, III.D.19, III.E.10, and III.E.11.c of this proposed rule, we propose to allow FFE States, including States performing plan management, to conduct their own provider access and/or ECP certification reviews provided the State demonstrates sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program (for provider access reviews) and/or an Effective ECP Review Program (for ECP reviews). FFE States that elect to conduct provider access certification reviews and are determined by HHS to have an Effective Provider Access Review Program under proposed § 155.1050(d) would be permitted to perform such reviews of non-network plans if the State satisfies all applicable criteria. Similarly, FFE States that elect to conduct ECP certification reviews and are determined by HHS to have an Effective ECP Review Program under proposed § 155.1051 would be permitted to perform such reviews of non-network plans if the State satisfies all applicable criteria. For additional detail on the applicability of the proposed Effective Provider Access Review Program and Effective ECP Review Program to non-network plans under proposed § 156.236, please reference the discussions in sections III.D.18, III.D.19, III.E.10, and III.E.11.c of this proposed rule.

Furthermore, under § 156.236(b), we propose that a non-network plan applying for certification to be offered as a QHP through an FFE must report the following information to the FFE for the FFE's determination whether a non-network plan provides a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full (including ECPs and providers that specialize in mental health and substance use disorder services) to ensure that services will be accessible without unreasonable delay:

(1) The non-network plan's assessed percentage of available providers in each plan's service area that accept the plan's benefit amount as payment in full; and for ECPs, whether the non-network plan meets at least a minimum percentage, as specified by HHS, of

available ECPs that accept the plan's benefit amount as payment in full in each plan's service area, collectively across all ECP categories defined under § 156.235(a)(2)(ii)(B), and at least a minimum percentage of available ECPs that accept the plan's benefit amount as payment in full in each plan's service area within certain individual ECP categories, as specified by HHS;

(2) For ECPs, whether the non-network plan offers the benefit amount as payment in full to at least one ECP in each of the eight ECP categories per county in the plan's service area described in § 156.235(a)(2)(ii)(B);

(3) For ECPs, whether the non-network plan offers the benefit amount as payment in full to all available Indian health care providers in the plan's service area;

(4) The non-network plan's strategy for conducting continuous outreach to available providers (including ECPs) in the plan's service area to determine whether they would accept the plan's benefit amount as payment in full;

(5) The non-network plan's strategy for making benefit amounts available to the public, including plan enrollees, potential enrollees, and providers (including ECPs), in an easily accessible and understandable format;

(6) The non-network plan's methodology for determining benefit amounts;

(7) The non-network plan's strategy for providing consumer-friendly and public information about potential balance billing scenarios and expected out-of-pocket costs, including historical data on actual out-of-pocket costs incurred by its enrollees while accessing providers (including ECPs) in the area;

(8) The availability of an exceptions process under the non-network program for enrollees who cannot find providers (including ECPs) willing to accept the benefit amount as payment in full;²⁰⁶ and

(9) The non-network plan's strategy for providing adequate customer service or online provider directory assistance resources to assist plan enrollees and potential enrollees in finding providers (including ECPs) in their area who will accept the plan's benefit amount as payment in full.

These are among the factors that we have historically found useful in considering whether a non-network plan provides access to a sufficient choice of providers, including ECPs, to warrant the certification of non-network

²⁰⁶ Such an exceptions process could, for example, ensure that the non-network plan covers any additional out-of-pocket costs incurred by an enrollee who could not locate an ECP willing to accept the plan's benefit amount as payment in full.

plans for the FFEs. HHS, as operator of the FFEs, considered the QHP application submitted by a non-network plan for PYs 2021 and 2022 in Ohio. In assessing whether the plan was in the interests of qualified individuals on the FFE in Ohio (under § 155.1000(c)), we used similar factors to assess whether the non-network plan provided protection against additional out-of-pocket costs for EHB in a manner consistent with § 156.130, and we believe this was appropriate because these factors provide a more complete picture of how well a non-network plan actually limits enrollees out-of-pocket costs.

The first proposed factor, the non-network plan's assessed percentage of available providers in each plan's service area that accept the plan's benefit amount as payment in full and, for ECPs, whether the non-network plan meets separate minimum percentage requirements of available ECPs that accept the plan's benefit amount as payment in full in each plan's service area, is an important indicator of how generous the non-network plan's benefit amounts actually are. It would provide an Exchange greater assurance that enrollees can actually access a sufficient number of providers, including ECPs, who will not seek additional payment from the enrollee after receiving the benefit amount from the plan. Requiring the non-network plan to have assessed the anticipated percentage of providers in the area who would accept the plan's benefit amount as payment in full also would provide Exchanges with assurance that the non-network plan issuer performed sufficient research and analysis in advance to determine sufficient benefit amounts for a relevant area. This would help ensure benefit amounts are generally sufficient to limit unanticipated additional out-of-pocket costs for enrollees.

The second proposed factor, whether the non-network plan offers its benefit amount as payment in full to at least one ECP in each of the eight ECP categories per county in the plan's service area described in § 156.235(a)(2)(ii)(B), is an important indicator of the plan's ability to cater to enrollee needs across a wide array of priority health needs and socioeconomic factors, which is required by the Affordable Care Act as a condition of QHP certification. Section 1311(c)(1)(C) of the Affordable Care Act requires access to ECPs, where available, that serve predominately-low income, medically underserved individuals, such as health care providers defined in section 340B(a)(4) of the PHS Act and providers described

in section 1927(c)(1)(D)(i)(IV) of the Act. In order to demonstrate that non-network plans comply with section 1311(c)(1)(C) of the Affordable Care Act and accordingly provide access to ECPs, where available, such as those under sections 340B(a)(4) of the PHS Act and 1927(c)(1)(D)(i)(IV) of the Act, Exchanges must be assured that the plan's benefit amounts are sufficient enough such that at least one ECP in each of the eight ECP categories per county within the plan's service area would accept the plan's benefit amount as payment in full.

The third proposed factor, whether the non-network plan offers its benefit amount as payment in full to all available Indian health care providers in the plan's service area, is an important indicator of the plan's ability to ensure Indian enrollees are able to receive applicable cost-sharing reductions for the plan variations described at §§ 156.420(b)(1) and (2) without incurring additional out-of-pocket costs. Additionally, Indian health care providers are among the providers described under section 340B(a)(4) of the PHS Act, which plans must demonstrate access to under § 156.235(a)(2)(ii), (b)(2)(ii), and (c), consistent with section 1311(c)(1)(C) of the Affordable Care Act.

The fourth proposed factor, the non-network plan's strategy for conducting outreach to available providers (including ECPs) in a particular area to determine whether they would accept the plan's benefit amount as payment in full, is an important indication of the non-network plan's recognition that whether any particular provider will accept a benefit amount as payment in full is a moving target. Providers that are not under contract to accept a non-network plan's payment as payment in full are generally not bound by any contract or law in setting prices. They may choose to change their charges for their services based on any multitude of factors, including changes in their operating expenses, changes in medical advancement, competitive pressure, or for no particular reason at all. And, they may choose to change this amount at any time. As a result, it is imperative that a non-network plan have in place a strategy for conducting continuous outreach to available providers (including ECPs) in a particular area to determine whether they would accept the plan's benefit amount as payment in full, so that the plan can make adjustments to its benefit amounts to ensure that enrollees can access a sufficient number of providers.

The fifth proposed factor, the non-network plan's strategy for making

benefit amounts available to the public, including plan enrollees, potential enrollees, and providers (including ECPs), in an easily accessible and understandable format, is an important indicator of the non-network plan's ability to effectively communicate the plan's benefit amounts. Making this information widely available to providers would give notice to providers that charge more than the plan's benefit amount that their charges may be too high and they should consider lowering them to attract plan enrollees. Non-network plans work best when information between the plan, the enrollee, and the provider is shared transparently; after all, an enrollee cannot be expected to shop for care if they do not understand what the plan will actually pay the provider.

The sixth proposed factor, the non-network plan's methodology for determining benefit amounts, is an important indicator that the non-network plan is not setting arbitrary benefit amounts for covered services; and, that the benefit amounts are well-informed through various analyses and research, so that the amounts reasonably cover costs associated with a particular service.

The seventh proposed factor, the non-network plan's strategy for providing consumer-friendly information to plan enrollees and potential enrollees about potential balance billing scenarios and expected out-of-pocket costs, including historical data on actual out-of-pocket costs incurred by its enrollees while accessing ECPs in the area, is an important indicator of the plan's ability to educate its enrollees about the plan's expectations on how the plan may be best utilized to minimize additional out-of-pocket costs. Non-network health plans do not currently exist in the individual and small group market, and are less commonly offered in the large group market and as excepted benefits products, so the plan design may not be immediately intuitive to enrollees. As such, it would be imperative that non-network plans have in place a cohesive strategy for providing consumer-friendly information about how the plan may be most effectively used to limit out-of-pocket costs and the impact of seeking care from providers who charge more than the plan's benefit amount.

The eighth proposed factor, the availability of an exceptions process under the non-network plan for enrollees who cannot find providers (including ECPs) willing to accept the benefit amount as payment in full, is an important indicator of the plan's commitment to be flexible for enrollees who have little choice in providers. The

provision of such an exceptions process would recognize that there may be some circumstances where a non-network plan may be unable to adequately protect consumers against out-of-pocket costs in circumstances where large numbers of providers refuse the plan's payment as payment in full. In recognition of this possibility, such an exceptions process would be able to shift the burden of paying any unavoidable, additional out-of-pocket costs from the enrollee to the non-network plan.

The ninth proposed factor, the non-network plan's strategy for providing adequate customer service or online provider directory assistance resources to assist plan enrollees and potential enrollees in finding providers (including ECPs) in their area who will accept the plan's benefit amount as payment in full, is another important indicator of the plan's ability to educate its enrollees about the plan's expectations on how the plan may be best utilized to minimize additional out-of-pocket costs.

Under this proposal, non-network plans would be subject to and allowed to demonstrate that they meet all of the general certification criteria at § 155.1000(c), which would allow Exchanges the ability to certify non-network plans as QHPs. These general certification criteria include the minimum certification requirements outlined in subpart C of part 156,²⁰⁷ which include the requirement that each QHP must comply with benefit design standards as defined in § 156.20, which requires the provision of the EHB package. Thus, under this proposal, non-network plans would be required to provide this EHB package as a condition of QHP certification, which includes the provision of EHB in accordance with § 156.115, the cost-sharing requirements at § 156.130, and the levels of coverage requirement at § 156.140. This requirement to provide the EHB in accordance with § 156.115 would mean that the non-network plan would, among other things, provide benefits that are substantially equal to the relevant State's EHB-benchmark plan. This would require the non-network plan to ensure that any covered benefits under the plan that are not EHB in the State are not treated as EHB under the plan. Non-network plans that do not comply with these minimum certification requirements would be subject to denial of certification in accordance with § 155.1000(e) and

decertification in accordance with § 155.1080(c).

Non-network plans that are applying for QHP certification or are QHPs would also be required to structure their plans so that they provide all the consumer protections that apply to individual and small group health coverage including, but not limited to, those specified in PHS Act title XXVII parts A through D, as all other plans applying for QHP certification are subject to providing. Under this proposal, a non-network plan would not be able to claim exemption from such protections merely because it does not enter into contracts with providers. Failure to offer these protections would also result in denial of certification in accordance with § 155.1000(e) and decertification in accordance with § 155.1080(c), even though they are not explicitly included in the minimum certification requirements outlined in subpart C of part 156. Under section 1311(e)(1)(B) of the Affordable Care Act and § 155.1000(c)(2), Exchanges have broad discretion to determine whether a plan is in the interest of qualified individuals and qualified employers, regardless of whether the plan meets other minimum certification requirements consistent with § 155.1000(c)(1). We confirm that an Exchange may use this authority to deny certification to a non-network plan that is not structured in a manner that provides all the consumer protections that apply to individual and small group health insurance coverage including, but not limited to, those specified in PHS Act title XXVII parts A through D. For example, the breadth of an Exchange's authority to deny certification under the interest standard extends to determinations that a non-network plan's benefit structure fails to provide protections against surprise medical bills in a manner similar to a network plan.²⁰⁸

The certification criteria at § 155.1000(c)(2) include the requirement that the Exchange determine that making the health plan available is in the interest of the qualified individuals and qualified employers. This proposal would not require States to approve non-network plans for sale nor would it require Exchanges to certify such plans. We have long maintained that Exchanges are free to exercise the

authority at section 1311(e)(1) of the Affordable Care Act (as implemented at § 155.1000(c)(2)) to refuse certification to a plan if it determines that making available such health plan through such Exchange is not in the interests of qualified individuals and qualified employers in the State,²⁰⁹ even if the plan otherwise meets all other QHP certification requirements. In the Exchange Establishment Rule (77 FR 18405), we stated that an Exchange may want to choose among one of several strategies for making this determination: (1) an Exchange may choose to utilize an "any qualified plan" strategy for certifying QHPs in its Exchange, such that an Exchange certifies all health plans as QHPs that meet and agree to comply with minimum QHP certification requirements; (2) an Exchange could undertake a competitive bidding or selective contracting process and limit QHP participation to only those plans that ranked highest in terms of certain Exchange criteria; (3) an Exchange may also choose to negotiate with health insurance issuers on a case-by-case basis and could request that an issuer, upon meeting the minimum certification standards, amend health plan offerings to further the interest of qualified individuals and qualified employers served by the Exchange; or (4) an Exchange may implement selection criteria beyond the minimum certification standards in determining whether a plan is in the interests of the qualified individuals and employers.²¹⁰

We reaffirm these flexibilities under this proposal; Exchanges would be able to require non-network plans to meet additional criteria beyond those described in the model approach outlined above to be certified as QHPs, and they may determine that such plans are not in the interests of qualified individuals and qualified employers in the State, regardless of whether the non-network plan otherwise meets the

²⁰⁹ Except that the Exchange may not exclude a health plan: (i) on the basis that such plan is a fee-for-service plan; (ii) through the imposition of premium price controls; or (iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly (77 FR 18405).

²¹⁰ As explained in the Exchange Establishment Rule (77 FR 18405), some examples of such additional selection criteria include: (1) reasonableness of the estimated costs supporting the calculation of the health plan's premium and cost-sharing levels; (2) past performance of the health insurance issuer; (3) quality improvement activities; (4) enhancements of provider networks, including the availability of network providers to new patients; (5) service area of the QHPs (that is, the size of a service area and the amount of choice afforded to the consumers within that service area); and (6) premium rate increases from previous years and proposed rate increases.

²⁰⁷ Except for §§ 156.230 and 156.235, which would only be applicable to network plans.

²⁰⁸ Section 1311(e)(1)(B)(i) of the Affordable Care Act and § 155.1000(c)(2)(i) prohibit Exchanges from excluding health plans from certification on the basis that such plan is a fee-for-service plan. We confirm that under this proposal, an Exchange may properly conclude that a non-network plan that is a fee-for-service plan may be denied certification under the interest standard for other criteria besides the fact that it is a fee-for-service plan.

certification criteria at § 155.1000(c)(1), and refuse them certification.

We are seeking comment regarding the PY 2027 effective date of this proposal. This includes comments from any QHP issuers that may be interested in submitting non-network plans for QHP certification for PY 2027, or whether PY 2028 may be the soonest that any QHP issuer could realistically consider submitting non-network plans for QHP certification.

In connection with this proposal, we have not identified any barriers to non-network plans' participation in the HHS-operated risk adjustment program. However, because these plans are not under contractual relationships with providers, we recognize that they may have difficulty obtaining medical records from providers for the purposes of HHS-RADV, which is a requirement for risk adjustment covered plans under § 153.630. EDGE-reported diagnoses for which no medical record can be obtained are considered to be non-validated diagnoses in the HHS-RADV process and would result in higher error rates and higher HHS-RADV adjustments. As such, we seek comment on considerations for non-network plans in the HHS-RADV process.

d. Effective Provider Access Review Program Requirements for Non-Network Plans

Under sections III.D.18 and III.E.10 of this proposed rule, we propose to allow FFE States, including States performing plan management, to elect to conduct their own provider access certification reviews of issuers' plans applying for certification as a QHP through an FFE, provided the State determines it has sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program under proposed § 155.1050(d)(2) through (d)(4), as determined by HHS. We propose that in FFE States that do not elect to conduct provider access reviews or that we determine do not have an Effective Provider Access Review Program, we would continue to conduct provider access certification reviews consistent with § 156.230 for network plans.

To ensure that non-network plans would be held to similar requirements as network plans in meeting regulatory requirements to provide sufficient choice of providers under section 131(c)(1)(B) of the Affordable Care Act, we also propose to apply the Effective Provider Access Review Program to FFE States, including States performing plan management, that wish to conduct provider access reviews of non-network

plans. This means that if an FFE State elects to conduct their own provider access certification reviews of issuers' plans applying for certification to be offered as a QHP through an FFE and we determine that the State has satisfied all the applicable criteria to be considered to have an Effective Provider Access Review Program, then the State would have the ability to conduct provider access certification reviews of non-network plans. An FFE State would need to demonstrate that it meets applicable criteria for both network and non-network plans under proposed § 155.1050(d)(2) through (d)(4) prior to HHS determining that a State has an Effective Provider Access Review Program. This would mean an FFE State would not be permitted to elect to conduct provider access certification reviews for only network plans and not non-network plans, if they certify both such plans, or vice versa. However, should an FFE State notify us that it chooses not to certify non-network plans, and so does not offer non-network plans through the FFE operating in their State (regardless of if the State or HHS conducts the review), then we would determine whether it satisfies applicable criteria to be considered to have an Effective Provider Access Review Program under proposed § 155.1050(d)(2) through (d)(4) for network plans only. We seek comment on this approach. Additionally, similar to the approach for network plans, if we determine FFE States do not satisfy applicable criteria to be considered to have an Effective Provider Access Review Program, then we would conduct provider access certification reviews for non-network plans under new standards proposed at § 156.236.

We propose that an FFE State would need to demonstrate that it meets applicable criteria for both network plans and non-network plans under proposed § 155.1050(d)(2) through (d)(4), if they decide to certify such plans, to receive the designation to have an Effective Provider Access Review Program. This would mean that an FFE State would not be permitted to elect to conduct provider access certification reviews for only network plans and not non-network plans, if they certify such plans, or vice versa. We believe this is important, as some QHP issuers may choose to offer both network and non-network plans and centralizing reviews to a single entity, whether the FFE State or HHS, for the same issuer, would reduce administrative inefficiencies that may result if the FFE State and HHS have to coordinate provider access certification review results across a

range of network and non-network plans. We also believe that review authority being limited to a single entity, either the FFE State or HHS, would allow both network and non-network plans to undergo consistent, standardized reviews conducted by the same reviewing entity. We believe this would ensure similar requirements and methodologies would be applied fairly across network and non-network plans and reduce potential differences in provider access review results. This may also reduce variabilities in access across the FFE State between enrollees in non-network plans versus network plans that may result if these plans undergo different levels and types of provider access certification reviews by separate review entities, and it could make it more difficult to effectively compare provider access review results between network and non-network plans during certification if alternative review methods are applied within the same FFE State. Overall, just as with network plans, non-network plans must ensure sufficient access to a range of providers in a manner consistent with section 1311(c)(1)(B) of the Affordable Care Act.

We propose to implement similar requirements for non-network plans as network plans under the Effective Provider Access Review Program at proposed § 155.1050(d). An FFE State must demonstrate it has sufficient authority and the technical capacity to conduct provider access certification reviews for non-network plans by satisfying all applicable criteria to be considered to have an Effective Provider Access Review Program under proposed § 155.1050(d)(2) through (d)(4), including criteria specific to non-network plans. Just as with network plans, an FFE State determined to have an Effective Provider Access Review Program would be expected to ensure sufficient access to providers under non-network plans. In this case, the FFE State would need to ensure that a QHP would be required to ensure access to a range of providers that accept the non-network plan's benefit amount as payment in full, including ECPs and providers that specialize in mental health and substance use disorder services, to ensure that services will be accessible without unreasonable delay.

Under our proposal, as with network plans, a State operating an FFE that elects to conduct its own provider access reviews, and which deems to certify non-network plans, must demonstrate it has established provider access standards that are set forth in State statute or regulation which are consistent with provider access standards set forth in §§ 156.230(a)(1)(ii)

and (iii) and are relevant to non-network plans. The FFE State would also need to demonstrate that the State's provider access review process includes reporting systems for State required provider access metrics related to non-network plans as well as documentation of methodology associated with non-network plan review; and that the State provides descriptions of all data collection systems, templates and methodologies used by the State, or the State's delegated entity, to collect and review provider access data for non-network plans and that this data and documentation received is sufficient to conduct an examination of non-network plans. The FFE State would also be required to establish and maintain clear procedures and timeline requirements for regular provider access reviews related to non-network plans, including processes that ensure reviews occur prior to each plan year's QHP certification cycle. Additionally, the FFE State would be required to have a process for monitoring and addressing consumer-related provider access complaints for non-network plans to ensure sufficient access to providers consistent with section 1311(c)(1)(B) of the Affordable Care Act and as set forth in State statute. The FFE State would also be required to have a process to collect and review information capable of demonstrating whether non-network plans provide access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full. We seek to understand whether the FFE State has a process for collecting and analyzing this information to demonstrate technical capacity during Effective Provider Access Review Program determinations. Additionally, we considered enumerating the information that non-network plans must submit to the FFE listed at 156.236(b)(4) through (b)(9) within 155.1050(d)(4)(vi) as requirements for FFE States with an Effective Provider Access Review Program to review non-network plans to ensure they be in alignment with HHS' proposed approach in an effort to further support consumer protectiveness in this novel plan design. These factors would include assessing a non-network plan's strategy for conducting outreach to providers in their area, making benefit amounts public to enrollees, methodologies for determining benefit amounts, strategy for publishing consumer-friendly information on balance billing and potential out-of-pocket costs, availability of exceptions processes for enrollees unable to locate providers who accept benefit amounts

as payment in full, and customer services resources. However, as HHS is seeking to broadly restore flexibilities to FFE States as a part of some QHP certification reviews, and empower FFE States who understand their consumer needs and local conditions best, we opted in this proposal to provide deference to FFE States in how they will review non-network plans for a sufficient choice of providers who accept the plans benefit amount as payment in full in accordance with information listed at 156.236(b)(4) through (b)(9). We seek comment on whether HHS should better align the reviews of non-network plans for QHP certification as described above.

While these factors for assessing whether a State has an Effective Provider Access Review Program, as related to non-network provider access reviews, are comprehensive, we believe this approach would provide ample flexibility to States to determine the best methodology to assess provider access under non-network plans within the State. We anticipate each State's approach would be dependent on available resources and population needs unique to each State and that these proposed factors serve to appropriately evaluate overall State processes for review of non-network plans to ensure sufficient consumer protection.

e. Effective Essential Community Provider Review Program Requirements for Non-Network Plans

Under sections III.D.19 and III.E.11.c of this proposed rule, we propose to allow FFE States, including States performing plan management, to elect to conduct their own ECP certification reviews of issuers' plans applying for certification as a QHP through an FFE provided the State demonstrates sufficient authority and the technical capacity to conduct these reviews by meeting the applicable criteria, as determined by HHS, to be considered to have an Effective ECP Review Program under proposed § 155.1051. Additionally, as discussed in section III.E.11.c, we propose that if we determine an FFE State does not have an Effective ECP Review Program, we would continue to conduct ECP certification reviews consistent with § 156.235 for network plans. To ensure that non-network plans would be held to similar requirements as network plans in meeting regulatory requirements to ensure reasonable and timely access to ECPs for low-income, medically underserved individuals, we propose to also apply the Effective ECP Review Program under § 155.1051 to

FFE States, including States performing plan management, that wish to conduct ECP certification reviews of non-network plans. That is, under this proposal, if FFE States elect to conduct their own ECP certification reviews of issuers' plans applying for certification to be offered as a QHP through an FFE and the State is determined by HHS to have satisfied all the applicable criteria to be considered to have an Effective ECP Review Program, then States would have the ability to conduct ECP certification reviews of non-network plans. An FFE State would need to demonstrate that it meets applicable criteria for both network plans and non-network plans under proposed § 155.1051(b) through (c), and demonstrate it has the sufficient authority and technical capacity to conduct reviews of such plans (as assessed by HHS under § 155.1051(e)), prior to HHS determining that a State has as an Effective ECP Review Program. This would mean an FFE State would not be permitted to elect to conduct ECP certification reviews for only network plans and not non-network plans, if they certify such plans, or vice versa. However, if an FFE State notifies us that it does not deem to certify such non-network plans, and consequently not offer these plans altogether through the FFE operating in their State (regardless of if the State or HHS conducts the review), then we would continue to review whether a State meets all applicable criteria for only network plans during the Effective ECP Review Program determination process. We seek comment on this approach. Lastly, similar to the approach for network plans, if FFE States do not satisfy criteria for having an Effective ECP Review Program, then we would perform ECP certification reviews for non-network plans under the proposed standards for non-network plans at § 156.236 discussed in section III.E.12.c of this proposed rule.

Furthermore, we believe HHS should primarily conduct ECP certification reviews as the default approach for issuers with non-network plans applying for certification as a QHP to be offered through an FFE, including States performing plan management, except if an FFE State elects to conduct ECP certification reviews and is determined to have an Effective ECP Review Program. We believe this is valuable for most of the same reasons that we propose to adopt this same approach for network plans under section III.E.11.c. of this proposed rule. In addition, as we stated in discussions above describing various characteristics of non-network

plans, there is no guarantee that a non-network plan's benefit amount is actually sufficient to cover the provider's full charges, which can leave enrollees with additional out-of-pocket costs that may disproportionately challenge low-income, medically underserved populations. These populations typically served by ECPs are often at a greater risk for lower health insurance coverage literacy and an increased risk for illness,²¹¹ which may make it more difficult for these populations to understand how to use non-network plans to meet their needs. Additionally, the health care services furnished by ECPs are much more specialized and can be very expensive for enrollees, for example, HIV/AIDS treatment furnished by Ryan White program providers, cancer care furnished by Free-standing Cancer Centers, tuberculosis treatment furnished by Tuberculosis Clinics, hemophilia treatment furnished by Hemophilia Treatment Centers, and more.²¹² Thus, if a non-network plan's

benefit amount is not sufficient to cover these expensive, specialized services often furnished by ECPs, then these enrollees could potentially face larger out-of-pocket costs that are more regressive for low-income, medically underserved populations. This necessitates some minimum standard to ensure these plans are as consumer protective as possible for the low-income, medically underserved populations traditionally served by ECPs, including criteria under proposed § 155.1051 to ensure FFE States have the authority and technical capacity to conduct these ECP certification reviews in a such a way that continues to ensure low-income, medically underserved populations have adequate access to ECPs through non-network plans.

Additionally, based on our experience conducting ECP certification reviews of network plans, we believe having adequate and accurate data on available ECPs in a geographic area, sufficient tools to collect and calculate issuer submitted ECP data, and sound methodologies to quantitatively assess this data to ensure access to ECPs in accordance with section 1311(c)(1)(C) of the Affordable Care Act would be crucial for any FFE State to demonstrate the technical capacity to also conduct their own ECP certification reviews of non-network plans. This would include having data collection capabilities and structured analyses to measure the adequacy of a non-network plan in providing access to a sufficient number and geographic distribution of ECPs in their service area that accept the plan's benefit amount as payment in full. While existing resources (for example, the Federal ECP List, MPMS, etc.) at the Federal level can be leveraged to efficiently conduct ECP certification reviews of non-network plans, it is unknown what tools FFE States may utilize to collect ECP data from non-network plans or to assess adequate access to ECPs within these plans. Further, it is especially unclear to what extent FFE States may already have experience in conducting reviews of non-network plans and what existing requirements States may have in place to ensure these plans provide reasonable and timely access to ECPs. Thus, to broaden our knowledge in this area, we solicit comment on whether FFE States, including States performing plan management, have experience conducting reviews of non-network plans; and we welcome any information on current State-specific requirements that would ensure these plans provide

reasonable and timely access to ECPs to medically underserved and low-income populations, including those ECPs that would accept a non-network plan's benefit amount as payment in full.

Moreover, we propose that an FFE State would need to demonstrate that it meets applicable criteria for both network plans and non-network plans under proposed § 155.1051(b) through (d), and the sufficient authority and technical capacity to conduct reviews of such plans (as assessed by HHS under § 155.1051(e)), to receive a designation as having an Effective ECP Review Program under proposed § 155.1051, as they decide to certify such plans. This would mean that an FFE State would not be permitted to elect to conduct ECP certification reviews for only network plans and not non-network plans, or vice versa. We believe this is important for several reasons. Some QHP issuers may choose to offer both network and non-network plans and centralizing the reviews to either the FFE State or HHS for the same issuer would reduce administrative inefficiencies that may result when FFE States and HHS have to coordinate ECP certification review results across a range of plans that may be offered by the same issuer.

Additionally, we believe that delegating reviews of both network and non-network plans to either the FFE State or HHS would allow both plan types to undergo consistent, standardized reviews conducted by the same reviewing entity, so that similar requirements and methodologies are applied fairly across all plan types to reduce differences in ECP certification review results. This may also reduce variabilities in access across the FFE State between enrollees in non-network plans versus network plans that may result if these plans undergo different levels and types of ECP certification reviews by separate review entities, and it could make it more difficult to effectively compare ECP review results between network and non-network plans during certification if alternative review methods are applied within the same FFE State. Under our proposal, non-network plans must still ensure sufficient access to ECPs in a manner consistent with section 1311(c)(1)(C) of the Affordable Care Act and must be held in parity with network plans to provide reasonable and timely access to ECPs.

Accordingly, we propose requirements at § 155.1051 that an FFE State must meet to be considered to have an Effective ECP Review Program and conduct ECP certification reviews of non-network plans. We propose that an FFE State must demonstrate that it

²¹¹ Edward J. Wiggins A, Young MH, Rayens MK. Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform. *Health Lit Res Pract.* 2019 Nov 5;3(4):e250-e258. doi: 10.3928/24748307-20190923-01. Available at <https://pmc.ncbi.nlm.nih.gov/articles/PMC6831506/>. Karen Pollitz, Kaye Pestaina, Alex Montero, Lunna Lopes, Isabelle Valdes, Ashley Kirzinger, and Mollyann Brodie. KFF. (2023, June 15). KFF Survey of Consumer Experiences with Health Insurance. Available at <https://www.kff.org/mental-health/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/>. OASH, Health People 2023, Literature Review. Available at <https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty#:~:text=Unmet%20social%20needs%2C%20environmental%20factors,for%20people%20with%20lower%20incomes.&text=For%20example%2C%20people%20with%20limit>.

²¹² For example, research indicates that among commercially insured adults with HIV, the mean all-cause and HIV-related per patient per month costs were \$2,657 and \$1,497, and all cause costs per patient per month for adults with PrEP were \$1,761. Other research shows that the estimated direct costs of 4 to 6 months of tuberculosis treatment is an estimated \$23,000 per person. Lastly, a meta-analysis found the average total annual costs for hemophilia treatment can start around \$200,000 per patient and be as high as \$869,940. Chen CY, Donga P, Campbell AK, Taiwo B. Economic Burden of HIV in a Commercially Insured Population in the United States. *JHEOR.* 2023;10(1):10–19. doi: 10.36469/001c.56928. PMID:36721765. Available at <https://jheor.org/article/56928-economic-burden-of-hiv-in-a-commercially-insured-population-in-the-united-states>. Winston CA, Marks SM, Carr W. Estimated Costs of 4-Month Pulmonary Tuberculosis Treatment Regimen, United States. *Emerg Infect Dis.* 2023 Oct;29(10):2102–2104. doi: 10.3201/eid2910.230314. PMID: 37735769; PMCID: PMC10521593. Available at <https://pmc.ncbi.nlm.nih.gov/articles/PMC10521593/>. Chen Y, Cheng SJ, Thornhill T, Solari P, Sullivan SD. Health care costs and resource use of managing hemophilia A: A targeted literature review. *J Manag Care Spec Pharm.* 2023 Jun;29(6):647–658. doi: 10.18553/jmcp.2023.29.6.647. PMID: 37276036; PMCID: PMC10387983. Available at <https://pmc.ncbi.nlm.nih.gov/articles/PMC10387983/>.

has sufficient authority and the technical capacity to conduct ECP certification reviews of non-network plans by meeting all the applicable criteria to be considered to have an Effective ECP Review Program under § 155.1051, including criteria specific to non-network plans. We continue to believe that to protect low-income, medically underserved populations, and to ensure that enrollees in all FFEs are provided a minimum standard of consumer protection for reasonable access to providers and that disparities in access are minimized across States, Effective ECP Review Program States must continue to demonstrate that issuers without a network of providers applying for certification as a QHP through the FFE operating in their State meet various requirements described in this section. We propose under § 155.1051(b) that FFE States with an Effective ECP Review Program must ensure that a non-network plan applying for certification to be offered as a QHP through an FFE demonstrates that it provides reasonable and timely access to ECPs that accept the plan's benefit amount as payment in full to ensure that services will be accessible without unreasonable delay. In lieu of the requirements for network plans that are based on contracts executed with and/or offered to an ECP, non-network plans would instead be required to indicate benefit amounts as payment in full that were accepted by and/or offered to an ECP, as reflected under proposed § 156.236(b)(1) through (b)(3). Thus, under § 155.1051(c), we propose that FFE States with an Effective ECP Review Program must also demonstrate that their ECP requirements are comparable to ECP requirements under proposed § 156.236 for issuers' plans without a provider network so that plans: meet the minimum percentage requirements under proposed § 156.236(b)(1) for non-network plans; meet the Indian health care provider requirement under proposed § 156.236(b)(3) for non-network plans; and meet the category per county requirements under proposed § 156.236(b)(2) for non-network plans. Similarly, our proposal under § 155.1051(d) would also apply to non-network plans. Specifically, we propose that FFE States with an Effective ECP Review Program that have alternative ECP requirements, including ECP requirements specific to non-network plans, compared to those requirements described under proposed § 155.1051(c)(1) through (c)(3), must demonstrate how their requirements would continue to promote a sufficient

number and geographic distribution of ECPs to ensure reasonable and timely access to ECPs, and an adequate level of service for low-income enrollees or individuals residing in Health Professional Shortage Areas. We understand that due to the newness of these plans, if this proposal is finalized, many FFE States would still be in the earlier stages of implementing new requirements for these plans. Thus, we would continue to work with FFE States to provide technical assistance to ensure any State ECP requirements (including alternative requirements) for non-network plans continue to ensure reasonable and timely access to ECPs across the State before and after making an Effective ECP Review Program determination.

Furthermore, consistent with the discussion in section III.E.11.c of this proposed rule for network plans, we would review information submitted by the FFE State to ensure the State receives adequate issuer data and documentation to conduct an examination of ECP requirements described in proposed § 156.236 for non-network plans to demonstrate it has the authority and technical capacity to conduct effective, timely reviews of a non-network plan's ECP data. Under §§ 155.1051(e)(1) through (10), as described in section III.E.11.c. of this proposed rule, we propose factors that we would consider in our review to determine if an FFE State has an Effective ECP Review Program, including factors related to a State's legal authority, State ECP requirements compared to ECP requirements under § 156.235 and proposed § 156.236, definition of an ECP, process for identifying qualified ECPs, data collection systems and methodologies to collect and review ECP data, delegation of ECP review to other entities, compliance and enforcement mechanisms, and consumer assistance. We would still consider all these criteria when determining if an FFE State has sufficient authority and the technical capacity to conduct ECP certification reviews including for non-network plans.

However, there are several additional criteria we would consider during our review of FFE States specific to only non-network plans. First, we propose under § 155.1051(e)(5) that we would consider if the FFE State utilizes the Federal ECP List or has a process they use to identify qualified ECPs that may accept a non-network plan's benefit amount as payment in full. We believe it is essential to have a means to identify the exact geographic location and distribution of ECPs that may be

available within an issuer's service area that may accept a non-network plan's benefit amount as payment in full; this would ensure issuers fulfill statutory requirements under section 1311(c)(1)(C) of the Affordable Care Act to include ECPs "where available" so that enrollees have sufficient access to ECPs through their plans. Additionally, we propose to consider under § 155.1051(e)(7) whether the FFE State collects information from issuers regarding the status of offers of benefit amounts as payment in full to an ECP. We believe this type of data is an important metric to assess an issuer's compliance with the minimum percentage, category per county, and Indian health care requirements under proposed § 156.236(b)(1) through (b)(3), which would be evaluated based on measurements of benefit amounts as payment in full that were offered to or accepted by an ECP.

Moreover, as we have previously stated under section III.E.11.c. of this proposed rule, States possess unique knowledge on local factors that could strengthen ECP reviews, such as on market conditions, geographic constraints, areas in the State with limited economic resources, provider shortages, workforce issues, and population demographics, and we believe States can leverage this same knowledge on local factors when conducting ECP reviews of non-network plans. However, we considered enumerating the information that non-network plans must submit to the FFE listed at 156.236(b)(4) through (b)(9) as requirements for FFE States with an Effective ECP Review Program to review non-network plans to ensure they be in alignment with HHS' proposed approach in an effort to further support consumer protectiveness in this novel plan design. Information described under proposed § 156.236(b)(4) through (9) are specific to non-network plans and reflect additional safeguards to ensure these plans maintain access to providers without traditional network arrangements. These factors would include assessing a non-network plan's strategy for conducting outreach to ECPs in their area and for making benefit amounts public to enrollees, methodologies for determining benefit amounts, strategy for publishing consumer-friendly information on balance billing and potential out-of-pocket costs, availability of exceptions processes for enrollees unable to locate providers who accept benefit amounts as payment in full, and customer services resources. These reflect more qualitative measures that would likely

require different data collection methods compared to the more quantitative measures of minimum percentage, category per county, and Indian health care requirements under proposed § 156.236(b)(1) through (b)(3). As HHS is seeking to broadly restore flexibilities to FFE States as a part of ECP certification reviews and empower FFE States who understand their consumer needs and local conditions best, we opted to defer to FFE States in how they wish to review non-network plans for this type of information, as applicable. Though, we seek comment on whether HHS should better align the reviews of non-network plans across the FFE, regardless of whether HHS or an FFE State is conducting ECP certification reviews, by enumerating the factors under 156.236(b)(4) through (b)(9).

Altogether, in addition to the proposal to revise §§ 156.230 and 156.235, and add §§ 156.236 and 155.1051, we propose revisions to §§ 155.1050 (including its section heading), 156.275, and 156.810 to clarify that provisions within these sections would apply to the certification of non-network plans in the same manner that they apply to network plans.

We seek comment on these proposals.

13. Strengthening HHS' Oversight of the Administration of Advanced Payments of the Premium Tax Credit, Cost-Sharing Reductions, and User Fee Programs and Clarify HHS' Compliance Review Authority (§ 156.480)

We propose two proposals related to § 156.480. First, we propose to modify § 156.480 to clarify HHS' authority to audit or conduct a compliance review of an issuer that offers a QHP through an Exchange for the purposes of administering and providing oversight of the APTC, CSR, and user fee programs. Specifically, we propose to amend § 156.480(c) to provide that HHS or its designee may audit or conduct a compliance review to assess compliance with all requirements related to APTC, CSR, and user fee programs applicable to issuers offering a QHP in an Exchange, rather than only the requirements of 45 CFR subpart E and § 156.50 as is currently provided. For consistency, we also propose to make conforming changes to § 156.480(c)(6) to provide that in instances where HHS enforces compliance with any requirements related to APTC, CSR, and user fee programs with respect to QHP issuers participating in State Exchanges or SBE-FPs, HHS may do so in accordance with § 156.805. Second, we propose to clarify that HHS may conduct a compliance review to assess

issuers' compliance with requirements related to these programs under § 156.480(c) as needed or on an annual basis rather than only on an ad hoc basis as previously stated in the preamble to part 2 of the 2022 Payment Notice (86 FR 24244 through 24247).

To explain our first proposal, in the 2014 Payment Notice (78 FR 65078), we established HHS' authority at § 156.480(c) to assess issuers' compliance with requirements in 45 CFR part 156 subpart E through audits to ensure the appropriate use of Federal funds related to the APTC and CSR programs. After several years of experience with operating the Exchanges, in part 2 of the 2022 Payment Notice (86 FR 24244, 24246), we expanded HHS' oversight tools at § 156.480(c) to include the authority for HHS to conduct compliance reviews, in addition to audits, and expanded the scope of such audits and compliance reviews to include requirements in § 156.50 related to the user fee program, in addition to those previously referenced in part 156 subpart E. We also provided that compliance reviews conducted under this oversight authority would follow the standards set forth in § 156.715. Now we are considering additional clarifications to HHS' authority on compliance reviews under § 156.480.

Currently, § 156.480(c) provides that in conducting APTC, CSR, and user fee audits or compliance reviews, HHS may assess an issuer's compliance with the requirements in 45 CFR part 156 subpart E and § 156.50. The regulatory text does not currently reference assessment of an issuer's compliance with other Exchange requirements related to administration of the APTC, CSR, and user fee programs that are outside of subpart E and § 156.50. For example, it does not include the assessment of grace period requirements at § 156.270(g), located in part 156 subpart C, which mandates that an issuer terminate an enrollee's enrollment after not receiving payments for any outstanding premium balance, or an amount within an issuer-established premium payment threshold, within the 3-month grace period. Noncompliance with this, and other enrollment and payment requirements can result in an issuer receiving APTCs on behalf of an enrollee who is not eligible for APTC due to the nonpayment of premiums, and to prevent these improper payments, it follows that HHS' administration and oversight of the APTC program should include assessment of issuers' compliance with these requirements.

To further explain, we have historically interpreted section 1313(a)(5) of the Affordable Care Act, which states that the Secretary shall implement any measure or procedure that the Secretary has authority to implement in title I of the Affordable Care Act or any other Act, to protect against fraud and abuse, and section 1321(c) of the Affordable Care Act to provide HHS with broad authority to implement oversight activities to assess compliance with all Exchange standards promulgated in accordance with section 1321(a)(1) of the Affordable Care Act. For example, compliance reviews conducted in accordance with § 156.715 as part of HHS' financial integrity oversight of QHP issuers in the FFE, and under the authority of Affordable Care Act section 1321(c), are not limited in scope to a set of listed regulatory requirements. Instead, § 156.715(a) identifies the scope of such compliance reviews as tools to generally ensure, "ongoing compliance with Exchange standards applicable to issuers offering QHPs in a Federally-facilitated Exchange." Audits and compliance reviews conducted as part of HHS' oversight of the APTC, CSR, and user fee programs, which ensure fiscal responsibility of issuers and compliance with the requirements for QHP issuers, fall under this same broad statutory authority. While requirements related to the APTC, CSR, and user fee programs are concentrated in § 156.50 and subpart E, it was an unintended limitation to confine the scope of audits and compliance reviews conducted in accordance with § 156.480(c) to only these requirements. HHS has promulgated regulations that impact administration of these programs in other regulatory sections. For example, noncompliance with the premium payment requirements established in subpart C of part 156 may result in an issuer's receipt of improper APTCs on behalf of ineligible enrollees.

As we continue to conduct audits and compliance reviews, we want to ensure that we are clear on our authority to assess and enforce compliance with requirements related to the APTC, CSR, and user fee programs that are outside subpart E and § 156.50. Therefore, to provide this clarity, we propose to revise the introductory text in § 156.480(c) and make conforming revisions to paragraph (c)(6) to state that HHS may audit or conduct compliance reviews and enforce issuer compliance with all applicable requirements related to the APTC, CSR and user fee programs.

To explain our second proposal, we propose to revise our current position in

the preamble of part 2 of the 2022 Payment Notice (86 FR 24244 through 24247) stating that HHS conducts compliance reviews on an ad hoc basis, to provide that HHS may conduct compliance reviews as needed, including on an annual basis based on HHS' assessment of noncompliance with the applicable requirements and any identified issues related to noncompliance.

In part 2 of the 2022 Payment Notice (86 FR 24244 through 24247), we stated that compliance reviews would be conducted on an ad hoc basis to provide HHS with a mechanism to address situations where a systemic error or issue is identified during an audit, and if HHS suspects similarly situated issuers may have experienced the same systemic error or issue but were not selected for audit in the year in question. However, we have found that this approach is insufficient. For example, annual APTC, CSR, and user fee program audits of issuers in State Exchanges often identify data inaccuracies in issuers' enrollment and payment data that resulted in APTC over- or underpayments. While annual, these audits are conducted on benefit year data after the close of the 3-year window for resolution of payment inaccuracies described in § 156.1210(c).²¹³ Annual compliance reviews would provide issuers with an opportunity to proactively correct these data inaccuracies prior to the scheduled audits, which would ensure better compliance with APTC and other related requirements and, in turn, more quickly resolve any APTC over- or underpayments. With compliance reviews only occurring on an ad hoc basis, we are unable to regularly and fully address these issues prior to the audit process. As a result, we propose to revise our position such that HHS may conduct compliance reviews as needed including on an annual basis based on its assessment of identified issues related to noncompliance. We do not seek to make amendments to regulation text at § 156.480(c) to address this; rather we are proposing to clarify in the preamble of a final rule that the compliance review authority would

allow us to conduct compliance reviews on an annual or as needed basis.

In summary, we propose to add language to the introductory text of § 156.480(c) which states that HHS may audit or conduct a compliance review of an issuer offering a QHP through an Exchange to assess its compliance with the applicable requirements related to administration of the APTC, CSR, and user fee programs. We also propose to add conforming language to § 156.480(c)(6) to state that in instances where HHS enforces compliance with any requirement related to APTC, CSR, and user fee programs with respect to QHP issuers participating in State Exchanges or SBE-FPs, HHS may do so in accordance with § 156.805. Finally, as discussed above, we propose to revise our position on the frequency of compliance reviews such that HHS would conduct compliance reviews as needed including on an annual basis based on its assessment of identified issues related to noncompliance, however, we are not proposing amendments to regulation text at § 156.480(c) to address this.

We seek comment on these proposals.

14. Factors Considered in Determining the Amount of CMPs and HHS' Authority To Impose CMPs Against Issuers in State Exchanges and SBE-FPs (§ 156.805)

We propose two proposals related to § 156.805. First, we propose to amend § 156.805(b) to reiterate what factors HHS considers when determining the amount of CMPs as enforcement remedies against QHP issuers in Exchanges. Specifically, to increase transparency in how HHS calculates the amounts of CMPs imposed against QHP issuers for violations described in § 156.805(a), including but not limited to substantial noncompliance with Exchange standards under parts 153 and 156 of title 45, we propose to reiterate in § 156.805(b) that in determining the amount of CMPs, in addition to the factors HHS takes into account when determining a CMP amount listed in § 156.805(b)(1) through (3), HHS would identify the lawful purpose or purposes of the CMP amount. As discussed in section III.A.1 of this proposed rule, to align with these proposed amendments to § 156.805(b), we also seek to clarify the factors considered in determining the CMP amount and the purpose of the CMP in § 150.317.

Second, we propose to amend § 156.805(f) to clarify the authority HHS has to impose CMPs against issuers in State Exchanges or SBE-FPs for identified violations. Specifically, we propose to amend § 156.805(f) to clarify

that HHS' authority to impose CMPs against issuers in State Exchanges or SBE-FPs includes the authority to impose CMPs for identified violations of any Exchange requirements and standards applicable to issuers offering a QHP in an Exchange, when a State notifies HHS that it is not enforcing these requirements or HHS determines that a State is failing to substantially enforce these requirements. As detailed further below, we are not proposing any other changes to the legal bases for imposing CMPs against issuers in FFEs nor the circumstances in which HHS may exercise its enforcement authority against issuers in State Exchanges or SBE-FPs.²¹⁴

Under the first proposal, sections 2723(b)(2), 2718(b)(3), and 2761(b) of the PHS Act and section 1321(c)(2) of the Affordable Care Act authorize the Secretary to impose CMPs when a QHP issuer fails to meet the required standards.²¹⁵ In prior rulemakings (78 FR 54121; 79 FR 15240, 15242 through 15243; 79 FR 30240, 30264; 81 FR 12204, 12313 through 12314; and 81 FR 61538, 61581), to implement these statutory provisions, we established provisions at § 156.805 to govern the bases and process for imposing CMPs against QHP issuers in Exchanges when HHS has reasonably determined that the issuer has engaged in one or more of the enumerated actions listed in § 156.805(a)(1)–(7), including noncompliance with issuer standards and requirements under 45 CFR parts 153 and 156. Further, in part 2 of the 2022 Payment Notice (86 FR 24242 through 24243), we set forth the framework for HHS' enforcement of the applicable Federal APTC, CSR, and user fee standards in situations where State authorities fail to substantially enforce those standards for the QHP issuers participating in State Exchanges and SBE-FPs, and HHS' authority to impose associated CMPs.

Since 2014, Exchange regulations have imposed standards and requirements on issuers offering QHPs participating in Exchanges, including, but not limited to, standards and requirements under 45 CFR subtitle A,

²¹⁴ The bases and processes for imposing CMPs in FFEs and the circumstances in which HHS may exercise enforcement in State Exchanges would not be impacted by a State's decision to implement the proposed DE option under § 155.221(j), if finalized.

²¹⁵ See PHS Act sections 2723(b)(2)(G), 2718(b)(3), and 2761(b) (indicating CMPs shall be paid to the Secretary and shall be available without appropriation and until expended for the purpose of enforcing the provisions for which the penalty was imposed); see also Affordable Care Act section 1321(c)(2) (authorizing the Secretary to impose CMPs on the same basis as detailed in section 2723(b) of the PHS Act).

²¹³ Plan year data inaccuracies described to HHS or the State Exchange (as applicable) before the end of the 3-year period described in § 156.1210(c) beginning at the end of the plan year to which the inaccuracy relates are eligible for resolution and payment to the issuer of any confirmed APTC underpayments. Data inaccuracies identified after the 3-year period are not eligible for repayment to the issuer. However, should an issuer identify a payment error after the 3-year period, the issuer must notify HHS or the State Exchange (as applicable) and repay any overpayments.

subchapter B, parts 153 and 156,²¹⁶ such as compliance with premium payment policies in part 156. Historically, to facilitate QHP issuers' compliance with Exchange standards and requirements, HHS conducted audits, the results of which played a critical role in ensuring that Federal funds are appropriately safeguarded. However, we exercised enforcement discretion and did not seek to impose CMPs to enforce the findings in such audits, to give issuers time to acclimate to a new market and learn the regulatory scheme, and relied instead on other mechanisms available, such as recouping overpayments, decertification of QHP issuers for egregious violations, and CAPs.²¹⁷ But as the markets have matured, HHS audits consistently reveal that in practice, issuers implement inconsistent policies, even after we have provided such issuers with guidance and recommendations to cure identified noncompliance. Continued violations put HHS at risk of making improper payments, such as APTC payments for enrollees with noncompliant effectuations or continued enrollment that should have been cancelled or terminated. Violations may be identified long after an improper payment is made,²¹⁸ and retroactive changes often involve loss of eligibility for APTC, disenrollment of coverage, and reversal of paid claims, which together can cause enrollees outsized financial harm. For example, if we were to find that an issuer maintained an enrollee's coverage in violation of an enrollment or payment requirement and directed the issuer to retroactively terminate the enrollee's coverage to correct the noncompliance, the enrollee would lose their APTC for the months they were covered, which may have tax implications, and the enrollee could be liable for claims costs previously covered under their plan which might, as a practical matter, be difficult for a QHP issuer to recover. To minimize these needless harms to enrollees and QHP issuers alike and bolster compliance with HHS standards and

requirements applicable to issuers offering QHPs participating in Exchanges, HHS oversees QHP issuer compliance in this area.

We propose to amend § 156.805 to reiterate that HHS would identify the lawful purpose or purposes of the CMP when calculating CMP amounts. As noted above, section 2723(b)(2) of the PHS Act and section 1321(c)(2) of the Affordable Care Act authorize HHS to impose CMPs to enforce Exchange standards and requirements applicable to issuers offering QHPs participating in Exchanges. Section 2723(b)(2)(C)(i) of the PHS Act caps the amount of the CMP at \$100 (as adjusted annually under the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 and other relevant laws)²¹⁹ for each day for each individual for which an entity fails to comply with a relevant statutory or regulatory requirement. Further, section 2723(b)(2)(C)(ii) of the PHS Act requires HHS to consider the previous record of compliance of the entity being assessed with the applicable legal provisions and the gravity of the violation.

That broad delegation of enforcement authority can encompass several traditional purposes of monetary remedies. For example, in some circumstances, when consistent with these provisions and applicable law, HHS might impose a CMP to penalize a QHP issuer when an audit reveals that it failed to comply with an applicable law in prior years and thereby collected payments for some period despite not being entitled to those payments under a public benefits program the government runs. In other circumstances, HHS might impose a CMP to bring a currently noncompliant QHP issuer into compliance with relevant laws, such as if HHS discovers that a QHP issuer is currently refusing to comply with particular laws. And in still other circumstances, HHS might impose a CMP to try to make a wronged party whole for harm caused by the QHP issuer's conduct, such as if HHS discovers violations that cost the public money and HHS is able to make the Government whole through its CMP authority.

These purposes for which HHS imposes CMPs related to enforcement of Exchange standards and requirements applicable to issuers offering QHPs participating in Exchanges are not mutually exclusive. To increase transparency in how HHS calculates the amounts of CMPs imposed against QHP issuers for violations described in

§ 156.805(a), including but not limited to substantial noncompliance with Exchange standards under parts 153 and 156 of title 45, we propose to clarify that HHS will identify the underlying lawful purpose or purposes of a CMP when calculating the relevant amount.

QHP issuers have been on notice of possible CMPs for noncompliance since the inception of the Exchange, through regulations, and directly through subsequent HHS communications. For example, in the 2019 CMS Program Integrity letter to FFE issuers,²²⁰ we stated that CMPs may be imposed against QHP issuers for violations of applicable regulatory requirements with FFE audits of APTCs and user fees beginning for benefit year 2020. We added similar language to APTC and user fee audit reports for FFE issuers for benefit years 2016–2019,²²¹ and we restated that we may begin imposing CMPs starting with 2020 benefit year APTC and user fee audits of FFE (and SBE–FP) issuers in a Fall 2023 webinar for all FFE and SBE–FP issuers.²²² QHP issuers now have over a decade of experience implementing applicable Exchange standards and requirements. Given the duty to safeguard Federal funds, ongoing concerns with QHP issuers' inconsistent premium payment policies, and in light of ongoing audit observations and findings of noncompliance,²²³ HHS plans to proactively monitor and enforce compliance with the Exchange standards and requirements applicable to issuers offering QHPs participating in Exchanges, including through the imposition of CMPs, as warranted.

Second, we propose to clarify the authority HHS has to impose CMPs against issuers in State Exchanges or SBE–FPs when a State notifies HHS that it is not enforcing the applicable requirements or HHS determines that a State is failing to substantially enforce these requirements. Specifically, we propose to amend § 156.805(f) to clarify that HHS' authority to impose CMPs against issuers in State Exchanges or SBE–FPs includes authority to impose CMPs for identified violations of the

²¹⁶ CMPs may be imposed on an issuer in an Exchange, if, based on credible evidence, HHS has reasonably determined that the issuer has engaged in one or more of the actions listed under § 156.805(a).

²¹⁷ See, for example, § 156.480(c)(4), which requires, in part, that a QHP issuer must comply with actions set forth in a final audit report and provide a written CAP for HHS approval and QHP issuer implementation.

²¹⁸ Improper payments are often discovered long after an improper payment is made because these audits are conducted on benefit year data after the 3-year window for resolution of payment inaccuracies described in § 156.1210(c) closes, which is well after an issuer receives an APTC on behalf of an enrollee and claims were processed.

²¹⁹ See Sec. 701 of Public Law 114–74; see also 45 CFR 102.3; see also 89 FR 64815.

²²⁰ See CMS Issuer Letter, available at <https://www.cms.gov/files/document/ppfmgca-audit-communication-non-auditees5cr071819.pdf>.

²²¹ See, for example, materials available at <https://www.cms.gov/files/zip/2019-ffe-audit-report-part-1.zip>.

²²² Registration for Technical Assistance Portal (REGTAP), available at https://regtap.cms.gov/reg_library_openfile.php?id=4647&type=1.

²²³ See CMS. The Center for Consumer Information & Insurance Oversight: Advance Payments of the Premium Tax Credit (APTC) Audits. Available at <https://www.cms.gov/ccioo/programs-and-initiatives/health-insurance-market-reforms/auditreports>.

requirements applicable to the noncompliant actions described in § 156.805(a) that are applicable to issuers offering a QHP in a State Exchange or SBE–FP, including substantial noncompliance with issuer standards and requirements under parts 153 and 156 of title 45, as opposed to just those requirements in subpart E or § 156.50, as currently written. We also propose to make a conforming change to § 156.800.

In prior rulemaking (86 FR 24248 through 24252), we set forth the framework, consistent with section 2723(b) of the PHS Act and section 1321(c)(2) of the Affordable Care Act, for HHS' authority to enforce applicable Exchange standards for QHP issuers participating in State Exchanges and SBE–FPs. We further clarified that this enforcement authority arises when a State authority notifies HHS that it is not enforcing these standards or HHS determines that a State has failed to substantially enforce these standards, and, that if HHS has this enforcement authority, HHS could impose a CMP. However, when establishing this framework, we inadvertently limited the scope of HHS' authority under § 156.805(f) to enforcement of only those requirements in subpart E of part 156 or in § 156.50.

To align with HHS' statutory authority, we propose to amend § 156.805(f) to expressly provide that when appropriately triggered, HHS has the authority to enforce the requirements applicable to the noncompliant actions described in § 156.805(a) that are applicable to issuers offering a QHP in a State Exchange or SBE–FP, and has the authority to impose CMPs against a QHP issuer in a State Exchange or SBE–FP on the same grounds for which it can impose CMPs for QHP issuers in a FFE under § 156.805. Further, amending the language to expressly address HHS' enforcement authority with respect to these requirements would help to ensure that HHS can hold all issuers accountable for violations of requirements that result in improper APTC payments.

This proposed amendment would not usurp States' power to enforce these requirements in their own Exchanges. As previously established in prior rulemaking, the process for imposing CMPs must either require that the State notify HHS that it is failing to enforce the requirements of subpart E or § 156.50 or that HHS make its own determination, following the standards in § 150.201, *et seq.*, that the State is failing to substantially enforce these requirements.

In summary, we propose to amend § 156.805(b) to reiterate that in determining the amount of CMPs, in addition to the factors HHS takes into account when determining a CMP amount listed in § 156.805(b)(1) through (3), HHS would identify the lawful purpose or purposes of the CMP amount. We also propose to amend § 156.805(f) to provide that when appropriately triggered, HHS would enforce the requirements applicable to the noncompliant actions described in § 156.805(a) that are applicable to issuers offering a QHP in a State Exchange or SBE–FP, and has the authority to impose CMPs against a QHP issuer in a State Exchange or SBE–FP on the same grounds for which it can impose CMPs for QHP issuers in an FFE.

We seek comment on these proposals.

15. Administrative Review of QHP Issuer Sanctions (§§ 156.903 and 156.935)

To improve the accuracy of hearing decisions and increase hearing efficiency, we propose to amend the review process that governs administrative appeals of QHP issuer sanctions imposed under § 156.800, including QHP decertification actions and CMPs imposed against QHP issuers for, among other actions, violations of Exchange standards. First, under § 156.903, we propose to allow an administrative law judge (ALJ) who presides over an administrative appeal of a QHP issuer sanction imposed in accordance with § 156.800 to issue subpoenas, upon his or her own motion or at the request of a party, if the subpoenas are reasonably necessary for the full presentation of a case. Second, to expedite the process of appeals and limit duplication, we propose to amend § 156.935 so that the discovery provisions set forth therein do not apply to administrative appeals of proposed CMPs for violations identified through audits of the APTC, cost sharing reduction, or user fee programs conducted in accordance with § 156.480(c). If finalized as proposed, these amendments would apply to appeals filed on or after the effective date of the final rule.

In the 2014 Payment Notice (78 FR 65079), we codified the administrative appeals process for QHP issuers in an FFE to challenge the imposition of a sanction, as described in § 156.800. These procedures include the opportunity for a hearing before an ALJ of the HHS Departmental Appeals Board (DAB). In part 2 of the 2022 Payment Notice (86 FR 24253), we further amended these procedures to affirm that

the process applies to appeals of sanctions imposed against QHP issuers participating in any Exchange and to align with the DAB's internal practices for administrative hearings to appeal CMPs.

The DAB's internal practices include procedures that ALJs and parties must follow for appeals and administrative hearings, and ALJs and parties must also follow any relevant agency's administrative hearing procedures as prescribed by the agency through regulation for the agency's programs.²²⁴ The DAB's procedures currently allow parties to request subpoenas, and they allow ALJs to issue a subpoena, if the ALJ is authorized by law to issue a subpoena and applicable regulatory requirements are met.²²⁵ However, current 45 CFR part 156 subpart J does not provide the authority for the ALJ to issue subpoenas in hearings requested by parties to appeal the imposition of a QHP issuer sanction, as defined in § 156.800. Having the option to issue a subpoena would help the ALJ obtain necessary documentation, information, and potential testimony from witnesses to fully develop a case before issuing a decision, which could streamline hearing processes and improve the accuracy of DAB decisions, benefiting both parties. Granting ALJs the authority to issue a subpoena would also align with other similar programs.²²⁶ Therefore, to further align HHS administrative appeal procedures with the DAB's procedures and improve the speed and accuracy of the hearing process, we propose add the ability to issue a subpoena in the ALJ's current authority under § 156.903.

As part of this provision, we also propose that a party must file a written request for a subpoena with the ALJ at least 5 calendar days before the date set for the hearing and that the request must identify the witness(es) or documents to be produced, describe their address(es) or location(s) with sufficient particularity to permit them to be found, and specify the pertinent facts the party expects to establish by the witness(es) or documents, and indicate why those facts could not be established without

²²⁴ See HHS. Appeals to DAB Administrative Law Judges (ALJs). Available at <https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-alj/index.html>.

²²⁵ See HHS. Department Appeals Board (DAB): Discovery. Available at <https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-alj/procedures/discovery/index.html>. See also HHS. Department Appeals Board (DAB): Summoning Witnesses. Available at <https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-alj/procedures/summoning-witnesses/index.html>.

²²⁶ See, for example, 42 CFR 498.58; see also 42 CFR 422.1044.

use of a subpoena. Establishing these requirements in regulation would provide structure to the subpoena request thereby increasing the efficiency with which ALJs can exercise the proposed subpoena authority. These requirements would also ensure that parties requesting subpoenas provide ALJs with all relevant information they will need to determine if the subpoena is reasonably necessary for full presentation of the case.

Second, to expedite the process of appeals and limit duplication, we propose to amend § 156.935 to ensure that the discovery provisions set forth therein do not apply to administrative appeals of notices of proposed CMP assessments for violations identified through audits of the APTC, cost sharing reduction, or user fee programs conducted in accordance with § 156.480(c). To explain, current audit processes under § 156.480(c)(3) require that HHS conduct an audit entrance conference with each issuer selected for audit to discuss the scope of the audit, provide issuers with preliminary audit findings and an opportunity to refute the preliminary findings prior to receiving the final audit report, and provide issuers with an opportunity to discuss final audit findings during an exit conference. In addition, audits are collaborative, meaning at any point issuers can ask questions of the auditors or seek clarification on the information or documentation needed. Further, in conjunction with these audit processes and in accordance with § 156.806, when imposing a CMP, HHS must provide written notice to the issuer that describes the potential violation(s), provides 30 days from the date of the notice to respond and provide additional information to refute the allegations, and states that a CMP may be assessed if the allegations are not refuted as determined by HHS.

During the established audit processes, HHS makes relevant information that HHS relies on in making final audit determinations available to issuers, including written audit procedures, and provides issuers with multiple opportunities to ask HHS questions about the audit procedures and audit findings. Should HHS determine that a CMP is appropriate, HHS would also make relevant information that HHS relied on to determine the CMP amount available to the issuer during the audit process. Therefore, under these established audit processes, issuers are able to develop an extensive record that can inform a CMP appeal. For these reasons, we believe that issuers would not need to rely on the time-consuming process of

discovery for information to develop a record for an administrative appeal.

Similarly, these established audit procedures allow HHS to obtain information necessary to inform final audit findings from the issuer during the audit process, limiting the need for discovery of information. Therefore, to prevent duplicative efforts for gathering documentation and information and to reduce burden on both parties to an appeal, we propose adding a new paragraph to § 156.935 which would exclude appeals of CMPs resulting from audits at § 156.480(c) from the process of discovery.

In summary, we propose to add a new paragraph to § 156.903 which provides the ALJ with the authority to issue subpoenas, upon his or her own motion or at the request of a party, if they are reasonably necessary for the full presentation of a case for an administrative appeal brought under § 156.805 or § 156.810. We also propose to add a new paragraph to § 156.935 to ensure that the discovery provisions set forth therein do not apply to appeals of proposed CMPs imposed under § 156.805 resulting from audits at § 156.480(c). If finalized as proposed, these amendments would apply to appeals filed on or after the effective date of the final rule.

We seek comment on these proposals.

16. Quality Standards: Quality Improvement Strategy (§ 156.1130)

We propose to require QHP issuers to submit quality improvement strategies (QISs) addressing any two of the five topic areas listed in section 1311(g)(1) of the Affordable Care Act, without mandating which specific topic areas a QHP issuer would be required to address to meet the QIS statutory certification requirement beginning with PY 2027.

In accordance with section 1311(c)(1)(E) of the Affordable Care Act, QISs described in section 1311(g)(1) of the Affordable Care Act must be implemented across Exchanges as a QHP certification requirement. Section 1311(g)(1) of the Affordable Care Act defines a QIS as a payment structure that provides increased reimbursement or other market-based incentives for implementing activities related to five health care topic areas identified in statute: improving health outcomes of plan enrollees, preventing hospital readmissions, improving patient safety and reducing medical errors, promoting wellness and health, and reducing health and health care disparities. Under § 156.1130(a), an issuer participating in an Exchange for two or more consecutive years must implement

and report on a QIS, including a payment structure that provides increased reimbursement or other market-based incentives in accordance with the health care topic areas in section 1311(g)(1) of the Affordable Care Act, for each QHP offered in an Exchange, consistent with the guidelines developed by HHS under section 1311(g) of the Affordable Care Act. In the 2016 Payment Notice (80 FR 10844 through 10848), we established a phase-in approach for QIS implementation standards and reporting requirements to provide QHP issuers time to understand the populations enrolling in a QHP offered through the Exchange and to build quality performance data on their respective QHP enrollees. In the 2023 Payment Notice (87 FR 27341 through 27345), we finalized a guideline to require QHP issuers to address health and health care disparities as a specific topic area within their QIS, in addition to at least one other topic area described in section 1311(g)(1) of the Affordable Care Act, beginning in 2023. We noted our commitment to addressing the persistent inequities in health care outcomes for QHP enrollees and aligning with health equity efforts across Federal governmental policies and programs.

We propose to modify the approach finalized in the 2023 Payment Notice (87 FR 27208) to instead require QHP issuers to submit QISs addressing any two of the five topic areas listed in section 1311(g)(1) of the Affordable Care Act, without mandating which specific topic areas a QHP issuer would be required to address to meet the QIS statutory certification requirement. We are not proposing any amendments to the regulatory text outlined in § 156.1130.

We believe this proposal would align with current Administration priorities, provide increased flexibility and reduced burden for QHP issuers that are required to submit QISs, and would better allow these QHP issuers to define the health outcome needs of their enrollees, set goals for improvement, and provide increased reimbursement to their providers or other market-based incentives to reward achievement of those goals, as initially described in the 2015 Payment Notice (79 FR 13744) when establishing the QIS program. Specifically, by allowing QHP issuers to select the two topic areas most relevant to their population and operational context, the proposal would empower issuers to focus resources on areas with the greatest potential for meaningful improvement, rather than adhering to a one-size-fits-all approach. This targeted

flexibility would support innovative strategies for improving patient outcomes, encourage adoption of best practices across diverse settings, and help ensure that incentives are aligned with measurable progress on priority health outcomes, consistent with the objectives articulated in the 2015 Payment Notice (79 FR 13744) when establishing the QIS program.

We continue to believe that improving health care quality and outcomes for all is important. QHP issuers have a critical role in promoting high quality health care by designing QISs that tie provider payments or other market-based incentives to measures of performance, such as when providers meet quality indicators or when enrollees make certain choices associated with improved health. For each QIS topic area, issuers may select quality measures, such as those from the Marketplace Quality Rating System, or other performance targets based on their programmatic goals and the needs of their enrollee populations, to monitor QIS progress.

Although QHP issuers would no longer be required to submit a QIS that addresses health and health care disparities as a specific topic area within their QIS under this proposal if finalized, they would be permitted to continue to choose this topic area as one of the two topic areas they address in their QIS. We further note that health and health care disparities may relate to various factors such as geographic, economic, educational, disability status, and other factors that impact high quality health care for all.

We seek comment on this proposal.

17. Netting and Establishment of Debt Regulations To Include CMPs (§ 156.1215)

We propose to amend the payment and collections processes set forth at § 156.1215. In particular, we propose to amend § 156.1215(b) to provide that any CMPs assessed²²⁷ against health insurance issuers for violations of any applicable Exchange standards and requirements or PHSA requirements applicable to health insurance issuers would be subject to netting as part of HHS' integrated monthly payment and collections cycle. We propose to apply the netting provisions of the payment and collections process to CMPs assessed against health insurance issuers to allow the payment and collections process to evolve with the

needs of the programs administered by HHS, ensure stability and consistency in the monthly payment and collections process, and improve HHS' ability to recover Federal debts by withholding funds payable by HHS to, or held by HHS for, health insurance issuers to satisfy a debt to HHS for CMPs assessed against health insurance issuers.

Since finalizing the netting rules at the beginning of the Affordable Care Act financial management programs (79 FR 13817, 81 FR 12317 through 12318), the programs under title XXVII of the PHS Act have evolved, and existing Exchange programs have matured and stabilized. We have undertaken efforts to adapt our payment and collections process to fit the current needs of the Exchanges and other programs administered by HHS. As we work to enhance enforcement of these maturing programs, we believe that the payment and collections process should reflect this change by further evolving to provide that CMPs assessed against health insurance issuers, for violations of any applicable Exchange standards and requirements or PHS Act requirements, including the No Surprises Act, applicable to health insurance issuers, are also subject to netting as part of HHS' integrated monthly payment cycle.

Accordingly, we propose to amend § 156.1215(c) to provide that any amount owed to the Federal Government by an issuer and its affiliates for these unpaid CMP amounts due to the Federal Government from these issuers and their affiliates, after HHS nets amounts owed by the Federal Government under these programs, would be the basis for calculating the determination of the debt.

HHS' current integrated monthly payment and collections cycle is designed to streamline payment processing for both health insurance issuers and HHS, and includes statements to health insurance issuers that reflect how payments have been netted in the monthly payment and collections cycle. The proposed changes, to provide for netting of CMPs assessed against health insurance issuers and their affiliates, would ensure stability and consistency in the monthly payment and collections process and support HHS' continued ability to recover Federal debts by withholding funds payable to (or held by HHS for) issuers to satisfy an outstanding balance due to HHS for CMPs. Netting supports HHS' integrated monthly payment and collections cycle by limiting the number of charges flowing back and forth between HHS and issuers, mitigates the need for additional steps for Federal

debt collection when internal netting may resolve the outstanding balance due to HHS from a determined debt, and may prevent inappropriately enriching an issuer if a payment is made from HHS when the issuer has an outstanding CMP.

In summary, we propose to amend § 156.1215(b) to add language which applies the netting provisions of the payment and collections process to CMPs assessed for violations of any applicable Exchange standards and PHSA requirements applicable to health insurance issuers. We also propose to amend § 156.1215(c) to add language which provides that any amount owed to the Federal Government by an issuer and their affiliates for unpaid CMP amounts due to the Federal Government, after HHS nets amounts owed by the Federal Government under these programs is a determination of debt.

We seek comment on these proposals.

18. Technical Correction To Cross Reference (§ 156.1220(b)(1))

We propose a technical correction to § 156.1220(b)(1) to update a cross-reference in the regulation text from paragraph (a)(5) to (a)(6). The process for administrative appeals consists of requests for reconsideration, described in § 156.1220(a), followed by informal hearings, described in § 156.1220(b). Section 156.1220(b)(1) serves to explain the manner and timing of the request for an informal hearing, in the event that a request for reconsideration is not accepted by HHS. Currently § 156.1220(b)(1) references § 156.1220(a)(5) which is the scope of review of the reconsideration decision and we propose to correct this reference to § 156.1220(a)(6) on the reconsideration decision.

We seek comments on this technical correction.

F. Part 158—Issuer Use of Premium Revenue: Reporting and Rebate Requirements

1. Comment Solicitation on Potential Adjustment to the MLR for a State's Individual Market (Subpart C)

Section 2718(b)(1)(A) of the PHS Act requires individual market health insurance issuers to pay rebates to enrollees if issuers do not spend at least 80 percent or a higher percentage that a State may by regulation determine (the MLR standard) of their premium revenue (after certain adjustments) on reimbursement for clinical services provided to enrollees under health insurance coverage and on activities that improve health care quality.

²²⁷ A CMP is assessed only after any applicable imposition and appeal processes set forth in 45 CFR subtitle A, subchapter B have been exhausted or expire.

Section 2718(b)(1)(A)(ii) of the PHS Act provides that the Secretary may adjust the 80 percent MLR standard in the individual market with respect to a State if the Secretary determines that application of the MLR standard may destabilize the individual market in such State. In an interim final rule relating to the MLR program issued in the **Federal Register** on December 1, 2010 (75 FR 74864), we set forth the framework for a State to request an adjustment of the MLR standard pursuant to section 2718(b) of the PHS Act, and under this framework, the State requesting the adjustment must demonstrate a reasonable likelihood that the 80 percent MLR standard would destabilize its individual market. The interim final rule also established a process and criteria for the Secretary to determine whether to grant a State's request to adjust the MLR standard in that State (75 FR 74910). In the 2019 Payment Notice (83 FR 16930), we finalized amendments throughout subpart C of part 158 to allow for adjustments to the individual market MLR standard in any State that demonstrates a reasonable likelihood that a different MLR standard will help stabilize its individual market, and to streamline the process for applying for such adjustments to reduce burdens for States and HHS. Subpart C of part 158 specifies that the adjustment request must be initiated by the State (§ 158.310), that the adjustment may be granted for up to 3 years at a time (§ 158.311), the information that the State must provide to support its request (§§ 158.320 and 158.321), and the criteria that HHS may consider in making a determination (§ 158.330). It also requires the Secretary to invite public comments on the adjustment requests (§ 158.342), allows States to hold optional public hearings (§ 158.343), and enables States to request reconsideration of adverse determinations (§ 158.346).

Given the instability in the individual market in recent years, we are seeking comment on the impact of the Federal MLR standard on individual market stability, including the impact of MLR on costs and premiums and how such impact, if any, may affect individual market stability. We are taking a comprehensive look at HHS regulations to determine whether any changes to these regulations could be proposed that would help stabilize the individual market, including potentially by lowering premiums for consumers, and, as such, are seeking comment on whether and how to amend subpart C of part 158 to enable HHS to adjust the

Federal MLR standard in the individual market, under the authority provided in section 2718(b) of the PHS Act and 45 CFR 158.301, in States that do not request such an adjustment. We also seek comment on whether and how much HHS could adjust the Federal MLR standard in a given State and how to determine the amount of adjustment to best stabilize the individual market in those individual States. We seek comment on whether by making any adjustments to the 80 percent MLR standard, HHS could affect a given State's individual market stability, including by lowering premiums or reducing incentives for market consolidation. We welcome comments and data analysis on whether, by what mechanism, and to what extent, adjusting the MLR standard would benefit consumers as well as reduce volatility in the individual market in applicable States. We also seek comment on specific amendments to subpart C of part 158 that we should consider, such as whether the amendments should provide that HHS would consult with the State and/or provide an opportunity for public comments on a potential adjustment to the Federal MLR standard in a State, in the absence of a State-initiated request for such an adjustment; how HHS should resolve any disagreements between HHS and State determinations of whether an adjustment to the individual market MLR standard in that State would help stabilize the market or the size of the adjustment; and whether HHS should publish the data and analyses that led to its determination that an adjustment to the MLR standard was warranted.

After promulgating rules in the 2019 Payment Notice to better enable States to seek adjustments to the individual market MLR standard in a particular State, HHS has not received any requests from States to help stabilize their individual market by adjusting the MLR standard as allowed under subpart C of 45 CFR part 158. However, we seek comment on whether and what further burden reductions for States interested in adjusting the MLR standard for the individual market could further facilitate making such a request. Specifically, we seek comment on whether to modify § 158.311 to allow States to request an adjustment for up to 5 instead of 3 MLR reporting years. We also seek comment on whether to further reduce the information requirements in § 158.321 regarding the State's individual health insurance market that support the requests for an adjustment to the MLR standard. We

further seek comment on whether to modify § 158.330, which specifies the criteria HHS uses for assessing a request for adjustment to the MLR standard, in a manner that would further reduce administrative burden on States and allow States more flexibility to design standards that are unique for their individual markets, and suggestions for specific modifications to the criteria in § 158.330.

G. Severability

As demonstrated by the number of distinct programs addressed in this rulemaking and the structure of this proposed rule in addressing them independently, we generally intend the rule's provisions, if finalized, to be severable from each other. For example, this proposed rule outlines proposed payment parameters and provisions for the HHS-operated risk adjustment program and HHS-RADV, the 2027 user fee rate for issuers in the risk adjustment program, the 2027 FFE and SBE-FP user fee rates, and provisions related to administration of CMPs. We also propose, among other proposals, to disallow APTC for individuals who are ineligible for Medicaid due to their immigration status and have income below 100 percent of the FPL for taxable years beginning after December 31, 2025, limit APTC eligibility among aliens lawfully present who are not "eligible aliens" effective January 1, 2027, and extend the removal of the 150 percent FPL SEP beyond PY 2026 to align with the WFTC legislation. We believe that the proposed provisions in this rule, if finalized, are generally capable of functioning sensibly on an independent basis. It is our intent that if any provision of this proposed rule, if finalized, is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, the other provisions in this proposed 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 if finalized is found to be utterly invalid or unenforceable, we intend for that provision to be severable.

We seek comment on the severability of these provisions in the proposed rule.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an

information collection 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, including the validity of the methodology and assumptions used.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the

affected public, including automated collection techniques.
We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs).

A. Wage Estimates

To derive wage estimates, we generally use data from the Bureau of Labor Statistics to derive labor costs (including a 100 percent increase for the cost of fringe benefits and overhead) for estimating the burden associated with the ICRs.²²⁸ Table 12 presents the median hourly wage, the cost of fringe

benefits and overhead, and the adjusted hourly wage.

As indicated, employee hourly wage estimates have been adjusted by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly across employers, and because methods of estimating these costs vary widely across studies. Nonetheless, there is no practical alternative, and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

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TABLE 12: Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Median Hourly Wage (\$/hr.)	Fringe Benefits and Overhead (\$/hr.)	Adjusted Hourly Wage (\$/hr.)
Business Operations Specialist	13-1199	\$39.07	\$39.07	\$78.14
General and Operations Manager	11-1021	\$49.50	\$49.50	\$99.00
Management Analyst	13-1111	\$48.65	\$48.65	\$97.30
Compliance Officer	13-1041	\$37.70	\$37.70	\$75.40
Computer and Information Systems Manager	11-3021	\$82.31	\$82.31	\$164.62
Computer Systems Analyst	15-1211	\$49.90	\$49.90	\$99.80
Computer Programmer	15-1251	\$47.44	\$47.44	\$94.88
Secretaries and Administrative Assistants, Except Legal, Medical, and Executive	43-6014	\$22.26	\$22.26	\$44.52
Insurance Sales Agent	41-3021	\$29.02	\$29.02	\$58.04
Eligibility Interviewers, Government Programs	43-4061	\$24.76	\$24.76	\$49.52
Database and Network Administrators and Architects	15-1240	\$51.67	\$51.67	\$103.34
Actuary	15-2011	\$60.47	\$60.47	\$120.94
Data Scientist	15-2051	\$54.13	\$54.13	\$108.26
Claims Specialist	13-1031	\$36.92	\$36.92	\$73.84
Project Manager	13-1082	\$48.44	\$48.44	\$96.88
Computer Programmer	15-1251	\$47.44	\$47.44	\$94.88

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We propose to adopt an hourly value of time based on after-tax wages to quantify the opportunity cost of changes in time use for unpaid activities. This approach matches the default

assumptions for valuing changes in time use for individuals undertaking administrative and other tasks on their own time, which are outlined in an Assistant Secretary for Planning and Evaluation (ASPE) report on “Valuing

Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices.”²²⁹

²²⁸ 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.

²²⁹ 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>.

We start with a measurement of the usual weekly earnings of wage and salary workers of \$1,206.²³⁰ We divide this weekly rate by 40 hours to calculate an hourly pre-tax wage rate of approximately \$30.15. We adjust this hourly rate downwards by an estimate of the effective tax rate for median income households of about 17 percent, resulting in a post-tax hourly wage rate of approximately \$25.02. We adopt this as our estimate of the hourly value of time for changes in time use for unpaid activities.

We seek comment on these burden estimates and assumptions.

B. ICRs Regarding Rate Filing
Justification—OMB Control Number 0938–1141 (§ 154.215)

1. ICR Regarding Estimating CSR Load Factor Using the Standard Methodology

Pursuant to § 154.215(a)(1) through (3) and CMS's Unified Rate Review Instructions,²³¹ issuers are required to submit a rate filing justification that consists of three parts: (1) the URRT; (2) a written description justifying any premium rate increase when a plan within a product has a rate increase that is subject to review; and (3) an Actuarial Memorandum when a plan within a product has a rate increase, regardless of the size of the increase, when a product contains a QHP, or when a State requires it. Section 156.80(d)(2)(i) specifies that 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 actuarial value 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.

As discussed in section III.C. of this proposed rule, CSR loading is a permissible practice if permitted by the State and the amounts are actuarially justified plan-level adjustments which issuers must report when they submit a rate filing to the State or CMS for review, to ensure compliance with the Federal rating rules, including § 156.80. In order to provide regulators with information to help determine whether CSR loads are actuarially justified, this rule proposes that the actual CSR amount paid on behalf of eligible enrollees and the amount previously generated by any load factors be reported on the URRT and calculated using the most recent annual data available the standard methodology set forth in § 156.430(c)(2) and historical data.

Assuming a cross-functional team, we estimate that issuers would incur an initial one-time cost and burden in 2026 to develop and implement a claim-level re-adjudication process using the standard methodology set forth in § 156.430 to produce the required values. We estimate that for each issuer it would require 2,400 hours (at an hourly rate of \$120.94) for Actuaries to define the plan mappings and business

rules and set reasonableness thresholds, 3,000 hours (at an hourly rate of \$108.26) for Data Scientists to design the approach and data flows, prototype the logic, and validate results, 3,000 hours (at an hourly rate of \$94.88) for Computer Programmers to develop and maintain the production code and workflows, automate runs, and ensure reliability and performance, 2,000 hours (at an hourly rate of \$73.84) for Claims Specialists to assemble and interpret claims, eligibility, and accumulator data, and 1,000 hours (at an hourly rate of \$96.88) for a Project Manager to coordinate timelines, handoffs, and deliverables to produce the experience-period actual CSR amount paid on behalf of eligible enrollees (using the most recent annual data available, generally 2 years before the upcoming plan year, using the CMS standard methodology set forth in 156.430(c)(2)), the amount previously generated by any load factors from the most recent annual data available, the projection-period expected CSR amount to be paid on behalf of enrollees for the upcoming plan year, and the plan-level CSR load factor for the upcoming plan year, and the expected amount generated by the load factor for the upcoming plan year for URRT reporting, resulting in a total one-time burden of 11,400 hours, with an associated cost of approximately \$1,144,236. For all 366 issuers, we estimate a total burden of 4,172,400 hours, with an associated cost of approximately \$418,790,376.

TABLE 13: One-Time Cost and Burden to Implement and Run the Standard Methodology Calculations

Number of Respondents	Number of Responses per Respondent	Burden per Response (Hours)	Labor Cost per Response	Total Burden for all Respondents (Hours)	Total Cost for all Respondents
366	1	11,400	\$1,144,236.00	4,172,400	\$418,790,376.00

In subsequent years, we assume that issuers would require targeted updates to ensure their systems are accurately calculating the required values using the most recent data. We estimate that for each issuer it would require 1,200 hours (at an hourly rate of \$120.94) for Actuaries to update plan parameters and CSR-to-standard-plan mappings using the most recent annual data that is available prior to the applicable filing

year, 1,500 hours (at an hourly rate of \$108.26) for Data Scientists to update specifications, oversee execution, and review outputs, 1,500 hours (at an hourly rate of \$94.88) for Computer Programmers to reload data, apply configuration and code updates, and run and monitor the processing, 1,000 hours (at an hourly rate of \$73.84) for Claims Specialists to reconcile corrected claims, and 500 hours (at an hourly rate

of \$96.88) for a Project Manager to manage review and sign-off for the cycle, resulting in an annual ongoing burden of 5,700 hours, with an associated cost of approximately \$572,118. For all 366 issuers, we estimate a total burden of 2,086,200 hours, with an associated cost of approximately \$209,395,188.

²³⁰ 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.

²³¹ See *Unified Rate Review Instructions at: https://www.cms.gov/files/document/unified-rate-review-instructions.pdf*.

TABLE 14: Annual Cost and Burden to Update and Run the Standard Methodology Calculations

Number of Respondents	Number of Responses per Respondent	Burden per Response (Hours)	Labor Cost per Response	Total Burden for all Respondents (Hours)	Total Cost for all Respondents
366	1	5,700	\$572,118.00	2,086,200	\$209,395,188.00

Some issuers could incur a lower one-time cost if they currently have a system in place that is able to calculate the load factor and other required values using the standard methodology, or if their systems only require updates and minor changes to function properly. We also acknowledge that some issuers could incur higher costs if they are required to develop and build a new system to meet the proposed requirements and calculate the appropriate values. We further acknowledge that some issuers could incur higher or lower annual costs depending on their volume of CSR-eligible claims.

2. ICR Related to the Submission of Unified Rate Review Templates (URRTs)

As discussed in section III.C. of this proposed rule, this rule proposes to change the instructions for the URRT so

that issuers would enter the actual amount of CSRs they paid on behalf of eligible enrollees (using the most recent annual data that is available prior to the applicable filing year, generally two years prior to the upcoming plan years), the amount previously generated by any load factors from the most recent annual data available, the amount of CSRs they expect be paid on behalf of enrollees in the upcoming plan year, the CSR load factor for the upcoming plan year, and the expected amount generated by the load factors for the upcoming plan year.

Issuers would incur ongoing burden to gather all the required CSR-related data elements and enter them into the URRT in their appropriate places. We estimate that for each plan an issuer would require 0.5 hours (at an hourly rate of \$120.94) for Actuaries to collect all required CSR-related data elements

(actual CSR amounts paid on behalf of eligible enrollees, amount previously generated by load factors, expected CSR amounts to be paid on behalf of enrollees in the upcoming plan year, CSR load factor for the upcoming plan year, and expected amount generated by the load factor for the upcoming plan year) and ensure the data is accurately entered into the URRT, resulting in an ongoing burden of 0.5 hours, with an associated cost of approximately \$60 per plan. We estimate that each issuer would need to submit data for an approximate average of 7 plans²³² that include CSR load factors and thus would incur an estimated burden of 3.6 hours, with an associated cost of approximately \$430.²³³ For all 366 issuers, we estimate a total burden of 1,300 hours, with an associated cost of approximately \$157,222.

TABLE 15: Annual Cost and Burden to Provide CSR Related Information in the URRT – Part 1

Number of Respondents	Number of Responses per Respondent	Burden per Response (Hours)	Labor Cost per Response	Total Burden for all Respondents (Hours)	Total Cost for all Respondents
366	7	3.6	\$429.57	1,300	\$157,222.00

3. ICR Related to the Submission of Actuarial Memorandum

As discussed in section III.C. of this proposed rule, this rule proposes that information regarding CSR-related plan-level adjustments to the index rate should be provided in the URRT and should continue to be provided in the Actuarial Memorandum so that issuers provide numerical values in the URRT and explain how they reached those values in the Actuarial Memorandum.

Issuers would incur additional ongoing burden to develop, draft, and add the explanation of the methodology

used to determine the load factor and an explanation of how the expected amount generated by the load factor for the upcoming plan year compares to the amount of CSRs expected to be paid on behalf of enrollees for the same period. We estimate that for each plan an issuer would require 2 hours (at an hourly rate of \$120.94) for Actuaries to develop, draft the required explanations (methodology for determining the load factor for the upcoming plan year and comparison of expected load revenue to expected CSR payment on behalf of enrollees for the same period), and add

them to the Actuarial Memorandum for submission via SERFF and/or MPMS, resulting in an ongoing burden of 2 hours, with an associated cost of approximately \$242 per plan. We estimate that each issuer would need to submit explanations for an average of 7 plans and thus would incur an estimated burden of approximately 14.2 hours, with an associated cost of approximately \$1,718. For all 366 issuers, we estimate a total burden of 5,200 hours, with an associated cost of approximately \$628,888.²³⁴

²³² Average number of plans per issuer derived from the PY 2025 URRT data using the PUF found at <https://www.cms.gov/marketplace/resources/data/rate-review-data>.

²³³ Certain values are rounded for readability and are indicated by the use of terms such as 'approximately' or 'average.' All cost and burden calculations are based on unrounded figures to ensure accuracy.

²³⁴ Certain values are rounded for readability and are indicated by the use of terms such as 'approximately' or 'average.' All cost and burden calculations are based on unrounded figures to ensure accuracy.

TABLE 16: Annual Cost and Burden to Provide CSR Calculation Explanation in the Actuarial Memorandum – Part III

Number of Respondents	Number of Responses per Respondent	Burden per Response (Hours)	Labor Cost per Response	Total Burden for all Respondents (Hours)	Total Cost for all Respondents
366	7	14.2	\$1,718.27	5,200	\$628,888.00

The information collection described in this section will be submitted as a revision to the currently approved PRA package CMS–10379 (OMB Control Number 0938–1141) for OMB review under the Paperwork Reduction Act.

Table 17 aggregates the burden and costs from Tables 13 through 16. The 2026 burden (11,418 hours per respondent) includes the one-time implementation (11,400 hours) plus ongoing URRT and Actuarial Memorandum submissions (18 hours

total). The 2027–2028 burden (5,718 hours per respondent) includes annual system updates (5,700 hours) plus ongoing URRT submissions (18 hours total). The three-year averages are calculated by summing the annual figures and dividing by three.²³⁵

TABLE 17: Three-Year Average Cost and Burden to Implement, Update and Calculate, and Submit the Required URRT Values and the Actuarial Memorandum

Year	Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Costs
2026	366	2,600	11,418	4,178,900	\$419,576,486.00
2027	366	2,600	5,718	2,092,700	\$210,181,298.00
2028	366	2,600	5,718	2,092,700	\$210,181,298.00
3-Year Average			7,618	2,788,100	\$279,979,694.00

4. Cost to Federal Government Related To Review of URRT Reporting Requirements Related to CSR Estimates

In 2026, the Federal Government would incur costs to review and evaluate the data and actuarial memoranda submitted by issuers into

MPMS or SERFF. To conduct the review of all required CSR-related data elements and explanations submitted, the Federal Government, at a minimum, would require staff at GS–14 level (at an hourly rate of \$154.76 for GS–14 step 5) 6 hours per plan to review the materials

submitted by issuers. The Federal Government would incur a burden of 15,600 hours, with an associated estimated cost of \$2,414,256 to review all URRT and actuarial memoranda related material related to CSR data and explanations.

TABLE 18: Annual Cost and Burden to Federal Government to Review and Evaluate the Data and Actuarial Memoranda Submitted by Issuers

GS Pay Grade	Hourly Rate	# of Reviews	Burden per Response (hr)	Cost per Response	Total Burden	Total Cost
14 Step 5	\$154.76	2,600	6	\$928.56	15,600	\$2,414,256.00

C. ICRs Regarding Mandating HHS-Approved and -Created Consumer Consent Form (§ 155.220)

As discussed in the preamble of this proposed rule, we propose amendments to § 155.220(j)(2)(ii)(A) and (j)(2)(iii)(A) to require agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review

documentation requirements and consent documentation requirements. Our proposal would eliminate the current broad allowances for meeting these requirements. The language in the regulation would also be changed to clarify what types of actions constitute “taking an action” to meet the regulatory requirements. The goal of this policy is to reduce confusion among agents, brokers, and web-brokers on

what constitutes compliant eligibility application review documentation and what constitutes compliant consumer consent by ensuring objective standards, which ultimately protects consumers. These proposals would also greatly improve HHS’ investigative abilities into agent, broker, and web-broker eligibility application review documentation and consumer consent documentation review by creating a

²³⁵ Certain values are rounded for readability and are indicated by the use of terms such as

‘approximately’ or ‘average.’ All cost and burden

calculations are based on unrounded figures to ensure accuracy.

clear and objective standard for all applications clearly outlining what HHS deems complaint.

We estimate there would be very minimal costs in time associated with this proposal as agents, brokers, and web-brokers are already required to document and maintain eligibility application review documentation information and consumer consent documentation information. As a result, this proposal would not add to those requirements, rather, it would only require that a specific form be used.

According to our records, as of September 18, 2025, there are a total of 105,988 agents, brokers, and web-brokers who have presently completed the FFE training who are registered to assist consumers on the Exchanges. Pursuant to our records, the percentage of agents, brokers, and web-brokers that currently submit only audio files for eligibility application review documentation and consumer consent documentation is approximately 24 percent, which equals 25,437 agents, brokers, and web-brokers who are utilizing this method. Additionally, per our records, the percentage of agents, brokers, and web-brokers that currently submit partial audio files in connection with eligibility application review documentation and consumer consent documentation is approximately 42 percent, which equals 44,514 agents, brokers, and web-brokers who are utilizing this method.

Regarding the costs related to requiring agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review documentation requirements and the consumer consent documentation requirements, we estimate it would take approximately 10 minutes of time for an enrolling agent, broker or web-broker to meet eligibility application review documentation requirements and to obtain consumer, or their authorized representative, affirmation of their consent. Using the current adjusted hourly wage rate of \$58.04²³⁶ for an insurance sales agent, each enrollment using the HHS-approved and -created consumer consent form would have approximately \$9.87 (10 minutes, or 0.17 hours, at an hourly wage rate of \$58.04) in additional cost associated with it based on the extra time commitment from these proposed policy changes. In PY 2024, agents submitted 9,800,000 policies. Based on this

number of enrollments, the total annual burden is 1,666,000 hours (9,800,000 submitted policies x approximately 0.17 hours) with a total annual cost of \$96,694,640 (1,666,000 hours x \$58.04 per hour).

HHS would require agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review documentation requirements and the consumer consent documentation requirements. The HHS-approved and -created consumer consent form can be submitted electronically, so there would be no costs associated with printing or mailing the HHS-approved and -created consumer consent form.

The estimated cost of requiring agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review documentation requirements and the consumer consent documentation requirements is \$96,694,640.

If this proposal is finalized, the new information collection requirements discussed in this section would be submitted for OMB review and approval in a new PRA package.

We seek comment on these burden estimates and assumptions.

D. ICRs Regarding Misleading Marketing (\$ 155.220)

As discussed in the preamble of this proposed rule, we propose amendments to § 155.220(j), creating new standards of conduct section on marketing requirements, which would be housed in § 155.220(j)(3). These new regulations would prohibit agents, brokers, and web-brokers from engaging in misleading marketing, while adhering to the requirements in newly proposed § 155.220(j)(3)(iii), and require agents, brokers, and web-brokers to provide marketing materials to HHS upon request. We estimate costs that would be associated with this proposal are mainly those involved in responding to HHS' requests for documentation. Producing such documentation would require the submission of electronic documents to HHS upon request.

We do not anticipate many costs for the agents, brokers, or web-brokers we investigate for misleading marketing. Based on our current investigative methods and volume of misleading advertisements we have uncovered thus far, we currently only plan to send 70 notifications annually to agents, brokers, and web-brokers for misleading marketing. Based on analysis of existing enforcement outreach conducted on misleading marketing, about 2/3 of the

notices we send would be part of our Technical Assistance (TA) enforcement workstream, only requires the agent, broker, or web-broker to indicate the ad(s) has been removed. The other 1/3 of the notices we send would be Notices of Intent to Terminate (NoITs). NoITs require the agent, broker, or web-broker to respond indicating (1) they removed the ad(s) in question and (2) they reviewed the marketing guidelines CMS sent them. Therefore, there would only be approximately 24 notifications sent annually that require agents, brokers, or web-brokers to submit documentation in response to HHS. We are proposing to allow HHS to request and review advertisements in new § 155.220(j)(3)(iv). If HHS were to utilize this regulatory authority and request advertisements from an agent, broker, or web-broker, it would be part of our NoIT requirements and the same 24 agents, brokers, or web-brokers would be impacted.

We believe responding to HHS requests to provide confirmation they removed the ads and/or reviewed the marketing guidelines would not be overly time-consuming or burdensome. Our notifications to the agents, brokers, or web-brokers detail what response is required and provide hyperlinks to the noncompliant ad(s). We estimate it would take each agent, broker, or web-broker one hour to remove any noncompliant ad(s), and/or review the marketing guidelines, and respond to HHS via email. This estimate incorporates the potential of HHS asking these 24 agents, brokers, and web-brokers to provide advertisements for HHS' review. Using the hourly wage rate for an insurance sales agent from Table 12, this means the total burden of responding to HHS regarding misleading marketing would be 24 hours at a cost of \$1,392.96 (\$58.04 per hour x 1 hour x 24 responses).

We seek comment on these burden estimates and assumptions.

E. ICRs Regarding State Exchange Enhanced Direct Enrollment (SBE-EDE) Option (\$ 155.221)

Current State Exchanges that elect to implement the SBE-EDE option will need to revise their Exchange Blueprint to notify HHS that the State proposes to implement the SBE-EDE option in compliance with related requirements. We believe that any costs of revising the Exchange Blueprint will be nominal, as this process involves logging into a CMS web interface that serves as the repository for all States' Exchange Blueprints to input additional information on the updated processes and controls the State would implement

²³⁶ See the 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.

to manage its new SBE-EDE program. The burden related to completing the Exchange Blueprint is currently approved under OMB Control Number 0938–1172 (Blueprint for Approval of Affordable State-based Health Insurance Exchanges (CMS–10416)). We seek comment on the burden associated with this activity.

F. ICRs Regarding Limiting APTC Eligibility to “Eligible Noncitizens” (§§ 155.20, 155.305(f)(1), and 155.320)

1. Basic Health Program

The following proposed changes would be submitted for review under OMB Control Number 0938–1218 for BHP.

As discussed in section III.D.8. of this proposed rule, lawfully present noncitizens who are not “eligible noncitizens” remain eligible for enrollment in the BHP, provided they meet the eligibility requirements of section 1331(e) of the Affordable Care Act and 42 CFR 600.305. However, because section 71301 of the WFTC legislation amended section 36B of the Code to provide that PTC is not allowed for the coverage of noncitizens who are lawfully present but not “eligible aliens,” this population is no longer allowed PTC for their coverage beginning January 1, 2027, and as such, States will stop receiving Federal payments associated with members of this population who are BHP enrollees effective January 1, 2027. States that operate a BHP will need to modify enrollment data sent to CMS in accordance with this provision to enable CMS to accurately calculate the State’s BHP funding.

We estimate that implementing this proposed policy would require ongoing costs for States to submit additional enrollment data to CMS. We estimate that it would take a Business Operations Specialist 2.5 hours at \$78.14 per hour and a General Manager 0.5 hours at \$99 per hour to compile and submit additional quarterly estimated enrollment data. We estimate that it would take a Business Operations Specialist 25 hours at \$78.14 per hour and a General Manager 2.5 hours at \$99 per hour to compile and submit additional quarterly final enrollment data. For the two States and DC currently approved to be operating a BHP in 2027 we estimate the in total annual ongoing cost to be \$29,350.20.

2. Exchanges

The following proposed changes would be submitted for review under OMB Control Number 0938–NEW for

Exchanges and OMB Control Number 0938–1218 for BHP.

As discussed in section III.D.8. of this proposed rule, we propose to align Exchange eligibility and verification rules with section 71301 of the WFTC legislation, which disallows PTC for the coverage of noncitizens other than “eligible aliens.” We propose to add a new definition of “eligible noncitizen” at 45 CFR 155.20 and update our regulations at § 155.305(f)(1)(ii) to align with 26 CFR 1.36B–1(d) and § 155.305(f)(1)(ii)(C) to clarify that an Exchange must grant eligibility for APTC to individuals defined as “U.S. citizens, U.S. nationals, and eligible noncitizens,” provided the other APTC eligibility requirements are met. For BHP, we propose to add a new definition of “eligible noncitizen” at 42 CFR 600.5 that cross-references to 45 CFR 155.20. This proposed change is effective beginning in PY 2027 and would apply to the 22 State Exchanges expected to be operating for PY 2027, Exchanges on the Federal platform, and to the two States that currently operate a BHP (Minnesota and Oregon) and to DC, which will begin operating a BHP in 2026.²³⁷

To implement these changes, the Federal Data Services Hub would need to make updates to its Verify Lawful Presence (VLP) service, to enable Exchanges to accurately verify whether an individual is an eligible noncitizen. In addition, Exchanges on the Federal platform and the 22 State Exchanges would need to update their eligibility and enrollment systems to collect applicant attestations regarding eligible noncitizen status, to correctly determine APTC and income-based CSR eligibility on the basis of such attestations, to determine whether such attestations can be considered verified, to set and process new inconsistencies in cases where such attestations cannot be verified. Exchanges would also need to ensure that current enrollees who would no longer be eligible for APTC or income-based CSRs as a result of this proposal have their APTC and CSR eligibility ended accordingly.

3. Implementation Costs

We estimate that implementing this proposed policy would require one-time costs for the Federal Government to make technical updates to its system. Based on preliminary analysis, we estimate that it would take the Federal Data Services Hub (the “Hub”) 2,000

hours in 2025 to make these technical updates. Of the 2,000 hours for Hub updates, we estimate it would take a database and network administrator and architect 500 hours at \$103.34 per hour and a computer programmer 1500 hours at \$94.88 per hour. Given this, to make Hub updates, we estimate that the Federal Government would incur a one-time burden in 2025 of \$193,990 [(500 hours × \$103.34 + (1500 hours × \$94.88)] to make these system updates.

We also estimate that it will take Exchanges on the Federal platform 7,000 hours to make the updates required to implement this provision. Of the 7,000 hours required to make updates for Exchanges on the Federal platform, we estimate that it would take a database and network administrator and architect 1,750 hours at \$103.34 per hour and a computer programmer 5,250 hours at \$94.88 per hour. Given this, Exchanges on the Federal platform would incur a one-time burden of \$678,965 [(1,750 hours × \$103.34) + (5250 hours × \$94.88)].

Similar to the one-time costs incurred by Exchanges on the Federal platform, we estimate that implementing this proposed policy would require one-time costs for each State Exchange. Of the 7,000 hours required to make updates for each State Exchange, we estimate it would take a database and network administrator and architect 1,750 hours at \$103.34 per hour and a computer programmer 5,250 hours at \$94.88 per hour. State Exchanges would incur a one-time burden of \$14,937,230 [(1,750 hours × \$103.34) + (5,250 hours × \$94.88)] × 22 State Exchanges) to implement these technical changes.²³⁸

4. Ongoing Burden Related to New DMI Type for “Eligible Noncitizens”

We anticipate that this proposed policy would not result in ongoing burden changes for Exchanges and individuals related to the creation of a new DMI type for “eligible noncitizens” because these individuals would already be required to submit documentation to verify their eligibility to enroll in a QHP.

The total estimated annual burden for these information collection requirements is \$15,810,185, representing 163,000 hours of burden.

²³⁷ CMS. (2025, August 4). Fact Sheets & Frequently Asked Questions (FAQs): State-based Exchanges. <https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/state-marketplaces>.

²³⁸ Section 3 figures are based on labor needs estimates internal to the FFM as well as Table 12: Adjusted Hourly Wages Used in Burden Estimates.

G. ICRs Regarding the Prohibition of APTC for Individuals Who Are Ineligible for Medicaid Due to Their Immigration Status and Have Income Below 100 Percent of the FPL (§ 155.305(f)(2))

1. Exchanges

We estimate that implementing this proposed policy would require one-time costs for Exchanges to make technical updates to their eligibility systems related to both APTC and the BHP. We estimate that it would take the Exchanges on the Federal platform 2,500 hours and each State Exchange 2,000 hours in 2025 to make these technical updates. Of those 2,500 hours for Exchanges on the Federal platform, we estimate it would take a database and network administrator and architect 625 hours at \$103.34 per hour and a computer programmer 1,875 hours at \$94.88 per hour. Of those 2,000 hours for State Exchanges, we estimate it would take a database and network administrator and architect 500 hours at \$103.34 per hour and a computer programmer 1,500 hours at \$94.88 per hour. Given this, we estimate that Exchanges on the Federal platform would incur a one-time burden in 2025 of \$242,488 [(625 hours × \$103.34) + (1,875 hours × \$94.88)] to make these system updates. State Exchanges would incur a one-time burden of \$4,073,790 [(500 × \$103.34) + (1,500 × \$94.88)] × 21 State Exchanges to implement these technical changes.²³⁹

2. Ongoing Burden Reduction—Medicaid Lawful Presence (MLP) and Annual Income (AI) Data Matching Issue (DMI) Processing

We anticipate that this proposed policy would result in ongoing burden reduction for Exchanges on the Federal platform related to no longer generating Medicaid Lawful Presence (MLP) Data Matching Issues (DMIs) and for all Exchanges related to no longer generating annual income (AI) DMIs for those who attest to income under 100 percent of the FPL. Today, these DMIs are generated when an individual attests that they are a lawfully present noncitizen and have an attested household income under 100 percent of the FPL, but the Exchange is not able to verify promptly whether their immigration status disqualifies them from full Medicaid coverage or verify their attested annual household income with trusted data sources. Currently, Exchanges must require individuals to submit documentation to verify their

attested application information when trusted data sources cannot verify.

3. Medicaid Lawful Presence (MLP) Data Matching Issue (DMI) Reduction

These inconsistencies are not generated by State Exchanges, so we do not estimate any change in burden to State Exchanges. Based on historical data from the FFE, we estimate a reduction of approximately 275,000 inconsistencies²⁴⁰ at the consumer level for the Exchanges on the Federal platform. The change would result in a decrease in burden on the Exchanges on the Federal platform. Once households have submitted the required verification documents, we estimate that it takes approximately 1 hour and 12 minutes (or 1.2 hours) for an eligibility support staff person (BLS occupation code 43–4061), at an hourly cost of \$49.52,²⁴¹ to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes. The revisions to § 155.305 would result in a decrease in annual burden for the Federal government of 330,000 hours (275,000 inconsistencies at the consumer level × 1.2 hours) with savings of \$16,341,600 (330,000 hours × \$49.52 hourly wage rate).

4. Annual Income (AI) Data Matching Issue (DMI) Reduction

Based on historical data from the FFE, we estimate that approximately 77,000 inconsistencies²⁴² would not be generated at the household level for the Exchanges on the Federal platform. On the State Exchanges, we estimate this figure to be 54,000 inconsistencies.²⁴³ The change would result in a decrease in burden on Federal and State Exchanges. Once households have submitted the required verification documents, we estimate that it would take approximately 1 hour and 12 minutes (or 1.2 hours) for an eligibility support staff person (BLS occupation code 43–4061), at an hourly cost of \$49.52,²⁴⁴ to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes. Therefore, removing these inconsistencies would result in a decrease in burden on the Federal Government of 92,400 hours (77,000 verifications × 1.2 hours per verification) with savings of \$4,575,648 (92,400 hours × \$49.52 per hour), and a

decrease in burden on the State Exchanges of 64,800 hours (54,000 verifications × 1.2 hours per verification) with savings of \$3,208,896 (64,800 hours × \$49.52 per hour), and the cost decrease across all Exchanges would be approximately \$7,784,544 (157,200 hours × \$49.52 hourly cost of eligibility support staff person).

The total estimated annual reduction in burden for these information collection requirements, beginning in 2026, is \$24,126,144 (\$16,341,600 + \$7,784,544), representing 487,200 (330,000 + 157,200) hours of burden across all affected entities.

We seek comment on these proposed burden estimates and assumptions.

H. ICRs Regarding Failure To File and Reconcile (§ 155.305)

We propose to amend paragraph § 155.305(f)(4) so that in PY 2028 and beyond, all Exchanges 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 one 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 (referred to as the “1-tax year FTR” process). We also propose that at the option of the Exchange, an Exchange may choose to implement this policy earlier in PY 2027 if it has the resources and capability to adopt the 1-year FTR process or continue to follow the 2-year FTR process until PY 2028. Exchanges on the Federal platform intend to adopt the 1-year FTR process in PY 2027, as HHS has the resources possible to do so. Section 71303(a)(6) of the WFTC legislation amended section 36B(c) of the Code such that term “coverage month” does not include, with respect to any individual enrolled in a QHP through an Exchange, any month for which the Exchange does not meet the requirements of § 155.305(f)(4)(iii) as published in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074) for PY 2028 and beyond, where effectively Exchanges are required to find enrollees ineligible for APTC after they or their tax filer has failed to file and reconcile their APTC for 1-tax year. However, minimal changes to the language of the Exchange application questions for States served by *HealthCare.gov* would be necessary to obtain relevant information; as such, we anticipate that the amendment proposed in this rule would not impact the information collection burden for

²⁴⁰ This estimate is based on internal FFM data.

²⁴¹ See Table 12: Adjusted Hourly Wages Used in Burden Estimates.

²⁴² This estimate is based on internal FFM data.

²⁴³ This population estimate is based on internal CMS data.

²⁴⁴ See Table 12: Adjusted Hourly Wages Used in Burden Estimates.

²³⁹ Section 1 figures are based on labor needs estimates internal to the FFM as well as Table 12: Adjusted Hourly Wages Used in Burden Estimates.

consumers. We anticipate that for some Exchanges, there would no longer be a 2-year FTR population for PY 2027, and thus the notices sent to the 1-year FTR population would be similar to the current 2-tax year FTR notices in inciting an urgency to act. Other Exchanges may choose to delay the change until PY 2028, but that all consumers with an FTR status will be in a 1-tax year FTR status for PY 2028. Due to this, we do not anticipate PRA impacts related to noticing requirements (OMB Control Number: 0938–1207).

We seek comment on these proposed burden estimates and assumptions.

I. ICRs Regarding Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))

We propose to update § 155.320(c)(3)(iii)(A) to extend the requirement for applicants to submit documentation when their attested household income is within the APTC range, but data sources indicate income less than 100 percent of the FPL. As finalized in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074), Exchanges are required to generate income DMIs when a tax filer's attested 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 income is under 100 percent of the FPL only through PY 2026. We propose to implement this policy as a new and permanent verification process within the Exchange, as detailed below.

We anticipate that extending this income verification requirement would result in approximately 1 hour of time spent by consumers to complete associated questions in the application or to submit supporting documentation for each year of operation. Based on historical data from the FFE, we estimate that approximately 340,000 inconsistencies would be generated at the household level for the Exchanges on the Federal platform annually starting in 2027. On the State Exchanges, we estimate this figure to be 208,000 inconsistencies annually starting in 2027. Therefore, adding these inconsistencies would 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 \$25.02 per hour in section IV.A. of this proposed rule, we estimate that the increase in cost for each consumer in 2027 would be approximately \$25.02, and the cost increase for all consumers who would

generate this income inconsistency in 2027 and onwards would be approximately \$13,710,960 (548,000 hours × \$25.02 cost of unpaid activities) per year.

Additionally, we estimate that adding this income verification requirement would result in an increase in burden on the Exchanges on the Federal platform. Once households have submitted the required verification documents, we estimate that it would take approximately 1 hour and 12 minutes (1.2 hours) for an eligibility support staff person (BLS occupation code 43–4061), at an hourly cost of \$49.52,²⁴⁵ to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes. Therefore, adding these inconsistencies would result in an increase in annual burden on Exchanges on the Federal platform 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) starting in 2027, and an increase in annual burden on the State Exchanges of 249,600 hours (208,000 verifications × 1.2 hours per verification) at a cost of \$12,360,192 (249,600 hours × \$49.52 per hour) starting in 2027.

In addition to these administrative costs, we anticipate system expenses occurring in 2026 to establish this policy ahead of the proposed effective date in 2027. These costs are to support updating technical systems, including the eligibility system. In the 2025 Marketplace Integrity and Affordability final rule (90 FR 27185), we estimated that it would take the Exchanges on the Federal platform and each State Exchange 8,000 hours in 2026 to make these updates and sunset the policy. Of those 8,000 hours, we estimated that it would 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 would 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 would incur a one-time burden of \$16,295,160 ((2,000 × \$103.34 + 6,000 × \$94.88) × 21). Because we are now proposing this as a new and permanent verification process within the Exchange, we anticipate that many State Exchanges and the Federal Platform would incur the totality of these expenses to implement this policy as proposed.

²⁴⁵ See Table 12: Adjusted Hourly Wages Used in Burden Estimates.

We seek comment on these proposed burden estimates and assumptions.

J. ICRs Regarding Income Verification When Tax Data Is Unavailable (§ 155.320(c)(5))

We propose to remove § 155.320(c)(5), which would allow Exchanges to continue the income verification process when IRS is successfully contacted but IRS returns no data rather than accepting an applicant's annual household income attestation. We are proposing to implement this policy as a new permanent verification procedure, and we are presenting these estimates as costs inherent to implementing the policy as proposed in this proposed rule.

Based on internal historical DMI data, we estimate that approximately 1,722,000 inconsistencies would be generated annually at the household level for Exchanges on the Federal platform, and 1,056,000 would 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 would take approximately 1 hour and 12 minutes (1.2 hours) for an eligibility support staff person (BLS occupation code 43–4061), at an hourly cost of \$49.52,²⁴⁶ 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) would result in an increase in annual burden for Exchanges on the Federal platform 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) starting in 2027 and an increase in annual 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) starting in 2027.

In addition to the increased administrative burden on Exchanges, this change would increase the number of consumers who are required to submit documentation to verify their income. We estimate that consumers would 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 would be generated at the household level across all Exchanges yearly. Using the estimate of the hourly value of time for changes in

²⁴⁶ See Table 12: Adjusted Hourly Wages Used in Burden Estimates.

time use for unpaid activities calculated at \$25.02 per hour in section IV.A. of this proposed rule, we estimate that the increase in annual cost for each consumer starting in 2027 would be approximately \$25.02 and that the proposed change would increase burden on consumers by 2,777,000 hours per year at an associated cost of \$69,480,540 (2,777,000 hours $\times$ \$25.02 per hour).

In addition to these administrative costs, we anticipate system expenses occurring in 2026 to establish this policy ahead of the proposed effective date in 2027. We estimated that it would take Exchanges on the Federal platform and each State Exchange 9,000 hours in 2026 to implement this policy. Of those 9,000 hours, we estimated it would 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. Therefore, we estimated that Exchanges on the Federal platform would incur a one-time burden in 2026 of \$872,955 (2,250 $\times$ \$103.34 + 6,750 $\times$ \$94.88) to make these eligibility system updates, and State Exchanges would incur a one-time burden total in 2026 of \$18,332,055 (\$872,955 $\times$ 21) associated with a total of 189,000 (9,000 $\times$ 21) burden hours. Because this proposed policy would be implemented as a new permanent verification procedure, we anticipate that the full costs described in this provision would be applied to the State Exchanges and Exchanges on the Federal platform prospectively.

We seek comment on these proposed burden estimates and assumptions.

K. ICRs Regarding Pre-Enrollment SEP Verification (§ 155.420(g))

In this proposed rule, we are proposing the provision allowing the Federal Exchange to conduct pre-enrollment verification for SEPs other than Loss of Minimum Essential coverage and adding the requirement that Exchanges on the Federal Platform conduct pre-enrollment verification for at least 75 percent of new enrollments.

We anticipate that maintaining this expansion of pre-enrollment verification for SEPs would 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 would continue to be generated at the household level for Exchanges on the Federal platform. Therefore, maintaining these inconsistencies would continue to 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 \$25.02 per hour in section IV.A, we estimate that the cost increase for all consumers who generate this income inconsistency would be approximately \$7,332,686 annually starting in 2027.

Additionally, we estimate that maintaining expanded pre-enrollment verification for SEPs would result in an increase in burden on Exchanges using the Federal platform. Based on historical FFE data, we anticipate that approximately 293,073 inconsistencies would be generated at the household level for Exchanges on the Federal platform. Once households have submitted the required verification documents, we estimate that it would take approximately 12 minutes (0.2 hours) for an eligibility support staff person (BLS occupation code 43-4061), at an hourly cost of \$49.52,²⁴⁷ to review and verify submitted verification documents. Therefore, expanding verification would result in an increase in burden on Exchanges on the Federal platform of 58,615 hours (293,073 verifications $\times$ 0.2 hours per verification) at a cost of \$2,902,615 (58,615 hours $\times$ \$49.52 per hour) annually starting in 2027.

We seek comment on these proposed burden estimates and assumptions.

L. ICRs Regarding Expansion of Hardship Exemption Eligibility (§ 155.605(d)(1))

Under this proposal, individuals ineligible for APTC or CSRs due to projected household income may apply for a hardship exemption to qualify for catastrophic coverage. While the FFE automatically grants these exemptions through the application system when consumers apply for catastrophic coverage, some consumers may submit paper applications for hardship exemptions.

The burden associated with this requirement includes the time for consumers to complete and submit paper hardship exemption applications, and the time for Exchanges to review and process these applications.

This information collection is currently approved under OMB control number 0938-1191 (CMS-10440), which covers hardship exemption applications and related documentation. The proposed expansion of hardship exemption eligibility would not create a new information collection but would expand the scope of an existing

collection to include a new category of eligible applicants.

Based on current FFE implementation, we estimate that it will continue to require consumers approximately 16 minutes to complete and submit a paper hardship exemption application.

The four State Exchanges that process their own exemptions—California, Connecticut, Maryland, and the District of Columbia—would experience an administrative burden associated with reviewing and processing hardship exemption applications under the expanded eligibility criteria.

We estimate that Exchange staff will require approximately 19 minutes to manually review and process each paper hardship exemption application. Using the adjusted hourly wage of \$49.52 for Eligibility Interviewers, Government Programs (occupation code 43-4061), we estimate the cost per application to be \$15.75 [(19 minutes + 60 minutes) $\times$ \$49.52/hour].

Based on the FFE implementation data and accounting for the enrollment share of the four State Exchanges that process their own exemptions (estimated at approximately 10 percent of total Exchange enrollment), we estimate these four State Exchanges would collectively process approximately 1,072 applications annually under the expanded hardship exemption eligibility criteria. Using the per-application manual processing cost of \$15.75, we estimate the total annual cost burden for these four State Exchanges in total to be approximately \$16,884 (1,072 applications $\times$ \$15.75 per application).

Individual State burden would depend on each State Exchange's enrollment volume and the proportion of consumers who fall into the expanded hardship exemption category. States with larger enrollment volumes and higher proportions of consumers with income below 100 percent FPL or above 250 percent FPL may experience higher application volumes than States with smaller enrollment or different demographic characteristics.

Additionally, if these four State Exchanges adopt automated exemption processing similar to the FFE system, then manual processing time estimates would essentially be eliminated as the system automatically grants the exemption when consumers apply for catastrophic coverage.

We note that the burden estimates presented above may not reflect the actual burden on both consumers and Exchanges. The FFE experience demonstrates that automated exemption processing significantly reduces the

²⁴⁷ See Table 12: Adjusted Hourly Wages Used in Burden Estimates.

need for manual paper application review. Exchanges may implement similar automated systems that grant hardship exemptions automatically when consumers ineligible for APTC due to income apply for catastrophic coverage, thereby eliminating the need for separate exemption applications in most cases.

Additionally, State Exchanges currently processing their own exemptions may choose to delegate exemption processing to HHS, which would eliminate the direct administrative burden on the State while ensuring consumers have access to the expanded hardship exemption eligibility. This delegation option is available under existing regulations and would result in zero additional burden to the delegating States.

M. ICRs Regarding Amendment of Exchange Network Adequacy Standards (§ 155.1050)

The burden associated with QHP issuers and States in State Exchanges and SBE-FPs in implementing changes for PY 2026 to meet time and distance standards at § 155.1050 is covered by the currently approved information collection (OMB Control Number: 0938-1341 (CMS-10592)/Expiration date: April 30, 2027). We seek comment on these proposed burden estimates in the context of the proposed changes at § 155.1050(a)(2) discussed directly below.

We propose to amend § 155.1050(a)(2) to eliminate, for plan years beginning on or after January 1, 2027, the requirements under § 155.1050(a)(2)(i) and (ii) for State Exchanges and SBE-FPs to establish and impose quantitative time and distance network adequacy standards for QHPs that are at least as stringent as standards for QHPs participating on the FFEs under § 156.230 and to no longer require State Exchanges and SBE-FPs to conduct quantitative network adequacy reviews to evaluate a plan's compliance with network adequacy standards under § 156.230(a)(1)(ii), (a)(1)(iii), and (a)(2)(i)(A) prior to certifying any plan as a QHP. Instead, we would require that State Exchanges and SBE-FPs ensure that each QHP provides sufficient access to providers in a manner that meets applicable standards specified in § 156.230(a)(1)(ii) and (a)(1)(iii) for network plans, or proposed § 156.236(a) for non-network plans, as applicable. Many State Exchanges and SBE-FPs demonstrated to HHS that they have robust network adequacy standards and reviews in place beyond the requirements specified in § 156.230(a)(1)(ii) and (a)(1)(iii) for

network plans, or § 156.236(a) for non-network plans. This approach recognizes that States are often best positioned to evaluate local provider networks and market conditions.

We estimate there would be minimal increase in burden to issuers associated with the modification of this policy as it was in effect for only one plan year, and prior to the PY 2026, each State Exchange and SBE-FP was evaluated by HHS to understand their current state of network adequacy reviews, with all States being deemed as already having sufficient authority and technical capacity in place to review for network adequacy in some capacity.

We previously estimated that the total annual burden associated with State Exchanges and SBE-FPs in establishing and conducting network adequacy reviews to be up to 900 hours, which we anticipate would still apply, as we do not anticipate State Exchanges or SBE-FPs would need to make changes to their systems or policies to support the restoration of flexibilities to conduct network adequacy. Assuming the compliance officer average hourly rate of \$75.40,²⁴⁸ we estimate the cost of the data collection, operations, and maintenance pertaining to these proposed requirements on each State Exchange and SBE-FP would be \$67,860 per year (900 hours × \$75.40 per hour). In total, for the 22 State Exchanges and 1 SBE-FPs anticipated to be operational in 2027, we estimate a burden of 20,700 hours (23 State Exchanges and SBE-FPs × 900 hours per Exchange) at an annual cost starting in 2027 of \$1,560,780 (23 State Exchanges and SBE-FPs × 900 hours per Exchange × \$75.40 per hour).

We seek comment on these proposed burden estimates and assumptions.

N. ICRs Regarding General Program Integrity and Oversight Requirements (§ 155.1200)

We propose to amend § 155.1200(d) to reduce duplication between the proposed SEIPM program described in proposed subpart Q and the annual independent external programmatic audit requirements and standards described at § 155.1200(c) and (d). We propose to add § 155.1200(e) to permit a State Exchange to satisfy certain annual independent external programmatic audit requirements, as described at § 155.1200(d), by completing the proposed required annual SEIPM program process. As a result, we estimate that there would be a general burden reduction for State

Exchanges related to the programmatic audit requirement under § 155.1200(c). In particular, the 22 State Exchanges that operate their own eligibility and enrollment platforms would incur lower costs for contracts with independent external auditors, since many requirements under subparts D and E would be addressed through completion of the SEIPM process for the applicable benefit year.

Based on industry estimates of the average cost of contracting an auditor to perform an independent external programmatic audit, we project that the reduced audit scope would lower annual costs by approximately \$45,000 for each State Exchange. This is based on an estimated average annual programmatic cost of \$150,000. We anticipate the total cost annual reduction across 22 State Exchanges would be approximately \$990,000 and that these savings could begin as early as 2027, coinciding with the submission of independent external audits for the PY 2026 SMART. However, this change would also introduce a new burden associated with completing the SEIPM process, as discussed in the section below.

We seek comment on these proposed burden estimates and assumptions and specifically seek feedback from State Exchanges regarding the annual cost of the programmatic audit process.

O. ICRs Regarding the State Exchange Improper Payment Measurement (SEIPM) (§§ 155.1600–155.1650)

As described in the preamble to § 155.1600, SEIPM is proposed to replace the previous IPPTA program with requirements related to mandatory participation in SEIPM. SEIPM is designed as a process for HHS to review payments of APTC that were determined by State Exchanges to produce an estimate of improper payments.

In the preamble to § 155.1615(a)(1), we propose that State Exchanges would provide to HHS: the State Exchange's Program Information which consists of policy, operational and technical documentation concerning business rules and calculations, entity relationships, data dictionaries, operating procedures, and system technology. This information is currently retained by State Exchanges in a digital format and can be electronically transmitted to HHS. We estimate that the burden associated with the collection and transfer of this information to HHS would be no more than 40 hours.

In the preamble to § 155.1615(a)(2), we propose that State Exchanges would

²⁴⁸ See Table 12: Adjusted Hourly Wages Used in Burden Estimates.

provide HHS with the universe of tax household information respective to the plan year being reviewed, that being a listing of the population of tax households that were enrolled in a QHP, where payments of APTC were made. The listing must include an identifier for each tax household, an identifier for each QHP policy within that tax household, the tax household size, the total payment amounts for each sampled unit for the benefit year, and information about the existence of an eligibility verification inconsistency associated with each sampled unit. The burden associated with the proposed collection of information includes the time it would take each State Exchange to meet with HHS to review the submitted information. We estimate that the burden associated with this data collection and transfer would be no more than 40 hours.

In the preamble to § 155.1615(a)(3), we propose that State Exchanges would provide HHS with review unit data, that being the specific information that is required to review each of the sampled QHP tax household, which includes the following information at the tax household level:

- Information pertaining to the calculation of the APTC benefits paid. This would include monthly enrollment premium amounts, monthly APTC payment amounts, monthly Second Lowest Cost Silver Plan Premium amounts, and monthly essential health benefit amounts.

- Information provided by policy issuers relevant to enrollment reconciliation. This would include dates and amounts of effectuation payments, APTC and premium payment information, and policy start and end dates.

- Information relevant to the determination of eligibility for a SEP (where applicable), this would include consumer attestations and representations, copies of documentary evidence submitted by applicants, electronic verification information, and timing information.

- Information about timing of certification and coverage area of the associated QHP. This would include the coverage area of the QHP, timing of QHP certification or approval, and timing of QHP decertification or suppression.

- For each person on the policy who is included in the APTC payment calculation:

- Attestation and demographic information relevant to initial QHP. This would include the demographic information and consumer attestations and representations.

- Information relevant to electronic eligibility verifications and payment determinations. These include the electronic source consulted, the timing of the verification, and the results of the verification.

- Information relevant to QHP and APTC manual eligibility verifications and the resolution of electronic verification inconsistencies. This would include copies of documentary evidence submitted by applicants, the timing of submission, the timing of adjudication, and information about good faith extensions.

HHS would specify the manner in which the data is collected. HHS anticipates utilizing a standardized data request form with specific required fields for the collection of this information. The final collection instrument and methodology would be specified in subsequent guidance and would be designed to minimize burden while ensuring data quality and consistency across State Exchanges. HHS would provide State Exchanges with detailed specifications for data formatting, submission procedures, and technical requirements prior to implementation. We estimate that the burden associated with this data collection and transfer would be no more than 8 hours per sample. We anticipate each State Exchange would need to provide between 50 to 250 samples proportionate to the total amount of APTC payments processed by the State Exchange. At the aggregate level, a total sample size of approximately 2000 tax households would be used to support improper payment measurement across all State Exchanges. In future periods, the total sample size may be adjusted based on factors such as observed error rates, statistical precision requirements, State Exchange participation levels, and available program resources, while ensuring compliance with OMB statistical sampling guidance for improper payment measurement.

The burden associated with completion and return of the proposed required information would be the time it would take each State Exchange to meet with HHS to review the information being requested, analyze and design any database queries needed to produce the information, organize the information into a document or documents for the purposes of transmittal to HHS, electronically transmit the information to HHS, and meet with HHS to verify and validate the information.

We estimate that for each State Exchange, the total costs would range between \$24,950 and \$124,750

depending on the identified sample size. The calculation at the low end of the range was produced by multiplying 50 (the smallest number of samples that will be used in SEIPM) $\times$ \$499 (the average cost per sampled record) = \$24,950. The calculation at the high end of the range was produced by multiplying 250 (the largest number of samples that will be used in SEIPM) $\times$ \$499 = \$124,750.

The annual, aggregated burden for the total 22 State Exchanges to complete the SEIPM is estimated to be \$1,097,800. This calculation was made by multiplying 2200 (the total number of samples to be used in SEIPM) $\times$ \$499 (the average cost per sample). This cost estimate encompasses the processes at the State Exchanges that includes but is not limited to the following: sampling procedures, data collection protocols, and analytical frameworks required to produce an annual improper payment estimate while maintaining statistical validity and regulatory compliance standards.

To compile our estimates, we utilized industry-standard burden estimation methodologies commonly employed for Federal data collection initiatives. We conducted a comprehensive task analysis to identify specific personnel roles and time requirements across all phases of the data collection process, including transition and SEIPM preparation, system setup and maintenance, materials preparation, tool and data preparation for review processes, pre-engagement activities, sampling procedures, review conduct, collaborative observations, and closeout activities. This systematic approach ensures our estimates reflect realistic operational requirements based on established Federal data collection practices.

Hourly wage rates vary across the occupational specialties necessary to perform the information collection and are as follows:

Occupational Code Occupational Title
Adjusted Median Hourly Wage

11-1021	General and Operational Manager	\$99.00
11-3021	Computer Information Systems Manager	\$164.62
13-1111	Management Analyst	\$97.30
15-1211	Computer Systems Analyst	\$99.80
12-1251	Computer Programmer	\$94.88

This establishes a mean hourly rate of \$111.12 across all of the occupational specialties that would be needed for performing this collection.

While the initial burden estimate assumes 8 hours per sample as a baseline, HHS recognizes that State

Exchanges would realize significant economies of scale when processing multiple samples within the same collection period. The initial sample requires the upfront costs in system setup, query development, staff training, and process establishment. However, subsequent samples within the same collection cycle will benefit from:

- Established data extraction processes and validated database queries
- Trained personnel familiar with HHS requirements and submission procedures
- Streamlined workflows and standardized documentation templates
- Reduced coordination overhead through established communication channels

These efficiencies typically reduce the per-sample burden for subsequent samples after the initial setup. The 8-hour baseline represents the maximum expected burden per sample, with actual burden decreasing as State Exchanges leverage established processes and systems for additional samples within the same collection period, equating to an average hourly burden per sample of 4.49 hours.

The calculations in this paragraph demonstrate how the cost estimates were derived for the data collection process across State Exchanges. The mean hourly rate of \$111.12 was calculated by averaging the five adjusted median occupational wage rates (\$99.00 + \$164.62 + \$97.30 + \$99.80 + \$94.88 = \$555.60 ÷ 5 = \$111.12). While the baseline estimate assumes 8 hours per sample initially, economies of scale reduce the average burden to 4.49 hours per sample as State Exchanges develop efficient processes for subsequent samples. The cost per sample is calculated by multiplying the average burden hours by the mean hourly rate (4.49 hours × \$111.12 = approximately \$499 per sample). Finally, the aggregate cost estimate of \$1,097,800 across all 22 exchanges represents the total expected cost when these efficiencies are realized across the entire sample collection process, which works out to an average of approximately \$49,900 per State Exchange, calculated with the premise that each State Exchange would submit on average 100 samples. In summary, the total cost of \$1,097,800 is derived from multiplying the estimated average cost per sample (\$499) times the total samples (2200) to be drawn across all the State Exchanges.

The costs associated with the SEIPM program will begin in 2027, coinciding with the effective date of the regulation as specified in § 155.1605(a). These are annual recurring costs that State

Exchanges will incur each year as part of the ongoing SEIPM requirements. The annual nature of these costs reflects the ongoing data submission processes that State Exchanges must perform to support HHS' annual improper payment measurement and reporting obligations under the Payment Integrity Information Act of 2019.

We will request to account for the associated information collection burden under OMB control number: 0938–NEW/CMS–10942.

Additionally, as described in the preamble to § 155.1535, we are proposing that State Exchanges may be required to develop and implement corrective action plans (CAPs) following a completed SEIPM measurement designed to reduce improper payments as a result of eligibility determination errors, beginning in 2029. The burden associated with this requirement is the time and effort put forth by State Exchanges to develop and submit a CAP to HHS. We estimate that it would take each selected State Exchange up to 1,000 hours to develop a CAP. We estimate that the total annual burden associated with this requirement for up to 22 State Exchange respondents would be up to 22,000 hours. Assuming the management analyst average hourly rate of \$97.30 per hour, we estimate that the cost of a corrective action plan per State Exchange could be up to \$97,300, and for all 22 State Exchanges, up to \$2,140,600. The burden related to this information collection will be submitted to OMB for approval after future rulemaking has been completed regarding the CAP process and requirements.

We seek comment on these proposed burden estimates and assumptions.

P. ICRs Regarding the Discontinuation of Standardized Plan Options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv))

We propose to remove the following from our regulations effective beginning in PY 2027: the definition of “standardized options” at § 155.20; all requirements pertaining to standardized plan options at § 156.201 (the requirements for FFE and SBE–FP QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one another at paragraph (c)); the differential display of standardized plan options on *HealthCare.gov* at § 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE

pathway to facilitate consumer enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv).

Under §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv), approved web-brokers and QHP issuers using a DE pathway to facilitate enrollment through an FFE or SBE–FP must differentially display standardized plan options in accordance with § 155.205(b)(1) in a manner consistent with how standardized plan options are displayed on *HealthCare.gov*, unless we approve a deviation. Any requests from web-brokers and QHP issuers seeking approval of an alternate differentiation format are reviewed based on whether the same or a similar level of differentiation and clarity is provided under the requested deviation as is provided on *HealthCare.gov*.

This information collection is currently undergoing renewal under *Non-Exchange Entities* (OMB Control Number: 0938–1329 (CMS–10666)/estimated Expiration date: February 20, 2029). Given that we propose to discontinue the full suite of standardized plan option policies from our regulations (including standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv)), if this policy is finalized as proposed, we also anticipate requesting to discontinue this information collection—as these entities would no longer be required to submit a request to deviate from the form of display on *HealthCare.gov*.

We seek comment on these proposed burden estimates and assumptions.

Q. ICRs Regarding Non-Standardized Plan Option Limits (§ 156.202)

We propose to discontinue non-standardized plan option limits and exceptions at § 156.202. If this policy is finalized as proposed, we also anticipate requesting to discontinue the corresponding ICR, which is *Non-Standardized Plan Option Limit Exceptions* (OMB Control Number: 0938–1461 (CMS–10878)/Expiration date: July 31, 2027), since issuers that seek to offer plans that are tailored to the treatment of chronic and high-cost conditions would be able to do so without submitting information that is currently required under the exceptions process.

We seek comment on these proposed burden estimates and assumptions.

R. ICRs Regarding Provider Access Standards for Network Plans (§ 155.1050 and § 156.230)

We propose at § 155.1050(d), for PY 2027 and beyond, to allow FFE States, including States that perform plan management, that elect to do so, to conduct provider access reviews for issuers' plans that use and do not use a provider network, provided that the State has sufficient authority and the technical capacity to conduct such reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program, as described at proposed § 155.1050(d)(2) through (d)(4). We would continue to conduct network adequacy reviews consistent with § 156.230 for QHP issuers that use and do not use a provider network in FFE States that do not elect to conduct such reviews, or in FFE States that do not demonstrate sufficient authority and the technical capacity to conduct such reviews by satisfying the applicable criteria to demonstrate they have an Effective Provider Access Review Program, as described at proposed § 155.1050(d)(2) through (d)(4). Under this proposal, we would continue to collect network adequacy data, including time and distance and appointment wait time data. We would continue collecting this data from all FFE issuers, either to use to conduct Federal network adequacy reviews in FFE States that do not elect to do so, or do not demonstrate they have sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program as described at § 155.1050(d)(2) through (d)(4), or with a view to make it available in a standardized format to States that are determined to have an Effective Provider Access Review Program, to assist them in their network adequacy analysis. We do not believe this proposal would introduce new burdens associated with data collection, as we would continue to utilize the same systems, processes, and data requirements currently in place. We believe the ICRs associated with this proposal are assessed and are encompassed by the revised information collections for QHP certification and network adequacy data collection (Continuation of Data Collection to Support QHP Certification and other Financial Management and Exchange Operations (OMB Control Number 0938–1187 (CMS–10433)/Expiration date: June 30, 2025) and Essential Community Provider-Network

Adequacy (ECP/NA) Data Collection to Support QHP Certification (OMB Control Number. 0938–1415 (CMS–10803)/Expiration date: December 31, 2027)). Overall, we expect any change in burden cost to be negligible under this proposal. We do expect the total burden cost associated with the network adequacy review process to decrease for QHP issuers in States with an Effective Provider Access Review Program, as outside of initial data submission and validation, these issuers would not be subject to review processes conducted by HHS. However, burden costs saved by QHP issuers on the Federal level may be lost at the State review level, depending on how a State implements network adequacy review processes. It is unknown how States would implement network adequacy data collection and certification reviews under this proposal and the number of States that would elect to conduct these reviews, thus the total burden associated with undergoing this provider access certification review process on the State-level is uncertain.

We seek comment on these proposed burden estimates and assumptions.

S. ICRs Regarding Essential Community Providers (§ 155.1051 and § 156.235)

In this proposed rule, we propose to reduce the minimum percentage requirements described under § 156.235(a)(2)(i) and (b)(2)(i) from 35 to 20 percent for the overall, FQHC, and family planning ECP thresholds. We also propose to amend the narrative justification requirement language at § 156.235(a)(3) and 156.235(b)(3) to reflect current operations and data submission requirements as part of ECP certification reviews, as narrative justifications are no longer required for issuers not meeting the ECP standard since they input contract statuses directly into the ECP User Interface in the MPMS. The ICRs associated with QHP certification and ECP Data Collection to Support QHP Certification have already been assessed and are encompassed by the currently approved information collections (*Continuation of Data Collection to Support QHP Certification and other Financial Management and Exchange Operations* (OMB Control Number 0938–1187 (CMS–10433)/Expiration date: June 30, 2025) and *Essential Community Provider/Network Adequacy (ECP/NA) Data Collection to Support QHP Certification* (OMB Control Number. 0938–1415 (CMS–10803)/Expiration date: December 31, 2027)).

We note that the proposed changes to minimum percentage requirements from 35 to 20 percent would not change the

type of ECP data collected from issuers, as issuers would still be required to designate contracted ECPs included within their provider networks for each of their service areas to meet the ECP standard under § 156.235. However, we believe these proposed changes may contribute to decreases in issuer burden as part of ECP data submission for QHP certification reviews because issuers would have the flexibility to report fewer contracts with ECPs due to the reduced minimum percentage requirement. Issuers may also experience reductions in administrative costs due to fewer resources needed to demonstrate compliance with the ECP standard, and to pursue additional contracts and negotiations. Based on an analysis of PY 2025 FFE plan data among a total of 118 medical QHPs and 129 SADPs, an additional 18 medical QHPs would have been able to meet at least one of the thresholds (overall, FQHC, and family planning provider) if it were reduced from 35 to 20 percent, and an additional 15 SADPs would have been able to meet at least one of the thresholds (overall and FQHC). Specifically, among medical QHPs, an additional six would meet the overall threshold, five would meet the FQHC threshold, and seven would meet the family planning provider threshold. Among SADPs, an additional eight would meet the overall threshold and seven would meet the FQHC threshold. Therefore, these issuers may experience burden reductions as a result of the reduced minimum percentage requirements. Although some of these aforementioned issuers who previously did not meet the ECP standard may no longer choose to pursue additional contracts with ECPs if now meeting the ECP standard, it is unknown how many issuers would actually choose to reduce their number of contracts with ECPs to obtain a closer estimate on reduced burden associated with these proposed changes. Issuers that have consistently exceeded the minimum percentage may choose to maintain the number of contracted ECPs in their networks as opposed to not renewing or terminating their provider contracts, and those issuers that previously did not meet the 35 minimum percentage requirement but would now meet the 20 percent minimum percentage requirement may still choose to expand contracts with providers.

Furthermore, according to an analysis of PY 2025 FFE plan data, 14 medical QHPs (including one dual QHP) and eight additional SADPs would have been required to submit narrative justifications for not meeting the ECP

standard under § 156.235 if these data requirement collections were still in place. In the justification Excel format used prior to PY 2025, these 22 issuers would have had to spend on average an estimated minimum of at least 2 minutes per ECP inputting provider contact information and the status of negotiations. The modernizations to the ECP data collection process in the ECP UI implemented beginning for PY 2025 have contributed to burden reductions among these issuers, since the time spent reporting provider data would be reduced with issuers easily importing their prior year's ECP data into their current year's application or selecting ECPs with pre-populated contact information from the list embedded in MPMS. Additionally, in lieu of providing information on particular ECPs and writing responses to questions pertaining to monitoring and mitigating measures for ECP network gaps in the Excel justification format, these issuers now designate the status of negotiations with particular ECPs by selecting from a drop-down list in MPMS, which averages an estimated minimum of at least 5 seconds per ECP. As a whole, these efficiencies to the justification process through the ECP UI MPMS modernizations have reduced issuer burden as part of ECP certification reviews through reductions in the amount of time issuers spend submitting ECP data due to it being mostly prepopulated within MPMS, drop-down options to quickly append the status of contract negotiations, and by MPMS clearly identifying needed corrections and required fields for the issuer to complete a satisfactory justification to support their QHP certification.

In addition, we propose at § 155.1051 to allow FFE States, including States performing plan management, to elect to conduct their own ECP certification reviews of issuers plans' with or without a provider network provided the State demonstrates it has sufficient authority and the technical capacity to conduct these reviews by meeting the applicable criteria, as determined by HHS, to be considered to have an Effective ECP Review Program under § 155.1051. An FFE State would need to first express its interest to HHS and submit an attestation, and it would be granted an Effective ECP Review Program designation after HHS determines it meets all applicable requirements described for this program under § 155.1051. If we determine that an FFE State does not have an Effective ECP Review Program or an FFE State does not elect to conduct such reviews,

then we would continue to perform ECP certification reviews consistent with § 156.235 for network plans and proposed § 156.236 for non-network plans. We are revising the information collection currently approved under OMB Control Number 0938–1415 (CMS–10803) (Essential Community Provider-Network Adequacy (ECP/NA) Data Collection to Support QHP Certification) in order to reflect new requirements proposed under § 155.1051 for the Effective ECP Review Program. Since we would perform ECP certification reviews for issuers in FFE States without an Effective ECP Review Program consistent with our current operations, processes, and data submission requirements as part of QHP certification, we do not believe this proposal would introduce any new burdens associated with data collection. In addition, for QHP issuers in Effective ECP Review Program States, we do expect the total annual hours and annual burden cost associated with the ECP certification review process to slightly decrease on the Federal level. While QHP issuers in FFE States with an Effective ECP Review Program would still need to submit ECP Data to HHS, issuers would not be required to undergo the extensive ECP review process to address corrections identified by HHS by resubmitting data, if they instead go through this process in FFE States with an Effective ECP Review Program. However, burden costs saved by QHP issuers on not undergoing the extensive ECP certification review process on the Federal level may be offset at the State level if FFE States impose new, additional ECP certification data collection and review procedures for QHP issuers that do not already exist in order to comply with § 155.1051. It is unknown how FFE States would implement ECP data collection and certification reviews and the number of FFE States that would elect to conduct these reviews, thus the total burden associated with undergoing this ECP certification review process on the State-level is uncertain.

We seek comment on these proposed burden estimates and assumptions.

T. ICRs Regarding QHP Certification of Non-Network Plans (§§ 155.1050, 156.230, 156.235, 156.236, 156.275, and 156.810)

In this proposed rule, we propose a number of revisions to Part 155 and Part 156 to allow plans that do not use a network (non-network plans) to receive QHP certification beginning with PY 2027 by demonstrating that they ensure a sufficient choice of providers in a manner consistent with sections

1311(c)(1)(B) and (C) of the Affordable Care Act. We propose to add new section § 156.236, that contains the provider access sufficiency standards (including ECP access) specific to non-network plans, and to revise §§ 156.230 and 156.235 to make clear that those sections address the provider access sufficiency standards (including ECP access) for network plans. Additionally, we clarify that non-network plans would be subject to and be able to meet all of the general certification criteria at § 155.1000(c), which would allow Exchanges the ability to certify non-network plans as QHPs. Furthermore, we propose to allow FFE States, including States performing plan management, to conduct provider access and/or ECP certification reviews provided the State elects to conduct these reviews and demonstrates it has sufficient authority and the technical capacity to conduct these reviews by meeting the applicable criteria, as determined by HHS, for each review program it wishes to administer; these review programs include the Effective Provider Access Review Program for provider access certification reviews under proposed § 155.1050(d) and/or the Effective ECP Review Program for ECP certification reviews under proposed § 155.1051. Accordingly, FFE States that elect to conduct provider access certification reviews, and are determined by HHS to have sufficient authority and the technical capacity to conduct these reviews by satisfying applicable criteria to be considered to have an Effective Provider Access Review Program under proposed § 155.1050(d)(2) through (d)(4) would be permitted to perform such reviews of non-network plans. Similarly, FFE States that elect to conduct ECP certification reviews, and are determined by HHS to have sufficient authority and the technical capacity to conduct these reviews by meeting applicable criteria to be considered to have an Effective ECP Review Program under proposed § 155.1051 would be permitted to perform such reviews of non-network plans. Accordingly, we are revising the information collection currently approved under OMB Control Number 0938–1415 (CMS–10803) (Essential Community Provider-Network Adequacy (ECP/NA) Data Collection to Support QHP Certification) to reflect proposed requirements under § 156.236 for non-network plans.

We believe that most of the current provider access data collection and submission requirements that apply to network plans would also apply to provider access reviews for non-network

plans. Relevant to provider access reviews, pursuant to proposed § 156.236(b)(1), non-network plans would be required to report their assessed percentage of providers in a service area that accept the plan's benefit amount as payment in full.

Additionally, to comply with proposed § 156.236(b)(4) through (9), non-network plans would be required to attest to a list of questions to indicate they meet these regulatory requirements. Non-network plans would be required to indicate they have processes and/or methodologies in place to conduct continuous outreach to available providers in a particular service area to determine whether they would accept the plan's benefit amount as payment in full; to make benefit amounts publicly available and accessible; to determine benefit amounts; to provide consumer-friendly and public information about potential balance billing scenarios and expected out-of-pocket costs; to offer an exceptions process for enrollees who cannot find providers (including ECPs) willing to accept the benefit amount as payment in full; and to provide adequate customer service or online provider directory assistance resources to assist plan enrollees and potential enrollees in finding providers (including ECPs) in their area who will accept the plan's benefit amount as payment in full. It is uncertain approximately how many non-network plans would apply for QHP certification to reasonably estimate the total annual burden cost and hours for attesting to these requirements. However, we expect the time for responding to the attestation questions for a single non-network plan would range between thirty seconds to one minute for each of the six attestation questions, likely requiring a maximum of six minutes total to complete. Overall, we believe the extra time and costs associated with completing this section would be negligible to flat.

Furthermore, we believe that many of the current ECP data collection and submission requirements that already apply to network plans would also apply to non-network plans. First, non-network plans applying for QHP

certification would similarly use MPMS, which has extensively streamlined data collection and submission, reducing burden among issuers during QHP certification. The MPMS ECP UI only displays qualified and eligible ECPs in the issuer's State, reducing the burden of filtering through the entire ECP List for applicable facilities. Instead of spending time and effort inputting individual ECP data (such as facility name, facility address, ECP reference number, NPI, etc.) for each applicable facility in each of the plan's applicable network and/or service area, QHP issuers, including SADPs, are able to use MPMS to select prepopulated ECPs from a list of available and eligible ECPs within the user interface. MPMS is also updated regularly during QHP certification to remove ECPs that have closed or are no longer eligible such that issuers do not spend time entering in ECP data that is no longer valid or applicable to their QHP application.

Non-network plans must submit ECP data in MPMS in order to demonstrate they meet ECP related requirements at § 156.236(b)(1) through (3) such as: whether the non-network plan meets at least a minimum percentage, as specified by HHS, of available ECPs that accept the plan's benefit amount as payment in full in each plan's service area collectively across all ECP categories defined under § 156.235(a)(2)(ii)(B), and at least a minimum percentage of available ECPs in each plan's service area within certain individual ECP categories, as specified by HHS; whether the non-network plan offers the benefit amount as payment in full to at least one ECP in each of the eight ECP categories per county in the plan's service area described in § 156.235(a)(2)(ii)(B); and whether the non-network plan offers the benefit amount as payment in full to all available Indian health care providers in the plan's service area. Network plans currently satisfy data collection requirements by designating contract statuses, including whether a contract was offered or fully executed, with select ECPs within their application in MPMS. To satisfy proposed § 156.236(b)(1) through (3), non-network plans would submit ECP data by

similarly selecting ECPs within their application in MPMS, but instead of contract statuses they would select modified statuses describing whether a select ECP was offered or accepted their benefit amount as payment in full. Thus, we do not believe the proposed ECP requirements under § 156.236(b)(1) through (3) for non-network plans would impose significantly new, additional information collections. Thus, we believe new ECP requirements under proposed § 156.236(b)(1) through (3) would be negligible in both total annual burden hours and cost.

In summary, we are revising the information collection currently approved under OMB Control Number 0938–1415 (CMS–10803) (Essential Community Provider-Network Adequacy (ECP/NA) Data Collection to Support QHP Certification) to reflect proposed requirements under § 156.236 for non-network plans. However, as stated in the discussions above, since non-network plans would be required to meet many of the current NA and ECP data collection and submission requirements that already apply to network plans, and since the additional total annual burden cost and hours associated with answering attestation questions consistent with proposed § 156.236(b)(4) through (9) would be negligible, the proposed revised information collection is not expected to increase total annual burden hours or costs compared to the previous information collection OMB Control Number 0938–1415 (CMS–10803) (Essential Community Provider-Network Adequacy (ECP/NA) Data Collection to Support QHP Certification)(Expiration Date: December 31, 2027).

U. ICRs Regarding Quality Improvement Strategy (§ 156.1130)

There is no information collection associated with this proposed policy and no changes are proposed to the QIS data collection requirements applicable to QHP issuers. QIS data collection from QHP issuers to the Exchange has been approved under OMB Control Number 0938–1286.

V. Summary of Annual Burden Estimates for Proposed Requirements

TABLE 19: Proposed Annual Recordkeeping and Reporting Requirements

Regulation Section(s)	OMB Control Number	Total Annual Burden (hours)	Total Cost (\$)
154.215	0938-1141	9,068,800	\$911,365,624.00
155.1050	0938-1341	20,700	\$1,560,780.00
155.1600 – 155.1650	0938-NEW	31,878	\$3,238,400.00
155.220	0398-NEW	1,666,000	\$96,694,640.00
155.220	0938-NEW	24	\$1,392.96
155.20, 155.305(f)(1), 155.320	0938-1218	91.5	\$29,350.20
155.20, 155.305(f)(1), 155.320	0938-NEW	163,000	\$15,810,185.00
155.305(f)(2)	0938-1191	(442,700)	(\$19,809,866.00)
155.320(c)(3)(iii)	0938-1191	1,381,600	\$63,346,432.00
155.320(c)(5)	0938-1191	6,308,600	\$253,765,422.00
155.420(g)	0938-1191	351,688	\$10,235,301.00
155.605(d)(1)	0938-1191	343.04	\$16,884.00
TOTAL		18,550,025	\$1,336,254,545

X. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed above, please visit CMS' website at www.cms.hhs.gov/PaperworkReductionActof1995, or call the Reports Clearance Office at 410-786-1326.

We invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule and identify the rule [CMS-9883-P], the ICR's CFR citation, CMS ID number, and OMB control number.

ICR-related comments are due [DATE].

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and when we proceed with a subsequent document, we will

respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

A. Statement of Need

This proposed rule includes payment parameters and provisions related to the HHS-operated risk adjustment and risk adjustment data validation (HHS-RADV) programs, as well as 2027 benefit year user fee rates for issuers that participate in the HHS-operated risk adjustment program and the 2027 benefit year user fee rates for issuers offering qualified health plans (QHPs) through FFEs and SBE-FPs. This proposed rule also includes proposed revisions to the defrayal policy; removal of the requirement for a State to operate a SBE-FP before operation of a State Exchange; amendment of the requirement to operate a centralized eligibility and enrollment consumer interface on the State Exchange's website; expanded marketing prohibition regulations and mandated use of the HHS-approved and created form for agents, brokers, and web-brokers; strengthened ability to take administrative actions against agents, brokers, and web-brokers; implementation of the State Exchange Direct Enrollment (DE) option; coordination of the new SEIPM process with existing independent external programmatic audit requirements; a

prohibition on including routine non-pediatric dental services as an essential health benefit (EHB); cost-sharing changes for catastrophic and bronze plans; clarifications for how catastrophic plans may have plan terms of up to 10 consecutive years; repeal of standardized plan options and non-standardized plan options limits and exceptions; revisions to network adequacy reviews; participation by QHPs that do not use a provider network; reduction of the essential community provider (ECP) thresholds; implementation of an Effective Essential Community Provider Review Program; modification to require QHP issuers to submit any two of five quality improvement strategies (QISs) topic areas listed in section 1311(g)(1) of the Affordable Care Act; imposition of civil monetary penalties (CMPs) against issuers in State Exchanges or SBE-FPs; revisions to rate filing justification; and income verification requirements. Finally, this proposed rule includes updates needed to align Exchange regulations with the WFTC legislation.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866, "Regulatory Planning and Review"; Executive Order 13132, "Federalism"; Executive Order 13563, "Improving Regulation and Regulatory Review"; Executive Order 14192,

“Unleashing Prosperity Through Deregulation”; the Regulatory Flexibility Act (RFA) (Pub. L. 96–354); section 1102(b) of the Social Security Act; and section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts). Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or Tribal governments or

communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impacts of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President’s priorities.

A regulatory impact analysis (RIA) was prepared for this rule in keeping with Executive Order 12866. Based on our estimates, the Office of Management and Budget’s (OMB) Office of Information and Regulatory Affairs (OIRA) has determined that this rulemaking is “significant” per section 3(f)(1). We have prepared an RIA that, to the best of our ability presents the costs and benefits of the rulemaking.

C. Impact Estimates of the Proposed Payment Notice Provisions and Accounting Table

As required by OMB Circular A–4 (available at <https://www.whitehouse.gov/wp-content/>

[uploads/2025/08/CircularA-4.pdf](#)), we have prepared an accounting statement in Table 20 showing the classification of the impact associated with the provisions of this proposed rule.

This proposed rule implements standards for programs that would have numerous effects, including providing consumers with access to affordable health insurance coverage, 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 all the benefits and costs of this proposed rule. The effects in Table 20 reflect qualitative assessment of impacts and estimated direct monetary costs and transfers resulting from the provisions of this proposed rule for Exchanges, health insurance issuers and consumers. The annual monetized transfers described in Table 21 includes changes to costs associated with the risk adjustment user fee paid to HHS by issuers.

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TABLE 20: Accounting Table

Benefits:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	\$24.66 Million	2026	7 percent	2026-2030
	\$24.67 Million	2026	3 percent	2026-2030
Quantitative: • Annual savings to the Federal Government of \$20.9 million and to States of \$3.2 million beginning in 2026 due to not needing to determine DMI outcomes for individuals attesting that they are a lawfully present noncitizen with an income under 100 percent of the FPL. • Annual savings to State Exchanges of approximately \$990,000 due to reduction of duplicate requirements between the independent external programmatic audit under 155.1200(c) and the SEIPM program established under new subpart Q, beginning in 2027. • Beginning in 2027, annual reduction of \$300,000 in Federal spending and reduction in income for the contractor for discontinuing the vendor program that conducts agent and broker training, sets standards for vendor participating in the program, requires publication of the approved list of vendors, states how participating vendors will be monitored by HHS, and describes applicable appeal rights available to vendors.				
Qualitative: • Reduction in abusive conduct by agents, brokers, and web-brokers, and increased transparency around program integrity oversight of the FFE. • Improved ability of HHS to investigate agent, broker, and web-broker eligibility application review and consumer consent review as a result of the proposal to require use of the HHS-approved and created form. • Increased consumer protections, such as avoiding surprise tax liabilities, as a result of the use of the mandatory forms containing all regulatory requirements and the proposed marketing standards of conduct. • Increased State flexibility regarding consumer interfaces supporting eligibility application submission and QIIP enrollment functionality, allowing State Exchanges to deliver these services primarily through consumer interfaces provided by web-brokers and other non-Exchange entities via the SBE-EDE option. • Potential direct benefit of reducing improper payments, with secondary effects including a boost of issuer confidence in State Exchanges, through implementation of the SEIPM. • Reduced potential for APTC recipients to incur large tax liabilities in 2027 as a result of the policies regarding income verification. • The enhanced CSR reporting would enable issuers to potentially increase the accuracy of their CSR payment amounts and improve future projections for rate setting, resulting in more accurate premium levels. • Potential increased accuracy in issuers' calibrated CSR load factors that would more adequately cover actual CSR costs, potentially leading to more stable and accurate premium pricing over time. • Potential for more predictable multi-year coverage arrangements for consumers enrolling in multi-year catastrophic plans with reduced need to navigate annual open enrollment periods and decreased risk of coverage gaps due to missed enrollment deadlines. • Potential enhanced access to care for enrollees in multi-year catastrophic plans with terms of at least 2 years through pre-deductible coverage for certain benefits designed to improve long-term health • Reduced administrative burden for issuers offering multi-year catastrophic plans through decreased annual re-enrollment activities and lower operational expenses.				
Costs:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	\$605.99 Million	2026	7 percent	2026-2030
	\$608.28 Million	2026	3 percent	2026-2030
Quantitative: • Information collection costs incurred by State Exchanges related to SEIPM, estimated to be a recurring annual cost of approximately \$1,097,800 across all required State Exchanges beginning in calendar year 2027, and \$2,140,600 beginning in 2029 for State Exchanges submitting corrective action plans (CAPs). Additionally, annual Federal contracting costs of \$19.5 million and Federal staffing costs of \$2.3 million beginning in 2027. • Increased costs to issuers of approximately \$91,131 associated with conducting APTC, CSR, and user fee program compliance reviews beginning in 2026. • Costs of \$96,694,640 for agents, brokers, and web-brokers annually beginning in 2027 to use the HHS-approved and -created consumer consent form. • Costs of \$1,392.96 for agents, brokers and web-brokers annually beginning in 2027 to respond to HHS regarding misleading marketing.				

- One-time costs in 2026 of \$242,488 to the Federal Government and \$4.1 million to State Exchanges for updating systems to comply with the policy prohibiting APTC for individuals who are ineligible for Medicaid due to their immigration status and have income below 100 percent of the FPL under the WFTC legislation.
- One-time costs in 2026 of \$872,955 to the Federal Government and \$14.9 million to State Exchanges to implement the provision to limit APTC eligibility to “eligible noncitizens” under the WFTC legislation.
- Annual costs beginning in 2026 of \$29,350 for the three States anticipated to be operating a BHP to comply with the provision to limit APTC eligibility to “eligible noncitizens” under the WFTC legislation.
- Increased annual costs to the Federal Government of \$20.2 million and to State Exchanges of \$12.4 million beginning in 2027 for generating income DMIs when trusted data sources indicate an income under 100 percent of the FPL.
- Regulatory review costs of \$5,968,281.42 for interested parties to review and analyze this proposed rule in 2026.
- Increase in annual burden of approximately \$102.3 million for the Federal Government and approximately \$62.8 million total for State Exchanges starting in 2027 to review and verify submitted documents, communicate with consumers, and process DMIs for applicants whose tax return data is unavailable.
- Increase in burden of \$13.7 million starting in 2027 for consumers with incomes below 100 percent of the FPL to fulfill income verification requirements addressing DMIs.
- One-time costs in 2027 of approximately \$19.4 million total for State Exchanges and approximately \$969,950 for the Federal Government due to not needing to complete the necessary system changes and other technical changes to reimplement the policy to require Exchanges to find consumers ineligible for APTC after failing to file their income taxes and reconcile their APTC after one tax year.
- One-time costs in 2026 of approximately \$16.3 million total for State Exchanges and \$775,960 for the Federal Government for necessary system and other technical changes to implement the policy to conduct additional verifications 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.
- Increase in annual burden of \$69.5 million starting in 2027 for consumers whose tax return data is unavailable to fulfill income verification requirements addressing DMIs.
- One-time costs in 2026 of approximately \$18.3 million total for State Exchanges and approximately \$872,955 for the Federal Government for necessary system and other technical changes to remove the policy to require Exchanges to accept an applicant's income attestation without further verification when tax return data is unavailable.
- Annual cost increase for consumers of approximately \$7,332,686 beginning in 2027 associated with the policies regarding SEP verification.
- Annual cost to the Federal Government of \$14,602,615 beginning in 2027 to develop and code changes and comply with the policies regarding SEP verification.
- One-time implementation costs in 2026 of \$418,790,376 for issuers to implement the standard methodology and generate new URRT entries.
- Annual ongoing costs beginning in 2027 of \$209,395,188 for issuers to update systems and recalculate URRT values.
- Annual ongoing costs beginning in 2026 of \$157,222 for issuers to enter all required CSR-related data elements in the URRT.
- Annual ongoing costs beginning in 2026 of \$628,888 for issuers to provide explanations in the Actuarial Memorandum of the methodology used to determine the CSR load factor and comparison of expected load revenue to expected CSR payment.
- Annual ongoing costs beginning in 2026 of \$2,414,256 for the Federal Government to review all required CSR-related data elements and explanations in submitted rate filing information.
- Annual cost to State Exchanges of \$16,884 beginning in 2027 to manually process documentation and one-time cost to State Exchanges of \$643,160 in 2026 to develop an automated processing system related to the expansion of the hardship exemption eligibility.

Qualitative:

- Increased administrative burden on issuers that operate in multiple States as a result of the proposal to remove the requirement for State Exchanges and SBE-FPs to conduct network adequacy reviews.
- Potential costs to State governments and private hospitals in the form of charity care for individuals who become uninsured due to administrative burden or income ineligibility as a result of the policies in this proposed rule.
- Issuers would incur costs related to developing new pricing models for multi-year catastrophic plans, and States and the Federal Government would face costs associated with reviewing and approving multi-year catastrophic plan filings.
- Possible higher out-of-pocket costs for enrollees in catastrophic plans and bronze plans who incur health costs in excess of the current annual limitation on cost sharing if they enroll in catastrophic plans or bronze plans at lower premiums under the provision to change the permissible cost-sharing parameters for bronze plans and updated requirements for catastrophic plans.

Transfers:	Low Estimate (million)	High Estimate (million)	Year Dollar	Discount Rate	Period Covered
Annualized	(3,550.47)	(6,465.63)	2026	7 percent	2026-2030
Monetized (\$/year)	(3,617.37)	(6,574.62)	2026	3 percent	2026-2030
Quantitative: • Annual reduction in APTC transfers from the Federal Government to [*] of \$213 million starting in 2027 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. • Annual reduction in APTC transfers from the Federal Government to [*] of \$1,069 million starting in 2027 for households across all Exchanges that receive fewer months of APTC due to reinstatement of DMIs when IRS data is not available. • Annual reduction in APTC transfers from the Federal Government to [*] of \$179 million starting in 2028 associated with the provision implementing section 71303 of the WFTC legislation for households across all Exchanges that receive fewer months of APTC due to losing their APTC eligibility due to failing to file and reconcile for one tax year as opposed to two consecutive tax years. • Annual reduction in APTC transfers from the Federal Government to [*] of approximately \$105.4 million due to pre-enrollment verification requirements for SEPs, associated with a reduction in premiums of approximately 0.5-1.0 percent, beginning in 2027. • Annual reduction in APTC transfers across all Exchanges due to reductions in enrollment associated with the provisions implementing section 71302 of the WFTC legislation prohibiting APTC for individuals who are ineligible for Medicaid due to their immigration status and have income below 100 percent FPL of \$1,869,180,495 beginning in 2026. [*] • Annual reduction in Federal BHP expenditures due to reductions in the number of individuals for whom the Federal Government can make a payment, associated with the provisions implementing section 71302 of the WFTC legislation prohibiting APTC for individuals who are ineligible for Medicaid due to their immigration status and have income below 100 percent FPL and limiting APTC eligibility to eligible “noncitizens” of \$100 million in 2026, \$118 million in 2027, \$111 million in 2028, \$112 million in 2029, and \$113 million in 2030. [*] • Annual reduction in APTC transfers of \$9,672,048,360 across all Exchanges beginning in 2027 due to the provisions implementing section 71301 of the WFTC legislation limiting APTC eligibility to eligible “noncitizens”. [*] • Annual reduction in APTC transfers from the Federal Government to [*] of \$3.8 billion starting in PY 2027 associated with the provision implementing section 71304 of the WFTC legislation for the removal of the 150 percent FPL SEP beyond PY 2026. [*] Transfers may be experienced most directly by issuers and are ultimately experienced by some combination of issuers, enrollees (or potential enrollees), public jurisdictions and private entities that bear the cost of charity/uncompensated care, and programs such as Medicaid.					
Qualitative: • Potential adjustments to PTCs as a result of silver plan premium changes due to CSR load calculations.					

TABLE 21: Estimated Federal Government Outlays and Receipts for the Risk Adjustment and Reinsurance Programs from Fiscal Year 2027-2031, in billions of dollars²⁴⁹

Year	2027	2028	2029	2030	2031	2027-2031
HHS Risk Adjustment and Reinsurance Program Payments	16	15	15	15	16	77
HHS Risk Adjustment and Reinsurance Program Collections	-15	-15	-15	-16	-16	-77

Note: Risk adjustment program payments and receipts lag by one quarter. Receipts will fully offset payments over time. Source: Congressional Budget Office. Health Insurance and Its Federal Subsidies: CBO and JCT’s June 2024 Baseline Projections. Table 2. June 2024.

<https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf>.

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1. HHS–RADV Error Estimation Modification To Incorporate IVA Sampling Changes ²⁴⁹

In the 2026 Payment Notice, we finalized excluding enrollees with HCCs from IVA sampling beginning with benefit year 2025 HHS–RADV. As a consequence of this change to the IVA sampling methodology, we now propose to add an additional scaling factor to the error estimation methodology to ensure that HCC-associated error rates continue to apply to only the proportion of total PLRSs that are associated with HCC components of EDGE risk scores. The additional scaling factor will serve to

capture the proportion of issuer's total population's risk that is associated with enrollees with HCCs.

In simulating the impact of the additional scaling factor, we found that HHS–RADV adjustments to RA transfers decreased in magnitude by 11.7 percent in the individual market (going from \$148 million to \$139 million) and by 13.8 percent in the small group market (from \$81 million to \$69.8 million). Table 22 shows only the impact on positive HHS–RADV adjustments. Because HHS-operated risk adjustment, and HHS–RADV adjustments, are budget neutral, we would see the same impact on negative risk adjustment transfers, in that both would decrease in

magnitude. When examining the impact of the additional proposed scaling factor on HHS–RADV adjustments over premium, we see that there is only a 0.01 percent change in positive HHS–RADV adjustments in both markets between results with no additional factor and results with the additional scaling factor. This corresponds with a percentage point (PP) change of –0.02. This helps to contextualize the change in the magnitude of HHS–RADV adjustments. This proposal would more accurately assess the proportion of an issuer's population's risk that arises as a result of enrollees with HCCs.

We solicit comments on the estimated impacts of this proposal.

TABLE 22: Impacts of Proposed Scaling Factor on HHS–RADV Adjustments

Market	Positive* RADV Adjustments			Positive* RADV Adjustments Over Premium		
	No Factor	Proposed	% Change	No Factor	Proposed	PP Change
Individual	\$148,025,028	\$130,639,483	-11.7%	0.13%	0.12%	-0.02 pp
Small Group	\$81,069,952	\$69,873,392	-13.8%	0.12%	0.11%	-0.02 pp

*Note: Because the HHS Risk Adjustment program is budget neutral, total HHS–RADV Payments always net to zero. Therefore, to capture the impact of the proposal, we have used only positive adjustments.

2. HHS Risk Adjustment User Fee for 2027 Benefit Year (§ 153.610(f))

For the 2027 benefit year, HHS will operate risk adjustment in every State and the District of Columbia. As described in the 2014 Payment Notice (78 FR 15416 through 15417), HHS' operation of risk adjustment under section 1343 of the Affordable Care Act on behalf of States is funded through a risk adjustment user fee. For the 2027 benefit year, we propose to use the same methodology to estimate our administrative expenses to operate the HHS risk adjustment program as was used in the 2026 Payment Notice. As discussed previously in this proposed rule, risk adjustment user fee costs for the 2027 benefit year are expected to be similar to the prior 2026 benefit year budget estimates. Expected enrollment changes are minor compared to the overall enrollment in the individual and small group markets. Therefore, they do not significantly impact expected collections under this user fee rate. For these reasons, we propose a risk adjustment user fee of \$0.20 PMPM for the 2027 benefit year. We expect the

proposed risk adjustment user fee for the 2027 benefit year to retain the amount transferred from issuers of risk adjustment covered plans to the Federal Government and therefore there is no change in the transfer to the Federal government.

We seek comment on these proposed impact estimates and assumptions.

3. Submission of Rate Filing Justification (§ 154.215)

This rule proposes to collect as part of the rate filing justification information on adjustments to the index rate to account for unreimbursed CSRs. As detailed in section III.C of this preamble, issuers would be required to report on the URRT actual CSR amounts paid on behalf of eligible enrollees and additional revenue collected from the previous applied CSR load (using the most recent annual data that is available prior to the applicable filing year, generally two years prior, using the standard methodology set forth in 156.430(c)(2)), the amount previously generated by any load factors from the most recent annual data available, projected CSR amounts expected to be

paid on behalf of enrollees in the upcoming plan year and additional revenue to be collected as a result of the CSR load factor, and CSR load factors in a new dedicated line item. Issuers would also be required to report the expected amount generated by the load factor for the upcoming plan year. This rule also proposes to require issuers to provide an explanation in the Actuarial Memorandum of the methodology used to determine the load factor for the upcoming plan year and an explanation of how the expected amount generated by the load factor compares to the amount of CSRs expected to be paid on behalf of enrollees for the same period as part of the Actuarial Memorandum.

The proposed provisions would primarily affect health insurance issuers offering qualified health plans in the individual market, Federal and State regulators in their review capacity, and indirectly, Marketplace enrollees who receive cost-sharing reductions. The enhanced CSR reporting would enable issuers to more accurately determine their CSR payment amounts and improve future projections for rate setting. This increase in accuracy and

²⁴⁹ Reinsurance collections ended in FY 2018 and outlays in subsequent years reflect remaining payments, refunds, and allowable activities.

transparency could result in more appropriate premium levels if current CSR load factors are determined to be inaccurate or unreasonable, enabling issuers to better calibrate their load factors to adequately cover actual CSR costs, potentially leading to more stable and accurate premium pricing over time.

Issuers would incur a one-time cost, in 2026, of \$418,790,376 to implement the standard methodology and generate the new URRT entries, followed by annual ongoing costs, beginning in 2027, of \$209,395,188 to update their systems and recalculate the URRT values. Additionally, issuers would incur annual ongoing costs, beginning in 2026, of \$157,222 to enter the proposed values in the URRT and \$628,888 to provide an explanation in the Actuarial Memorandum of how the CSR load factor was determined. Costs might vary with issuer scale, data systems, and product complexity. Additionally, the Federal Government would incur annual ongoing costs, beginning in 2026, of \$2,414,256 to review the additional information submitted. These costs are discussed in detail in the Collection of Information section IV.B.4 of this proposed rule.

Enrollees could potentially experience changes in out-of-pocket costs as more accurate CSR reporting may lead issuers to adjust their load factors and premium pricing; the direction of these changes would depend on whether the current CSR load factors overestimate or underestimate actual CSR costs. If issuers have been overestimating actual CSR costs, they may decrease load factors and premiums, which could result in lower out-of-pocket costs for enrollees through decreased premiums. Conversely, if issuers have been underestimating CSR costs, load factors and premiums could increase.

Changes in CSR load calculations could result in corresponding adjustments to PTCs, as more accurate CSR load factors may increase or decrease silver plan premiums. If CSR loads decrease, silver plan premiums should decrease with corresponding Federal PTC outlays decreasing and offsetting changes in consumer net premiums. To the extent that improved estimates would change plan pricing, there might also be distributional enrollment shifts among enrollees across metal levels on-Exchange and in silver plans offered off-Exchange.

4. Approval of a State Exchange (§ 155.105)

We propose to remove § 155.105(b)(4) to rescind a requirement made in the

2025 Payment Notice,²⁵⁰ such that for a State seeking to operate a State Exchange, it must first operate for at least one plan year an SBE-FP. The original amendment was intended to give States sufficient time to create, staff, and structure a State Exchange. However, HHS recognizes that requiring States to first operate as an SBE-FP for at least one plan year could potentially create unnecessary barriers and delays for States that are well-prepared to implement a State Exchange more immediately. Ultimately, a State must demonstrate its ability to operationalize State Exchange functional requirements through a well-established and robust review process with HHS. Whether a State first operates an SBE-FP does not change our review process for determining whether a State is ultimately prepared to implement a State Exchange. The proposed changes therefore do not impose any new requirements on States in operating State Exchanges or SBE-FPs and instead returns flexibility to States regarding implementation of either a SBE-FP or State Exchange.

We seek comments on the practical utility of this data collection from potential users of this CSR amount data (for example, State regulators).

5. Approval of a State Exchange (§ 155.106)

We propose to amend § 155.106(a)(2) to rescind a requirement made in the 2025 Payment Notice²⁵¹ that, as part of a State's activities for its establishment of a State Exchange, the State must provide supporting documentation demonstrating progress toward meeting or implementing State Exchange Blueprint requirements. States recognize the need for HHS to request supplemental documentation in order for HHS to assess a State's readiness to operate a State Exchange, which assessment supports a State's successful State Exchange operation. States have provided such supplemental documentation upon HHS request similarly both before and after this requirement was originally finalized. The Blueprint Application already provides that we may require supporting documentation from a State as evidence of its progress toward meeting State Exchange Blueprint Application requirements, which is part of HHS' overall process for providing a State with approval to operate a State Exchange. The proposed changes do not

impose any new requirements on States in establishing a State Exchange.

We seek comment on these proposed impacts and assumptions.

6. Amending Requirements for State Exchanges To Operate a Centralized Eligibility and Enrollment Infrastructure (§§ 155.205(b) and 155.221(k))

a. Amending the Requirement for State Exchanges To Operate a Centralized Eligibility and Enrollment Consumer Interface on the State Exchange's website (§ 155.205(b))

We propose to amend § 155.205(b) to specify that a State Exchange is not limited to operating a centralized eligibility and enrollment consumer interface on the State Exchange's website as the only model for supporting consumer eligibility application submission and QHP enrollment functionality. Additionally, we propose revisions to § 155.302(a)(1) to require a State Exchange to make all determinations of eligibility for QHP coverage and insurance affordability programs and maintain records of all QHP enrollments, even if the Exchange no longer maintains a consumer interface on the State Exchange's website. These regulatory changes make clear that a State Exchange can also deliver consumer eligibility application submission and QHP enrollment services exclusively through the websites of non-Exchange entities, including a web-broker or direct enrollment entity under § 155.220 or § 155.221, that demonstrate operational readiness and compliance with applicable requirements via a robust approval and oversight process in accordance with § 155.221(j). The State Exchange must continue to maintain a centralized eligibility and enrollment system to process all determinations of eligibility for QHP coverage as well as a website providing standardized comparative information on such plans to enrollees and prospective enrollees of QHPs and related insurance affordability programs and maintain records of all QHP enrollments.

We expect minimal, if any, financial impact to current State Exchanges and States in the process of establishing their own State Exchange. All current State Exchanges operate an eligibility and enrollment consumer interface on the State Exchange's website. States that are presently in the process of establishing their own State Exchange for PY 2026 and PY 2027 plan to operate an eligibility and enrollment consumer interface on their website. Costs assumed by a State planning to transition from the FFE to establish and

²⁵⁰ See 89 FR 26259 through 26261.

²⁵¹ See 89 FR 26261 through 26263.

operate their own State Exchange after PY 2027 may vary depending on whether they choose to have an eligibility and enrollment consumer interface on their website to provide consumer eligibility application submission and QHP enrollment functionality.

b. SBE-Enhanced Direct Enrollment Option (§ 155.221(k))

We propose to add § 155.221(k) to establish a new State Exchange enhanced direct enrollment (SBE-EDE) option by which State Exchanges can leverage direct enrollment technology to transition primarily to private sector-focused enrollment pathways operated by QHP issuers, web-brokers, and agents and brokers, instead of or in addition to a centralized eligibility and enrollment website operated by an Exchange. State Exchanges can elect, subject to HHS approval, to implement the SBE-EDE option. The impact of the new SBE-EDE option would depend on the number of States that take advantage of the new option. There are various interested parties in States that elect to implement the SBE-EDE option that could be impacted, including consumers, State Exchanges, web-brokers, issuers, and agents and brokers, as well as the Federal Government.

The SBE-EDE option may have varied impacts on consumers relating to the corresponding increase in the number of potential websites through which consumers could shop for QHP coverage might impact consumers and consumer behavior for QHP enrollment.

Current State Exchanges that elect to implement the SBE-EDE option would be responsible for meeting certain requirements for approval, in particular revising their Exchange Blueprint under new § 155.221(k) to describe precisely how the State proposes to implement the SBE-EDE option. We believe that any costs of revising the Exchange Blueprint would be nominal, as this process involves logging into a CMS web interface that serves as the repository for all States' Exchange Blueprints to input additional information on the updated processes and controls the State would implement to manage its new Exchange EDE program. However, we seek comment on the burden associated with this activity, noting that the Exchange Blueprint is currently approved under the PRA under OMB Control Number 0938-1172.

For States seeking to transition to a State Exchange in future plan years and implement the SBE-EDE option, we anticipate that start-up costs may potentially be higher than the start-up costs for States seeking to transition to

a State Exchange without implementing the Exchange EDE option, due to the additional interfaces that must be implemented between the Exchange's eligibility platform and each approved EDE entity and managed on an ongoing basis by the Exchange. States transitioning to an SBE-EDE would be required to complete the Exchange Blueprint in the same manner as required prior to the final rule and would be required to meet all required minimum functions of an Exchange. In terms of implementation costs, these States can realize savings by virtue of not having to maintain and operate a consumer-facing enrollment website capable of handling all Exchange-related internet traffic for all State residents, instead relying on EDE entities and their websites to provide the majority of the Exchange's consumer-facing enrollment functionality.

The costs associated with consumer-facing enrollment functionality may be relatively lower than those associated with building the back-end Exchange eligibility platform, interfaces with EDE entities to accept Exchange applications and complete eligibility determinations, the connections required from an Exchange's back-end eligibility platform to the Federal Data Services Hub for eligibility verifications, connections from the Exchange's back-end eligibility platform to the respective State Medicaid agency for coordinating Medicaid and CHIP eligibility determinations, and the Exchange's data management and reporting functionality necessary to submit required eligibility and enrollment data regarding all Exchange enrollees to HHS and the IRS. Based on recent State transitions to the State Exchange model, the design, development, and implementation (DDI) costs for an Exchange depend on a number of factors. DDI costs have ranged from \$4 million for a smaller State, to almost \$24 million for a larger State based on self-reported budget figures. Only one State Exchange to date has implemented EDE while also transitioning to a State Exchange, with design, development, and implementation IT and call center costs during the transition year of \$25 million. States may be able to partner with existing Federal EDE partners who are already fully-compliant with Federal operational requirements to achieve administrative savings related to the approval process for EDE entities seeking to operate in their State. Any operational cost increases or savings may, in turn, affect a State Exchange's user fee and premium costs.

We anticipate that a State Exchange electing the SBE-EDE option would

have increased operational costs for ongoing monitoring and oversight of the approved EDE entities, as well as for maintaining and managing the individual interfaces and transactions with each EDE entity. However, any savings achieved through a decrease in call center volume or other consumer supports due to EDE partners assisting consumers with enrollment would offset any increased operational costs. Any operational cost increases or savings stemming from implementation of the Exchange EDE option could, in turn, affect a State Exchange's user fee and consumer premium costs.

We also anticipate that the Exchange EDE option can have significant impacts on prospective EDE entities (including web-brokers, agents and brokers, and issuers) and the Federal Government as a result of start-up, approval, and implementation costs. Such costs may be incurred by entities who enter a State's market as a new EDE entity for the first time, or by existing DE entities that expand into new markets. We presume that EDE entities would act rationally and enter a State's market or expand into new markets if the benefits exceed the costs.

In terms of privacy/security approval and startup costs, prospective EDE entities would be required to implement almost 300 security and privacy controls consistent with a system security and privacy plan provided by CMS. After control implementation, prospective EDE entities must contract with an independent third-party auditor to complete a security and privacy controls assessment test plan, which must be submitted to CMS for review. Once approved, an EDE entity must submit quarterly Plan of Action and Milestones (POA&Ms) to CMS to document the identification and resolution of any new or existing security or privacy risks. EDE entities must also incur costs to contract with a third-party auditor to perform an annual assessment of their security and privacy posture consistent with continuous monitoring requirements published by CMS, and feedback provided on their quarterly POA&Ms.

In terms of approval and startup costs of implementing appropriate business controls, prospective EDE entities that wish to participate and host an eligibility application also would be required to implement a dynamic user interface (UI) that adapts to consumer scenarios based on complex business rules and integration with a range of application programming interfaces (APIs). They must also implement post-enrollment support functionality.

There are additional technical startup and approval costs related to the

eligibility application functionality that EDE entities are required to implement. They must have the ability to provide the State Exchange with all the information necessary for it to determine eligibility to enroll in QHPs, as well as to determine eligibility for APTC, CSRs, Medicaid, and CHIP. Consumers who complete an eligibility application on an EDE entity's website must be provided with an eligibility determination notice (EDN) from the State Exchange, and related information must display within the EDE entity's website UI about consumers' eligibility. Therefore, if a consumer is determined eligible for Medicaid or CHIP after completing an eligibility application through an EDE entity's website, they would receive the same information in their EDN about that eligibility and next steps as if they completed the application on the State Exchange website.

We also anticipate that there would be costs specific to web-brokers and issuers that choose to enter into fee-based arrangements with other agents, brokers, or issuers, or that choose to enter new economic or legal arrangements with States, that help to offset the costs of the EDE services provided. In terms of costs to issuers, generally any changes in issuer costs associated with the SBE-EDE option could have downstream effects on premium rates. Issuers would be impacted by adjustments in State Exchange user fees and may have an incentive to promote direct enrollment if user fees are lower under the SBE-EDE option, and the savings achieved through those lower user fees exceed the new costs of arrangements with web-brokers. Issuers may also be impacted if the SBE-EDE option leads to shifts in consumer enrollment patterns, such as movement from a QHP offered by one issuer to another QHP. If issuers choose to build out standalone consumer-facing applications to enroll in coverage under the SBE-EDE option, this would be another cost to consider that could impact them directly and have downstream impacts.

There are some anticipated costs to the Federal Government associated with the SBE-EDE option. We anticipate that any HHS costs associated with supporting the additional monitoring and oversight in States that elect to implement the SBE-EDE option would be nominal given that State Exchanges would retain primary responsibility for overseeing their approved DE entities and HHS can leverage its existing State Exchange oversight mechanism and associated processes to ensure that this is occurring.

7. Additional Required Benefits (§ 155.170)

We propose to amend § 155.170(a)(2) to provide that any State-required benefits would be considered “in addition to EHB” (and thus not EHB) if they are: required by a State action taking place after December 31, 2011; applicable to the small group and/or individual markets; specific to required care, treatment, or services; and not required by State action for purposes of compliance with Federal requirements. Under this proposal, such State-required benefits would be considered in addition to EHB regardless of whether the mandated benefits are embedded in the State's EHB-benchmark plan. We propose that this change would be effective beginning with PY 2027. We also propose revisions to §§ 155.170(a)(2) and 156.115(a) to align with this proposal and to have State and issuer responsibilities with respect to State-required benefits appear in a more logical reading order in the CFR.

We believe that this revision would have a mixed effect on the cost to States and the Federal Government. A small number of States and issuers have taken significant action based on current § 155.170, including some States having sought or seeking EHB-benchmark plan changes under § 156.111 to add certain State-required benefits as EHB with the understanding that the cost of these additions would not require defrayal by the State. In such States, this proposal may frustrate such efforts should it become effective in PY 2027, as any State-required benefit that fulfills the four proposed conjunctive elements at proposed § 155.170(a)(1)(i) through (iv) would require defrayal, regardless of whether the benefit is included in the State's EHB-benchmark plan.

In States that ceased defraying the cost of State-required benefits included in their EHB-benchmark plans beginning in PY 2025 under the current regulation but would be required to defray the cost of State-required benefits beginning in PY 2027 if this proposal is finalized, the percentage of premium attributable to coverage of EHB for purpose of calculating APTC may decrease. Under this proposal, in a State that enacts a mandate for a benefit that is currently covered in its EHB-benchmark plan, there would be a decrease to Federal Government expense as the benefit would no longer be permitted to be included in the percentage of premium attributable to coverage of EHB for purpose of calculating APTC. States should evaluate the overlap between mandates and benefits covered in the State's EHB

benchmark-plans for benefits for which they would be required to defray the cost if this proposal is finalized. Specifically, a State that wants to avoid defrayal obligations for State-required benefits that are already in the State's EHB-benchmark would be able to do so by repealing the applicable State requirement as being applicable to QHPs. While we expect that there should not be any measurable operational implications or infrastructure changes needed for States to implement this provision, we seek comments from States on any administrative costs that would be incurred as a result of implementing this provision. We likewise recognize that States that opt to retain benefit-mandates that carry defrayal obligations would incur defrayal costs. The scale of these costs would depend on the cost attributable to the State-required benefit. We seek comments from States on such estimates where applicable. Issuers may have to make modifications to their plan designs and plan filings to reflect any possible changes in designation of benefits as EHB because of this proposal, if finalized, in the regular course of updating those annual materials. Given variation in State legislative calendars and session timing, and the need for issuers to update their plan filings and rates to account for benefits that will be defrayed by the State, we solicit comment on finalizing an effective date for PY 2028 instead of PY 2027.

We seek comment on these proposed impact estimates and assumptions.

8. Mandating the HHS-Approved and -Created Consumer Consent Form—Eligibility Application Review and Documenting Receipt of Consumer Consent (§ 155.220(j))

As discussed in the preamble of this proposed rule, we propose amendments to §§ 155.220(j)(2)(ii)(A) and (j)(2)(iii)(A) to require agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review requirements and consent documentation requirements. Our proposal would eliminate the current broad allowances for meeting these requirements. The language in the regulation would also be changed to clarify what types of actions constitute “taking an action” to meet the regulatory requirements. The goal of this policy is to reduce confusion among agents, brokers, and web-brokers on what constitutes compliant eligibility application review documentation and what constitutes compliant consumer consent by ensuring objective standards,

which protects consumers ultimately. These proposals also greatly improve HHS' investigative abilities into agent, broker, and web-broker eligibility application review and consumer consent review by creating a clear and objective standard for all applications clearly outlining what HHS deems complaint.

Given this proposal would require the usage of the HHS-approved and -created consumer consent form, agents, brokers, and web-brokers who had previously relied exclusively on phone recordings, text messaging, or other non-HHS-approved and -created consumer consent form methods would be particularly impacted by this change. Consumers who had exclusively been interacting with agents, brokers, and web-brokers via phone may perceive this new requirement using the HHS-approved and -created consumer consent form (electronically or in person) as burdensome. Importantly, the HHS-approved and -created consumer consent form guarantees and ensures all regulatory requirements are in the documentation provided to the consumer, as well as making documentation review of potentially noncompliant agents, brokers, and web-brokers more streamlined and efficient. The HHS-approved and -created consumer consent form²⁵² we propose to become standard also went through a readability analysis, which entails a review of language to help make text easier to understand, especially with documentation that may contain industry terms of art, such as healthcare. Mandating that this form be used in all consumer interactions would help ensure consumers are reviewing documentation that has been reviewed to be consumer-friendly but still contains the regulatory requirements. Agents, brokers, and web-brokers would still be able to provide more details than what is listed on the documentation and answer specific questions a consumer may have about a plan, policy, or the enrollment process.

As estimated in section IV.C of this proposed rule, the estimated annual cost of requiring agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review requirements and the consumer consent documentation requirements is \$96,694,640, beginning in PY 2027.

We seek comment on these proposed impact estimates and assumptions.

9. Misleading Marketing (§ 155.220(j)(3))

As discussed in the preamble of this proposed rule, the proposed regulatory amendments would create a new standards of conduct section in § 155.220(j) describing marketing requirements. These requirements would list certain prohibited practices, provide HHS audit authority, and put agents, brokers, and web-brokers on notice that they are responsible for marketing created by their downstream entities. This proposal would allow HHS to increase its efforts to engage in compliance actions for misleading marketing by providing agents, brokers, and web-brokers notice of the types of activities that are prohibited, allowing HHS to review marketing materials for compliance, and ensure agents, brokers, and web-brokers are not able to push responsibility to third-parties. Creating a marketing standards of conduct section is necessary to protect consumers and maintain the integrity of the Exchanges.

The proposals would provide instructive language agents, brokers, and web-brokers may utilize when creating Exchange marketing materials. This would help ensure agents, brokers, and web-brokers are creating compliant marketing from the beginning and would not be subject to enforcement actions.

As estimated in section IV.D, the estimated total cost for the burden of responding to HHS regarding misleading marketing would be \$1,392.96, beginning in 2027.

We seek comment on these proposed impact estimates and assumptions.

10. Removal of the Vendor Program (§ 155.222)

As outlined in the preamble of this proposed rule, we propose to remove the vendor program requirements established at § 155.222, that allow for certain training and information verification functions to be provided by HHS-approved vendors. Removing these requirements would permit HHS to discontinue the vendor program.

Considering the lack of utilization of this program by agents and brokers, as well as dwindling interest on the part of potential vendors, as outlined in the preamble, we do not anticipate potential vendors, nor agents and brokers, to be substantially impacted by these proposals. Agents and brokers would continue to have the ability to complete the annual training and information verification requirements through the MLMS at no cost.

This proposal would additionally save the government approximately \$300,000 each plan year beginning in

2027 by removing the contractual costs required to facilitate the program.

We seek comment on these proposed impact estimates and assumptions.

11. Limiting APTC Eligibility to "Eligible Noncitizens" (§§ 155.20, 155.305(f)(1), and 155.320)

We estimate that there are currently 1,227,000 individuals receiving APTC through Exchanges who are lawfully present noncitizens, but who are not "eligible noncitizens," and would therefore become ineligible for APTC and income-based CSRs beginning in PY 2027 under section 71301 of the WFTC legislation. This estimate is based on evaluating internal FFE data regarding "eligible noncitizen" enrollees and extrapolating that data to estimate the size of the impacted population in State Exchanges. Based on average monthly APTC expenditures of \$ 656.89 per person, we project that this population becoming ineligible for APTC would reduce annual APTC expenditures by \$9,672,048,360 (1,227,000 enrollees × \$ 656.89 average APTC × 12 months), beginning in 2027.

We also anticipate that this proposed change would result in costs to State Exchanges and the Federal Government to update eligibility systems in accordance with this proposal. As discussed further in section IV.F of this proposed rule, in aggregate we estimate \$15,810,185 in PY 2026 in estimated one-time costs for implementation (\$193,990 Federal government + \$678,965 Exchanges on the Federal platform + \$14,937,230 State Exchanges). For the three States in total anticipated to be operating a BHP beginning in 2026, we estimate the annual ongoing cost to be \$29,350.20.

As some non-citizens would no longer be eligible for PTCs under this new provision, there are also individuals for whom the Federal Government would not make a payment if enrolled in a BHP. We estimate that this provision would affect 1.6 percent of BHP enrollees starting in 2027 (using the same baseline as described in the previous subsection). These estimates are based on analysis of citizenship and residence status of enrollees in the health insurance exchanges. This would impact about 2,000 individuals each year and reduce Federal spending by about \$17 million in 2027. To develop these estimates, we reviewed the number of eligible non-citizens receiving PTCs through the Exchanges in 2025 using the Multidimensional Insurance Data Analytics System (MIDAS) database. We found about 1.6 percent of all individuals receiving PTC were eligible non-citizens who would

²⁵² See CMS Model forms, OMB Control Number: 0938-1438, Expiration Date: 07/31/2028. <https://www.cms.gov/files/document/cms-model-consent-form-marketplace-agents-and-brokers.pdf>.

not be eligible for PTC under this section of the legislation. We multiplied projected BHP enrollment by this percentage, which resulted in about

2,000 affected individuals annually. We multiplied the enrollment change by the projected average per member per year Federal BHP costs (see Table 25) to

develop the expenditure amounts. The annual estimates are shown in Table 23.

TABLE 23: Projected Impacts of Section 71301 on BHP Enrollment and Total Spending by Year

	2026	2027	2028	2029	2030
Enrollment – eligible for Federal BHP payment	0	-2,000	-2,000	-2,000	-2,000
Total spending (in millions of real 2026 dollars)	\$0	-\$17	-\$16	-\$16	-\$16

We seek comments on these proposed impact estimates and assumptions, the details of which may be found in section IV.F of this proposed rule.

12. Prohibition of APTC for Individuals Who Are Ineligible for Medicaid Due to Their Immigration Status and Have Income Below 100 Percent of the FPL (\$ 155.305(f)(2))

As described in the Collection of Information Requirements in section IV.G of this proposed rule, we estimate that implementing this proposed policy would require one-time costs for Exchanges to make technical updates to their eligibility systems totaling \$4,316,278 (\$242,488 for Exchanges on the Federal platform + \$4,073,790 for State Exchanges) in PY 2026. We also estimate that this proposed policy would result in a reduction of the amount of DMIs with a total estimated annual reduction in burden for these information collection requirements of \$24,126,144 (\$16,341,600 for removal of MLP DMIs for Exchanges on the Federal

platform + \$4,575,648 for removal of AI DMIs for Exchanges on the Federal platform + \$3,208,896 for removal of AI DMIs for State Exchanges), beginning in 2026.

As of the end of the Open Enrollment period for 2025, there were 237,125 enrollees who were part of the population of consumers with an annual household income of less than 100 percent of the FPL, who were also ineligible for Medicaid due to their immigration status and were enrolled in Marketplace coverage with APTC on the FFE. We estimate the average monthly value of that APTC was \$656.89. Through this proposed policy and subsequent elimination of APTC across all exchanges, we estimate \$1,869,180,495 (237,125 enrollees × \$656.89 average APTC × 12 months) in APTC cost savings per year, beginning in PY 2026.

In 2025, we estimate there are about 138,000 BHP enrollees in 2 States based on the quarterly enrollment estimates that States submit to CMS. With DC

starting BHP in 2026, we project that enrollment would increase by 11.3 percent in 2026 and by 1.2 percent in 2027, prior to any of the changes made by legislation and described in this proposed rule. We project enrollment would decrease in 2028 due to other legislative changes by 7.7 percent to about 143,000 and remain at about that level through 2030.

We also estimate that the current Federal BHP payment in 2025 is about \$644 per member per month, based on payments the Federal Government has made to the 2 BHP States this year. We project that these would increase by 0.2 percent in 2026 (due to the combination of increases in QHP premiums and the expiration of the temporary PTC increases after 2025) and increase 3.8 percent in 2027, with an average monthly payment of \$670 in 2027 prior to changes made by legislation. We project payments would increase at an average rate of about 5.2 percent after 2027.

TABLE 24: Projected BHP Enrollment, Federal Payment Rate, and Total Spending by Year Prior to Changes Made by the WFTC Legislation

	2025	2026	2027	2028	2029	2030
Enrollment	138,000	154,000	155,000	143,000	144,000	144,000
Federal payment (PMPM)	\$644	\$645	\$670	\$710	\$742	\$779
Total spending (in millions of nominal dollars)	\$1,068	\$1,190	\$1,250	\$1,222	\$1,282	\$1,345

We estimated the impact of disallowing PTC during periods of Medicaid ineligibility on BHP enrollment and spending. Prior to the enactment of the WFTC legislation, some noncitizens would have been

eligible for Medicaid on the basis of income and other criteria except for the 5-year waiting period for lawful permanent residents (LPRs) to be allowed to enroll in Medicaid. For those individuals, they would have instead

been eligible for PTC through enrolling in a QHP on the health insurance exchanges assuming they met all other criteria. Similarly, those individuals would have been included in Federal BHP calculations in States that had

elected to operate a BHP. Generally, these are individuals with household incomes up to 100 percent of the FPL.

Under section 71302 of the WFTC legislation, these individuals would no longer be eligible for PTC, and therefore

the Federal Government would not make a payment for these individuals if enrolled in a BHP. We reviewed current BHP enrollment data based on the quarterly enrollment estimates, and we estimate that in 2026 about 12,000 BHP

enrollees would no longer be eligible for PTC under this section, and thus there would not be BHP payments made for these enrollees. The annual estimates are shown in Table 25.

TABLE 25: Projected Impacts of Section 71302 on BHP Enrollment and Total Spending by Year

	2026	2027	2028	2029	2030
Enrollment – eligible for Federal BHP payment	-12,000	-13,000	-12,000	-12,000	-12,000
Total spending (in millions of real 2026 dollars)	-\$100	-\$101	-\$95	-\$96	-\$97

We seek comment on these proposed impact estimates and assumptions.

13. Failure To File and Reconcile (FTR) (§ 155.305(f)(4))

We propose to amend paragraph § 155.305(f)(4) so that in PY 2028 and beyond, all Exchanges 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 one 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 (referred to as the “1-tax year FTR” process). We also propose that, at the option of the Exchange, an Exchange may choose to implement this policy earlier in PY 2027 if they have the resources and capability to adopt the 1-year FTR process or continue to follow the 2-year FTR process until PY 2028. Exchanges on the Federal platform intend to adopt the 1-year FTR process in PY 2027, as HHS has the resources possible to do so. To conform with this proposal, we further propose to amend the notice requirement at § 155.305(f)(4)(iii), which is where the notice requirements have been reorganized. Our changes are aimed at addressing the notice messaging for tax filers who are at risk for losing APTC under a 1-year FTR policy, either for the Exchanges that adopt this option in PY 2027, and for all Exchanges in PY 2028. Exchanges operating under a 1-year FTR policy should use the more urgent language currently contained in the second year notice of the 2-year FTR policy notices in order to accurately convey to tax filers or their enrollees that they are at imminent risk of losing APTC if they do not file and reconcile.

This provision is proposed to align with the WFTC legislation starting in PY 2028, but we additionally propose that Exchanges can choose to implement this as early as PY 2027.

In light of the proposed policy changes for FY 2027 and beyond, we estimate that it would take the Federal Government and each State Exchange, if they choose to implement the 1-year FTR policy for PY 2027, instead of PY 2028 as required by the WFTC legislation, approximately 10,000 hours in 2026 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 2026 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 in 2026, if State Exchanges implement the 1-year FTR process for PY 2027. If Exchanges choose to implement the 1-year FTR process for PY 2028, these estimated costs would be delayed by one year to 2027. For the Federal Government, we estimate a one-time burden in 2026 of 10,000 hours at a cost of \$969,950 ((2,500 hours × \$103.34 per hour) + (7,500 hours × \$94.88 per hour)). In total, the burden associated with all system updates to revert back to the 1-year policy would be 210,000 hours at a cost of \$20,368,950.

We also estimate that by switching to the 1-year policy from the current 2-year policy in PY 2028 or at the Exchange's option in PY 2027, the Federal Government would save APTC from the population of 1-year FTR consumers who would otherwise have retained APTC eligibility for an additional coverage year under the 2-year FTR policy. We estimate that total enrollment for the Exchanges would decrease by approximately 725,000 to 1,800,000 individuals in PY 2026. This reduction in Exchange enrollment, along with the reduction in enrollment due to the expiration of enhanced APTC subsidies and the WFTC legislation, would also affect the total amount of expected households in FTR status. For PY 2025, the total FTR 1-year population dropped from almost 1.5 million households prior to Open Enrollment to less than 400,000 households during FTR Recheck. The total FTR 2-year population dropped from approximately 350,000 households prior to Open Enrollment, to approximately 300,000 households at FTR Recheck, and then after the final check of IRS data, HHS terminated APTC for approximately 200,000 households. Under our proposed 2028 1-year policy with the option to early adopt in 2027, we would expect to remove APTC from all households still in an FTR status in our final Recheck. Based on historical FTR data and expectations for Exchange population size due to changes from the PI final rule, expiration of enhanced APTC subsidies, and the WFTC legislation, we expect that the total amount of households that lose APTC could be approximately 28,500. This is the population that would otherwise retain their APTC in a 2-year policy during PY 2028. The annual savings generated by removing their APTC based on 8 months of enrollment and the average amount of APTC removed per household of \$784

per month is approximately \$179 million. Depending on how many Exchanges elect to adopt the 1-year FTR policy in PY 2027, the savings could be achieved as early as PY 2027, as the Exchanges on the Federal platform plan to early adopt the 1-year FTR policy.

For the purposes of this RIA, we assume the scenario that Exchanges will comply with the policy in PY 2028 to align with the WFTC legislation. We seek comment on these proposed impact estimates and assumptions.

14. Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))

In this proposed rule, we propose amending § 155.320(c)(3)(iii)(A) to indefinitely extend the requirement for applicants to submit documentation when they 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 starting in 2027.

As discussed further in section IV.I of this proposed rule, we estimate an approximate increase in burden costs of \$20.2 million for Exchanges using the Federal platform and \$12.4 million for State Exchanges starting in 2027 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. The implementation of this proposal would result in a one-time cost of \$775,960 to Exchanges on the Federal platform and approximately \$16.3 million total State Exchanges in 2026 to update the eligibility systems and perform other technical updates to implement the additional verification of an applicant's annual household income attestation when tax data is returned that is under 100 percent of the FPL while the household's annual income attestation is at or above 100 percent of the FPL. Finally, we estimate an increase in burden of approximately \$13.7 million across all Exchanges in 2027 and annually onwards for consumers to submit documentation to fulfill income verification requirements. We recognize the burden the continuation of policy may place on State Exchanges, and we seek comment from these and other impacted interested parties to inform this decision.

While there would be additional annualized budget impacts of this policy on State Exchanges and the Federal Platform, there may be some savings associated with an anticipated reduction in APTC for consumers. 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 would 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 \$656.89 per person, we estimate total APTC expenditures would be reduced by approximately \$213 million per year for the period in which we maintain this policy ($50,000 \times \$656.89 \times 4 + 31,000 \times \$656.89 \times 4$).

We seek comment on these proposed impact estimates and assumptions.

15. Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))

In this proposed rule, we propose to remove § 155.320(c)(5), which would allow Exchanges to continue the income verification process when IRS is successfully contacted but IRS returns no data rather than accepting an applicant's annual household income attestation.

As further discussed in section IV.J of the proposed rule, we estimate an increase in annual burden costs of approximately \$102.3 million for Exchanges on the Federal platform and approximately \$62.8 million total for State Exchanges starting in 2027 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. The implementation of this proposal would result in a one-time cost of \$872,955 to Exchanges on the Federal platform and approximately \$18.3 million total State Exchanges in 2026 to update the eligibility systems and perform other technical updates to implement the additional verification of an applicant's annual household income attestation when tax data is unavailable. As also further discussed in section IV.J of this proposed rule, we also estimate an increase in annual burden of \$69,480,540 for consumers in 2027 and beyond to submit documentation to fulfill income verification requirements associated with this proposal.

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 would 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, as estimated based on internal 2016–2020 APTC data, with an average monthly APTC rate of \$656.89 per person, we anticipate that this change could result in an annual reduction of \$1,069 million ($252,000 \times \$656.89 \times 4 + 155,000 \times \$656.89 \times 4$) in APTC expenditures starting in 2027. 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.

We seek comment on these proposed impact estimates and assumptions.

16. Extend the Removal of the 150 Percent FPL SEP Beyond Plan Year 2026 (§ 155.420)

We propose to no longer “sunset” the prohibition on Exchanges offering the 150 percent FPL SEP, in alignment with section 71304 of the WFTC legislation. As explained in preamble in section III.D.15 of this proposed rule, section 71304 of the WFTC legislation prohibits APTC for plans enrolled in through the 150 percent FPL SEP, and therefore eliminates the SEP's ability to facilitate access to affordable coverage. We are therefore proposing to no longer permit Exchanges to offer the 150 percent FPL SEP.

Absent the WFTC legislation, and assuming that the prohibition on Exchanges offering the 150 percent FPL SEP had “sunset” on December 31, 2026, we assume that all Exchanges would have elected to begin offering the 150 percent FPL SEP again in PY 2027. This assumption is based on past experience with the overwhelming majority of Exchanges choosing to offer this SEP.

If all Exchanges offered the 150 percent FPL SEP beginning in PY 2027, we assume that this would result in increased adverse selection, which would result in increases to premiums and APTC expenditures.

As a result, we estimate that this proposal would reduce premiums by 3 to 4 percent, as a result of improvements to the risk pool since the removal of this SEP would limit consumers' ability to wait until they need services to enroll in coverage. We estimate that the reduced premiums would result in an overall decrease in APTC expenditures of \$3.4 to \$4.5 billion per year, beginning in PY 2027. For the purposes of this RIA, we use \$3.8 billion as the estimated annual decrease in APTC expenditures, beginning in PY 2027.

We seek comment on these proposed impact estimates and assumptions.

17. Pre-Enrollment Special Enrollment Period Verification (§ 155.420(g))

In this proposed rule, we are proposing the provision to allow Exchanges on the Federal Platform to continue to conduct pre-enrollment verification for SEPs other than Loss of Minimum Essential coverage and add the requirement that Exchanges on the Federal Platform conduct pre-enrollment verification for at least 75 percent of new enrollments.

We anticipate that revisions to § 155.420 would have a positive impact on program integrity by verifying eligibility for SEPs. Increasing program integrity through continuing this policy would 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 would 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 would reduce premiums by approximately 0.5–1.0 percent and would maintain the reduction in APTC spending of approximately \$105.4 million.²⁵³

We anticipate this policy would moderately increase the regulatory burden on Exchanges using the Federal platform. Based on past experience, we estimate that maintaining 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 would result in an additional 293,073 individuals having their enrollment delayed or “pending” annually until eligibility verification is completed, although for the vast majority of individuals the delays would be less than 1–3 days. As mentioned in section IV.K of this proposed rule, we anticipate that maintaining the expansion of SEP verification would result in increased inconsistencies, with an associated cost increase for consumers of approximately \$7,332,686 beginning in 2027. There would 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 maintain compliance with this requirement for the FFE would be approximately \$11.7 million annually (293,073 additional SVI × \$40 cost per SVI). Furthermore, as mentioned in section IV.K, we anticipate that expanding verification would result in an increase in annual burden of labor costs on Exchanges on the Federal platform at a cost of \$2,902,615 annually.

We seek comment on these proposed impact estimates and assumptions.

18. Expansion of Hardship Exemption Eligibility (§ 155.605(d)(1))

This proposed rule would amend § 155.605(d)(1) to codify and expand hardship exemption eligibility to individuals who are ineligible for APTC or CSRs due to projected household income (below 100 percent or above 250 percent of the FPL). This expansion would allow these individuals to qualify for catastrophic coverage under section 1302(e) of the Affordable Care Act.

Most State Exchanges currently delegate hardship exemption processing to HHS. However, four State Exchanges—California, Connecticut, Maryland, and the District of Columbia—currently process their own exemptions. Following HHS guidance published on September 4, 2025, this policy expansion has been implemented for consumers in all States that currently delegate exemption processing to HHS. This proposed rule would extend the same hardship exemption eligibility to consumers in the four State Exchanges that currently process their own exemptions, ensuring that consumers in all States have access to affordable coverage.

We assume the four State Exchanges that process their own exemptions would experience an administrative burden associated with processing hardship exemption applications under the expanded eligibility criteria. Based on previous experience, we estimate that Exchange staff will require approximately 19 minutes (0.32 hours) to review and process each hardship exemption application. Using the median hourly wage of \$24.76 for Eligibility Interviewers, Government Programs (occupation code 43–4061), and adjusting for fringe benefits and overhead, we calculate an adjusted hourly wage of \$49.52. Based on these figures, we estimate the cost per application to be \$15.75, calculated as follows: (19 minutes ÷ 60 minutes) × \$49.52/hour = \$15.75 per application.

Based on our analysis of operational FFE data regarding existing hardship

exemption requirements and the new requirement proposed in this rule, we estimate these four State Exchanges would collectively process approximately 1,072 applications annually under the expanded hardship exemption eligibility criteria when considering their combined share of approximately 10 percent of total Exchange enrollment.

Using the per-application manual processing cost of \$15.75, we estimate the total annual cost burden for these four State Exchanges in total to be approximately \$16,884 (1,072 applications × \$15.75 per application). Individual State burden would vary depending on each State Exchange’s enrollment volume and the proportion of consumers who fall into the expanded hardship exemption category. States with larger enrollment volumes and higher proportions of consumers with income below 100 percent FPL or above 250 percent FPL may experience higher application volumes than States with smaller enrollment or different demographic characteristics.

We note that the actual burden may be lower over time than estimated if State Exchanges implement automated exemption processing similar to the FFE system. The FFE experience demonstrates that automated processing significantly reduces the need for manual paper application review, as the system automatically grants hardship exemptions for consumers ineligible for APTC due to income when they apply for catastrophic coverage. State Exchanges that adopt similar automated systems would experience reduced administrative burden while ensuring consumers have seamless access to hardship exemptions and catastrophic coverage.

To estimate the cost of developing an automated exemption processing system, we analyzed personnel and time requirements across three major phases: system development, testing and quality assurance, implementation and training. The hour estimates presented below are illustrative examples intended to demonstrate the general magnitude of costs that might be associated with automated system development.

We estimate that Computer Systems Analysts would need approximately 400 hours at an adjusted hourly wage of \$99.80, resulting in a cost of \$39,920. Computer Programmers would require the most substantial time investment, with an estimated 600 hours at an adjusted rate of \$94.88 per hour, totaling \$56,928. Database and Network Administrators would need approximately 200 hours at \$103.34 per hour to configure the necessary data

²⁵³ The reduction in APTC was calculated by multiplying the estimated new SVIs by the previous SVI expiration rate (293,073 × 0.137 = 40,151) and then multiplying that number by the estimated annual APTC amount per SEP consumer (40,151 × \$2,625 = \$105,396,375).

infrastructure and system architecture, costing \$20,668. A Project Manager would oversee the development effort for approximately 160 hours at \$96.88 per hour, adding \$15,501 to the total. The combined system development cost would be approximately \$133,017, requiring 1,360 total staff hours.

Following initial development, the system would require comprehensive testing to ensure accuracy, compliance with Federal regulations, and proper integration with existing Exchange systems. Computer Systems Analysts would conduct approximately 120 hours of testing at \$99.80 per hour, costing \$11,976. Compliance Officers would review the system for regulatory compliance for approximately 80 hours at \$75.40 per hour, adding \$6,032. The total testing and quality assurance cost would be approximately \$18,008, requiring 200 staff hours.

The final phase would involve deploying the automated system and training staff on any residual manual processes or system monitoring requirements. Management Analysts would coordinate the implementation for approximately 80 hours at \$97.30 per hour, costing \$7,784. Eligibility Interviewers would require approximately 40 hours of training at \$49.52 per hour to understand the new automated processes and handle any exceptions, totaling \$1,981. The implementation and training phase would cost approximately \$9,765, requiring 120 staff hours.

Combining all three phases, the total estimated one-time cost in PY 2026 to develop an automated exemption processing system would be approximately \$160,790, so in total \$643,160 for four State Exchanges. This estimate represents 1,680 total staff hours across multiple occupational categories and assumes a standard development timeline and complexity level.

We recognize that this cost estimate could vary significantly depending on several factors. States with more modern and flexible existing system infrastructure may experience lower development costs due to easier integration. Conversely, States with legacy systems may face higher costs. State-specific requirements, customizations, or additional compliance considerations could also increase costs.

We seek comment on these proposed burden estimates, including the estimated number of applications, time required for consumers to complete applications, and time required for Exchanges to process applications. We also seek comment on opportunities to

further reduce burden through automation or other streamlined processes.

19. Modification of Exchange Network Adequacy Standards (§ 155.1050)

We propose to amend § 155.1050(a)(2) to eliminate the requirements under § 155.1050(a)(2)(i) and (ii) for State Exchanges and SBE-FPs to establish and impose quantitative time and distance network adequacy standards for QHPs that are at least as stringent as standards for QHPs participating on the FFEs under § 156.230 and to no longer require State Exchanges and SBE-FPs to conduct quantitative network adequacy reviews to evaluate a plan's compliance with network adequacy standards under §§ 156.230(a)(1)(ii), (a)(1)(iii), and (a)(2)(i)(A) prior to certifying any plan as a QHP. Instead, we would require that State Exchanges and SBE-FPs ensure that each QHP provides sufficient access to providers in a manner that meets applicable standards specified in § 156.230(a)(1)(ii) and (a)(1)(iii) for network plans, or proposed § 156.236(a) for non-network plans, as applicable. State Exchanges and SBE-FPs have traditionally managed their respective network adequacy reviews, and many State Exchanges and SBE-FPs demonstrated to HHS that they have robust network adequacy standards and reviews in place beyond the requirements specified in § 156.230(a)(1)(ii) and (a)(1)(iii) for network plans, or proposed § 156.236(a) for non-network plans. We recognize that State Exchanges and SBE-FPs are often best positioned to evaluate local provider networks and market conditions.

We anticipate this proposal would maintain the regulatory burden on the 22 State Exchanges and 1 SBE-FP we expect for PY 2027, providing them with more flexibility to regulate and review for network adequacy in a manner that best protects their respective consumers. We estimate this impact to be \$1,560,780 beginning in PY 2027, as outlined in section IV.M of this proposed rule. We anticipate this proposal might increase the administrative burden on issuers that operate in multiple States as they navigate varying regulatory frameworks and standards. The impact to consumers is not known at this time but there is a risk of potential decreased access to care for consumers if those State standards and their reviews are less consumer protective than the Federal network adequacy review framework.

We seek comment on these proposed impact estimates and assumptions.

20. General Program Integrity and Oversight Requirements (§ 155.1200)

We propose to amend § 155.1200(d) to reduce duplication between the proposed SEIPM program described in subpart Q and the annual independent external programmatic audit requirements and standards described at § 155.1200(c) and (d). We propose to add § 155.1200(e) to permit a State Exchange to satisfy certain annual independent external programmatic audit requirements, as described at § 155.1200(d), by completing the proposed required annual SEIPM program process. As a result, we estimate that there would be a general burden reduction for State Exchanges related to the programmatic audit requirement under § 155.1200(c). In particular, the current 22 State Exchanges that operate their own eligibility and enrollment platforms would incur lower costs for contracts with independent external auditors, since many requirements under subparts D and E would be addressed through completion of the SEIPM process for the applicable benefit year.

Based on industry estimates of the average cost of contracting an auditor to perform an independent external programmatic audit, HHS projects that the reduced audit scope would lower annual costs by approximately 30 percent or \$45,000 for each State Exchange. This is based on an estimated average annual programmatic audit cost of approximately \$150,000 for a medium-size State Exchange. We anticipate the total cost annual reduction across 22 State Exchanges would be approximately \$990,000 and expect that these savings could begin as early as 2027, coinciding with the submission of independent external audits for the PY 2026 SMART. However, this change would also introduce a new burden associated with completing the SEIPM and the related CAP process, as discussed in the section below. For an estimate of the burden created under SEIPM, please refer to section VI.D.21.

We request comment on the reduction in burden proposed and specifically seek feedback from State Exchanges regarding the annual cost of the programmatic audit process.

21. State Exchange Improper Payment Measurement (§§ 155.1600 Through 155.1650)

This policy would allow HHS to implement the Payment Integrity Information Act of 2019 (PIIA) requirements for State Exchanges. As described in the preamble earlier in this

proposed rule, the PIA requires that agencies measure the improper payments rate for programs susceptible to significant improper payments. HHS already undertakes annual measurements for Medicare, Medicaid, FFEs, and SBE-FPs. This proposed rule would lay the groundwork to complete the Exchanges' measurement program by including State Exchanges and to enable HHS to estimate a comprehensive APTC improper payment rate as mandated by statute.

This policy would allow HHS to measure improper payments that are resultant from State Exchange operations related to the determination of eligibility and payment amounts for APTC and would require State Exchanges to provide Corrective Action Plans responsive to the findings of the measurement. Even slight decreases in this rate would accrue large taxpayer savings. To delineate the range of estimated burden across the State Exchanges, cost estimates were created at the State Exchange level using an average cost per sample of \$499. State Exchanges with proportionally smaller amounts of APTC are planned to produce a sample size of 50 while the largest States are planned to produce a sample size of 250. Using these numbers multiplied by the average cost estimate per sample of \$499, the SEIPM will incur a range of approximately \$24,950.00–\$124,750.00 in costs per respondent. As stated in the Information Collection in IV.O, the total costs for the State Exchanges to produce the proposed information and to undergo the proposed review process is estimated as being \$1,097,800. Additionally, State Exchanges would incur a cost to develop and submit a corrective action plan (CAP) to HHS following an SEIPM cycle beginning in 2029. We estimate that it would take each State Exchange up to 1,000 hours or \$97,300 to develop a CAP. We estimate that the total annual burden associated with this requirement for up to 22 State Exchange respondents would be up to 22,000 hours and \$2,140,600. The burden related to this information collection will be submitted to OMB for approval after future rulemaking has been completed regarding the CAP process and requirements.

Additionally, we estimate that six Full Time Equivalents (FTEs) will be necessary to complete the activities associated with SEIPM and SEIPM contract management. This estimate is based upon our experience with staffing the Improper Payment Pre-Testing and Assessment (IPPTA) which has been operationalized in a similar manner and format as will be the proposed SEIPM.

The estimated annual cost per Full-Time Equivalent (FTE) is \$376,075. This figure was derived by identifying the maximum salary for a Federal employee on the general pay table in the Baltimore area, which was \$183,500 in 2023. To ensure conservative budgeting and sufficient funding, this salary was used as the base. The base salary was then multiplied by a factor of two to account for employee fringe benefits and overhead costs. Consequently, the total annual estimate per FTE is \$376,075, leading to an aggregate annual cost of \$2,256,450 for all FTEs.

Finally, we anticipate total estimated annual contracting costs of \$19.5 million incurred by HHS. These costs include but are not limited to: collecting the information from the State Exchanges, building and completing automated review systems, creating the statistical methodology and identifying the sample, appeal adjudication, estimating the improper payment rate, generating required reports, and IT support and infrastructure costs.

In summary, we expect total annual costs incurred across the State Exchanges to being \$3.2 million, total HHS contracting costs to being \$19.5 million, and total HHS staffing costs to being \$2.3 million for a total cost of \$24.8 million annually.

We believe that the potential benefits of this regulatory action justify the present costs. We seek comment on these proposed impact estimates and assumptions.

22. FFE and SBE-FP User Fees (\$ 156.50)

We propose an FFE user fee rate of 2.5 percent for the 2027 benefit year, which is the same as the 2.5 percent FFE user fee rate finalized for 2026 benefit year. We also propose an SBE-FP user fee rate of 2.0 percent for the 2027 benefit year, which is the same as the 2.0 percent SBE-FP user fee rate we finalized for the 2026 benefit year.

Because we are retaining the same FFE and SBE-FP user fee rates from 2026 benefit year to 2027 benefit year, the FFE and SBE-FP user fee transfers from issuers to the Federal Government would remain the same compared to those estimated for the prior benefit year. We expect that available user fee collections from current and prior years would be sufficient to fund Exchange operations through 2027 at the proposed 2027 benefit year user fee rates.

We seek comment on these proposed impact estimates and assumptions.

23. Provision of EHB (\$ 156.115(d))

We propose to revise \$ 156.115(d) to prohibit issuers from including routine

non-pediatric dental services as an EHB. We do not anticipate any immediate costs to the Federal Government, States, issuers, or enrollees because of this proposed policy. This proposed policy would once again prohibit issuers from covering routine non-pediatric dental services as an EHB, which avoids the potential imposition of premium increases associated with these services. However, we do not expect that the removal of routine non-pediatric dental services as an EHB would have a significant impact on premium reduction, as all benefits a State adds to their EHB-benchmark plan are subject to the typicality standard at \$ 156.111(b)(2)(ii), which limits how generous the updated plan would be. For example, if a State added routine non-pediatric dental services as an EHB under the existing policy, as we explained in the 2025 Payment Notice final rule (89 FR 26348), they may have needed to consider removing and/or adjusting other benefits to make room for the non-pediatric dental services to ensure the scope of benefits falls within the typicality range.

Additionally, this proposed change only has a premium impact to the extent States already updated their EHB-benchmark plans to include routine non-pediatric dental services under the policy finalized in the 2025 Payment Notice that allows States to add routine non-pediatric dental services as an EHB beginning with PY 2027. Since no State has taken this action, this proposal has no premium impact. If finalized as proposed, this proposed policy to prohibit coverage of routine non-pediatric dental services as an EHB would be effective upon the effective date of the final rule, preventing any future premium impact from the former policy.

Consistent with our note in the 2025 Payment Notice final rule (89 FR 26409), which acknowledged that removing the prohibition on routine non-pediatric dental services as an EHB may increase costs for issuers who may need to expand their networks to cover these services, this policy may avoid cost increases for issuers that would have needed to expand their networks to cover these new required services, although issuers could have contracted with a dental vendor to administer the routine non-pediatric dental EHB if such a benefit was adopted by a State as an EHB. As we also noted in the 2025 Payment Notice final rule, the size of non-pediatric dental networks varies by State, therefore, some States would have been affected by the need to build a new network of dental providers (or contract with dental vendors) more than others.

Therefore, by reinstating the prohibition at § 156.115(d), this policy would avoid these potential network expansion costs.

While this proposed policy may limit potential premium increases for enrollees and cost increases for issuers related to network expansion, we acknowledge that this policy may impact long-term health outcomes and associated medical costs. As we explained in the proposed 2025 Payment Notice (88 FR 82597–98), oral health and overall health are inextricably linked; untreated oral health conditions can increase risk for and complicate the management of chronic conditions.²⁵⁴ As we also noted in the 2025 Payment Notice final rule (89 FR 26348), improving access to non-pediatric dental services would reduce health care costs by yielding downstream savings in overall health care expenditures and reducing costly emergency room department visits for dental care. However, as we mentioned in preamble of this proposed rule, we clarify that this prohibition on including routine non-pediatric dental services as an EHB does not prevent States from addressing non-pediatric oral health and overall health outcomes—and associated medical costs—through alternative policy mechanisms. For example, as we mentioned earlier in this proposed rule, States could mandate coverage of routine non-pediatric dental services as a non-EHB and defray the cost associated with that benefit. We believe ensuring better alignment of the regulatory requirements at § 156.115(d) with section 1302(b)(2)(A) of the Affordable Care Act regarding the EHB typicality standard outweighs these other policy considerations.

We solicit comment on the impact of this proposal to revise § 156.115(d) to prohibit issuers from including routine non-pediatric dental services as an EHB and whether other impacts should be considered.

24. Multi-Year Terms for Catastrophic Plans To Improve Health (§§ 156.130 and 156.155)

Under current regulations, catastrophic plans, like all qualified health plans offered through the Exchanges, are limited to annual contract periods that require consumers

to re-enroll each year during the open enrollment period. The proposed regulation would provide consumers who are eligible for catastrophic coverage with the potential of more predictable multi-year coverage arrangements, with a term of at least 2 years, compared to annual re-enrollment, though premiums and benefits may be adjusted during the contract term in accordance with applicable requirements. This could potentially reduce premium volatility and administrative burden while maintaining the EHB and consumer protections required under the Affordable Care Act. This proposal aims to enhance market stability for a segment of consumers who may benefit from longer-term coverage arrangements. The proposed regulation would be effective for plan years and policy years beginning on or after January 1, 2027.

We seek comments on issuer participation, State and State Exchange operational impacts, and market segmentation effects.

The proposed regulation is anticipated to deliver benefits for eligible consumers and participating issuers. Consumers who enroll in multi-year catastrophic plans could benefit from more predictable multi-year coverage, with a term of at least 2 years, arrangements, reduced need to navigate annual open enrollment periods, and decreased risk of coverage gaps due to missed enrollment deadlines. Additionally, the proposed regulation would permit catastrophic plans with terms of at least 2 years to utilize value-based insurance designs to offer preventive services before the deductible is satisfied, potentially enhancing access to care. Issuers offering multi-year catastrophic plans could experience reduced administrative burden associated with annual re-enrollment activities and lower operational expenses related to annual plan document preparation and filing. The extended contract periods could also promote continuous coverage among individuals. Nevertheless, there are potential unintended consequences associated with multi-year catastrophic plans such as a possible reduction in consumer flexibility to switch plans in response to changing health needs or life circumstances (for example, becoming eligible for employer sponsored coverage or relocating outside of the plans service area). Even though premiums may be adjusted during the contract term in accordance with applicable requirements, issuers may price plans conservatively to account for uncertainty, potentially

resulting in higher initial premiums. Additionally, there is uncertainty about how multi-year catastrophic plans might affect risk selection, including whether healthier individuals would disproportionately select multi-year plans. We note that there is currently no available evidence on these potential effects and data that could help understand the potential unintended consequences.

Issuers could incur costs related to developing multi-year catastrophic plans, such as developing new pricing models. States and the Federal Government would face costs associated with reviewing and approving multi-year catastrophic plan filings. We seek comments on costs and data that could be used to quantify these impacts.

The availability of multi-year catastrophic plans could result in transfer effects impacting consumers, issuers, States, and the Federal Government, with the magnitude dependent on uptake rates. We seek comments on transfer effects, premium impacts, Federal PTC expenditures, and data that could be used to quantify these impacts.

Given that this would be a new option for consumers, there is uncertainty regarding consumer demand for multi-year catastrophic plans. There is also uncertainty regarding how premiums would be structured for multi-year catastrophic plans, including the methodology and frequency of adjustments (such as annual adjustments tied to inflation or other factors) permitted under applicable requirements. There would also be actuarial challenges for issuers in pricing coverage for periods up to 10 years, particularly in projecting medical cost trends and utilization patterns over extended timeframes. Additionally, there is uncertainty about how consumers locked into multi-year catastrophic plans would respond if their health status changed and what implications this might have for consumers. We seek comment on these uncertainties and request data that could help quantify the potential impacts of multi-year catastrophic plans on enrollment patterns, premium levels, and Federal expenditures.

25. Cost-Sharing for Bronze and Catastrophic Plans (§§ 156.136 and 156.155)

To address an issue that has arisen in the implementation of section 1302(c) through (e) of the Affordable Care Act, we propose adding new § 156.136 to change the permissible cost-sharing parameters for bronze plans and

²⁵⁴ Kapila Y.L. (2021). Oral health's inextricable connection to systemic health: Special populations bring to bear multimodal relationships and factors connecting periodontal disease to systemic diseases and conditions. *Periodontology* 2000, 87(1), 11–16. <https://doi.org/10.1111/prd.12398>. Periodontal disease has been associated with diabetes, metabolic syndrome, obesity, eating disorders, liver disease, cardiovascular disease, Alzheimer disease, rheumatoid arthritis, adverse pregnancy outcomes, and cancer.

revisions to § 156.155(a)(3) for updated requirements for catastrophic plans.

We propose changes to the cost-sharing requirements at § 156.155(a)(3) for catastrophic plans in the individual market to address an irreconcilable conflict between section 1302(c) through (e) of the Affordable Care Act. Specifically, we propose to permit individual market bronze plans to exceed the maximum annual limitation on cost sharing (rounded down to the next lowest multiple of 50 dollars) in order to achieve an AV within the standard bronze *de minimis* variation at § 156.140(c), beginning with PY 2027. We propose to allow individual market issuers this option to offer one or more increased annual limitation on cost sharing plans only if they offer at least one bronze plan that meets the annual limitation on cost sharing (that is, does not have an increased annual limitation on cost sharing). We propose to require catastrophic plans to provide no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount equal to 130 percent of the annual limitation on cost sharing is reached, beginning in PY 2027. If finalized, we expect that this would incentivize enrollment in catastrophic plans because issuers would be able to offer their catastrophic plans at lower premiums than they are currently able under the current annual limitation on cost sharing restriction. This, in turn, would raise the expected out-of-pocket costs by up to 30 percent for enrollees in catastrophic plans that incur health care costs in excess of the current annual limitation on cost sharing; enrollees in bronze plans could see their rise even higher. We also believe that this would provide consumers with additional choice of bronze plans, including the potential for plan designs with lower deductibles and lower premiums.

We seek comment on these proposed impact estimates and assumptions.

26. Discontinuation of Standardized Plan Options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv))

We propose to discontinue the full suite of standardized plan option policies effective beginning in PY 2027. Specifically, we propose to remove the following from our regulations: the definition of “standardized options” at § 155.20; all requirements pertaining to standardized plan options at § 156.201 (the requirements for FFE and SBE–FP QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one

another at paragraph (c)); the authority to differentially display standardized plan options on *HealthCare.gov* at § 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv). Finally, we propose to cease the annual design and publication of these plans in the applicable Payment Notice for each plan year.

However, we recognize that some issuers and consumers may still find certain features of these plan designs valuable. This is why we are not proposing to require issuers to discontinue their existing standardized plan option offerings altogether. Instead, under this proposed approach, issuers would be permitted to choose whether to discontinue these offerings altogether or to continue offering them with either the same or modified cost sharing, while we simultaneously discontinue the differential display of these plans on *HealthCare.gov* and the DE pathways.

Under this proposed approach, if issuers wished to discontinue their standardized plan option offerings altogether, they would be permitted to do so, and enrollees in these plans would be crosswalked to a different plan in accordance with the crosswalk hierarchy at § 155.335(j). Additionally, if issuers wished to continue offering these standardized plan options with the same cost sharing, they would also be permitted to do so, and enrollees in these plans would continue to be auto-reenrolled in these plans from one plan year to the next. However, these plans would no longer be visually distinguished as standardized plan options on *HealthCare.gov* or the DE pathways. Finally, if issuers wished to continue offering these standardized plan options but also wished to modify these plans’ cost sharing structures, they would be permitted to do so, but these issuers would continue to be subject to the requirements under the definition of “plan” at § 144.103 and to the uniform modification requirements at § 147.106.

In most scenarios where an issuer modifies the cost sharing structure of one of its standardized plan option offerings, the newly modified plan that was formerly the standardized plan option would be considered a new plan and would therefore require a new plan ID. In this scenario, enrollees would be crosswalked from the discontinued plan to another plan in accordance with the crosswalk hierarchy at § 155.335(j). These enrollees could be crosswalked into the newly modified plan that was

formerly the standardized plan option, or an entirely different plan altogether, depending on the unique circumstances in each county.

However, under the definition of “plan” at § 144.103, a State may permit issuers to make greater changes to a plan’s cost sharing while still permitting that plan to be considered the same plan—thus maintaining the same plan ID. Furthermore, pursuant to § 147.106(e)(3)(iv), as long as the variation in cost sharing is solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level (and other applicable requirements under § 147.106(e) are met), the modifications could be considered uniform (thus, a viable exception to guaranteed renewability).

In the scenario where an issuer modifies what was formerly a standardized plan option’s cost sharing structure while maintaining the same plan ID, enrollees in the plan would be auto-reenrolled from one plan year to the next. In either case, whether the modification of a former standardized plan option’s cost sharing results in that plan being considered the same or a different plan, enrollees would be crosswalked in accordance with the crosswalk hierarchy at § 155.335(j), and that plan would no longer be differentially displayed as a standardized plan option on *HealthCare.gov* or the DE pathways.

Adopting this approach would effectively remove the standardization component of this suite of policies while simultaneously minimizing the risk of disruption for consumers enrolled in and issuers of these plans. This approach would also ensure that issuers of these plans that wish to continue offering them would be able to do so at their discretion. If issuers did choose to continue offering these plans, either with the same or modified cost sharing structures, they would be able to continue utilizing existing benefit packages, provider networks, drug lists, and formularies, including those paired with standardized plan options for PY 2026. This would further minimize burden for these issuers.

In addition, we have assumed the responsibility for differentially displaying standardized plan options on *HealthCare.gov* in accordance with § 155.205(b)(1), meaning that FFE and SBE–FP issuers have not been subject to this burden since the requirement to offer standardized plan options as well as the differential display of these plans were reintroduced in PY 2023. Thus, discontinuing the differential display of these plans on *HealthCare.gov* would

not affect issuers or impose any additional burden in this regard.

However, we acknowledge that the discontinuation of the differential display requirements for the DE pathways at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv) would impose a degree of burden on approved web-broker and QHP issuer enrollment partners using a direct enrollment pathway to facilitate consumer enrollment through an FFE or SBE-FP, since these entities would be required to modify their own platforms in some manner. However, we anticipate that the burden of making these modifications would be minimal, as decommissioning existing functionalities (such as the differential display of standardized plan options, which would include the full suite of differential display features discussed in greater detail in the preamble to § 156.201 of this proposed rule) and reverting to the previous state of display would entail significantly lower burden than introducing novel features and functionalities.

Further, since differential display of standardized plan options on *HealthCare.gov* is operationally contingent on these plans having the required cost sharing parameters, and since we would no longer design and publish standardized plan options in the applicable Payment Notice for each plan year, no plans would technically meet the requirements to be considered standardized plan options, meaning no plans would be differentially display on *HealthCare.gov*—even if we made no changes to the current functionality. The same would be true for approved web-broker and QHP issuer enrollment partners using a direct enrollment pathway to facilitate consumer enrollment through an FFE or SBE-FP, meaning the discontinuation of the differential display features could occur even without disabling the existing functionality to differentially display standardized plan options on their respective platforms.

We refer readers to the preamble section for the proposal to discontinue standardized plan options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv)) for a detailed discussion of relevant literature we considered in our approach to this proposal.

We seek comment on these proposed impact estimates and assumptions.

27. Discontinuation of Non-Standardized Plan Option Limits and Exceptions (§ 156.202)

We propose to discontinue non-standardized plan option limits and exceptions at § 156.202. However, we

recognize that some issuers and consumers may still find certain features of the chronic and high-cost condition plans that were originally offered through the non-standardized plan option limit exceptions process valuable. This is why we are not proposing to require issuers to discontinue these chronic and high-cost condition plans. Instead, under this proposal, issuers would be permitted to choose whether to discontinue the chronic and high-cost condition plans originally offered through the non-standardized plan option limit exceptions process altogether or continue offering them with either the same or modified cost sharing. Issuers would similarly be permitted to continue offering other non-standardized plan options not associated with the non-standardized plan option limit exceptions process.

Under this proposed approach, if issuers wished to discontinue the chronic and high-cost condition plans originally offered through the exceptions process (or other non-standardized plan options not associated with the non-standardized plan option limit exceptions process) altogether, they would be permitted to do so, and enrollees in these plans would be crosswalked to a different plan in accordance with the crosswalk hierarchy at § 155.335(j). Additionally, if issuers wished to continue offering the chronic and high-cost condition plans originally offered through the exceptions process (or other non-standardized plan options not associated with the non-standardized plan option limit exceptions process) with the same cost sharing structures, they would also be permitted to do so, and enrollees in these plans would continue to be auto-reenrolled in these plans from one plan year to the next. Finally, if issuers wished to continue offering the chronic and high-cost condition plans originally offered through the exceptions process (or other non-standardized plan options not associated with the non-standardized plan option limit exceptions process) but also wished to modify these plans' cost sharing structures, they would be permitted to do so, but these issuers would continue to be subject to the requirements under the definition of "plan" at § 144.103 and to the uniform modification requirements at § 147.106.

In most scenarios where an issuer modifies the cost sharing structure of one of its chronic and high-cost condition plans originally offered through the exceptions process (or other non-standardized plan options not associated with the non-standardized

plan option limit exceptions process), the newly modified plan that was formerly the exceptions process plan (or other non-standardized plan options not associated with the non-standardized plan option limit exceptions process) would be considered a new plan and would therefore require a new plan ID. In this scenario, enrollees would be crosswalked from the discontinued plan to another plan in accordance with the crosswalk hierarchy at § 155.335(j). These enrollees could be crosswalked into the newly modified plan that was formerly the exceptions process plan, or an entirely different plan altogether, depending on the unique circumstances in each county.

However, under the definition of "plan" at § 144.103, a State may permit issuers to make greater changes to a plan's cost sharing while still permitting that plan to be considered the same plan—thus maintaining the same plan ID. Furthermore, pursuant to § 147.106(e)(3)(iv), as long as the variation in cost sharing is solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level (and other applicable requirements under 45 CFR 147.106(e) are met), the modifications could be considered uniform (thus, a viable exception to guaranteed renewability).

In the scenario where an issuer modifies what was formerly an exceptions process plan's (or other non-standardized plan options not associated with the non-standardized plan option limit exceptions process) cost sharing structure while maintaining the same plan ID, those enrolled in the plan would be auto-reenrolled from one plan year to the next. In either case, whether the modification of a former exceptions process plan's cost sharing results in that plan being considered the same or a different plan, enrollees would be crosswalked in accordance with the crosswalk hierarchy at § 155.335(j).

Ultimately, adopting this approach would substantially reduce regulatory complexity and the burden associated with the non-standardized plan option limit and the corresponding exceptions process while simultaneously minimizing the risk of disruption to consumers enrolled in and issuers of the chronic and high-cost condition plans originally offered through the exceptions process (or other non-standardized plan options not associated with the non-standardized plan option limit exceptions process). If issuers did choose to continue offering these plans, either with the same or modified cost sharing structures, they would be able to continue utilizing

existing benefit packages, provider networks, drug lists, and formularies, including those paired with what were formerly the exceptions process plans for PY 2026. This would further minimize burden for these issuers.

We refer readers to the preamble section for the proposal to discontinue standardized plan options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv)) for a detailed discussion of relevant literature we considered in our approach to the proposal to discontinue non-standardized plan option limits and exceptions.

We seek comment on these proposed impact estimates and assumptions.

28. Provider Access Standards for Network Plans (§ 155.1050 and § 156.230)

We propose at § 155.1050(d), for PY 2027 and beyond, to allow FFE States, including States that perform plan management, that elect to do so, to conduct provider access reviews for issuers' plans that use and do not use a provider network, provided that the State demonstrates it has sufficient authority and the technical capacity to conduct such reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program as described at proposed § 155.1050(d)(2) through (d)(4). HHS would continue to conduct network adequacy reviews consistent with § 156.230 for QHP issuers that use a provider network and provider access reviews for QHP issuers that do not use a provider network in FFE States that do not elect to conduct such reviews, or in FFE States that do not demonstrate they have sufficient authority and the technical capacity to conduct such reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program, as described at proposed § 155.1050(d)(2) through (d)(4). Under this proposal, we would continue to collect network adequacy data, including time and distance and appointment wait time data. We would continue collecting this data from all FFE issuers, either to use to conduct Federal network adequacy reviews in FFE States that do not elect to do so or do not demonstrate they have sufficient authority and the technical capacity to conduct these reviews by satisfying the criteria to be considered to have an Effective Provider Access Review Program as described at § 155.1050(d)(2) through (d)(4), or with a view to make it available in a standardized format to States that are determined to have an Effective Provider Access Review

Program, to assist them in their network adequacy analysis.

The preceding years of conducting reviews of QHP issuer provider network adequacy, including analyzing issuer submitted data and through discussions with States, issuers and other various interested parties around diverse market conditions, have demonstrated that a one-size-fits-all approach to provider network adequacy review is not satisfactory. For example, issuers have highlighted to us persistent challenges in locating and contracting with enough providers of various specialties (e.g., allergy and immunology, behavioral health, gastroenterology) in remote or difficult to access areas of a State. States have brought to our attention various geographic constraints that impact QHP issuer's ability to satisfy time and distance requirements and have made arguments to assess based on time or distance individually rather than being required to meet a time and distance standard that may be insurmountable due to a topographical constraint such as a body of water or navigating roads in mountainous terrain. Partnerships with States performing plan management, that have elected to conduct their own network adequacy reviews, have highlighted for us how States may innovate in their approach to conducting network adequacy reviews in ways that are sensitive to conditions and capacity in the State. These are among the factors that have led us to revisit our previous approach to defer network adequacy reviews to States as we recognize that a State, with its more intimate knowledge of its own demographics, topographical considerations, and provider supply, is often best positioned to evaluate local provider networks and market conditions and can tailor network adequacy standards in a more nuanced way than the broader Federal Government requirements may. Thus, in recognition of the crucial role States have in developing and enforcing network adequacy standards and because we believe that States are often best positioned to evaluate local provider networks and market conditions, we propose at § 155.1050(d), for PY 2027 and beyond, to allow FFE States, including States that perform plan management, that elect to do so, to conduct provider access reviews for issuers' plans that use and do not use a provider network, provided that HHS determines the State has sufficient authority and the technical capacity to conduct the reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access

Review Program as described at proposed § 155.1050(d)(2) through (d)(4). In addition, we would continue collecting network adequacy data from all FFE issuers, either to use to conduct Federal network adequacy reviews in FFE States that do not elect to do so, or do not demonstrate they have sufficient authority and the technical capacity to conduct these reviews by satisfying the criteria to be considered to have an Effective Provider Access Review Program as described at § 155.1050(d)(2) through (d)(4), or with a view to make it available in a standardized format to States that are determined to have an Effective Provider Access Review Program, to assist them in their network adequacy analysis.

We do not anticipate any additional costs to the Federal Government as part of this proposal. While HHS still intends to collect data from QHP issuers in States with Effective Provider Access Review Programs, there is the potential for cost savings at the Federal level related to network adequacy reviews during QHP certification if HHS shifts these responsibilities to States that elect to conduct their own reviews. However, this may increase costs in States if they do not already possess capability and resources necessary to conduct sufficient provider access reviews, as well as ensure compliance and appropriate consumer protections. For QHP issuers, this proposal may have reduced administrative costs and efficiency gains. While HHS would still collect network adequacy data from issuers in these States, issuers would not have to undergo network adequacy certification reviews at the Federal level which often requires additional reporting to HHS to address corrections in network adequacy required to meet Federal standards. Additionally, many QHP issuers already have State specific network adequacy requirements with which they must comply to operate plans in the State. Thus, redirecting network adequacy review activities to States, that issuers already need to report to, could streamline the efficiency of the QHP certification process and reduce burden for issuers. However, requiring issuers to submit network adequacy data on both the State and Federal levels could potentially duplicate efforts and increase costs for issuers, though the extent of any administrative burden is uncertain as States may have different data collection and submission requirements, and it is not yet known how FFE States would implement or may change network adequacy data collection as part of an Effective Provider Access Review

Program and if existing data collection processes already exist or need to be modified to support requirements under proposed § 155.1050(d).

Regarding Federalism implications of this proposal, the Affordable Care Act does not require States to establish and enforce network adequacy certification criteria and review programs for QHP issuers; if a State elects not to establish any of these programs or is not approved to do so, HHS must establish and operate the programs in that State. As part of this proposal, we would not require that States elect to conduct provider access certification reviews as part of an Effective Provider Access Review Program. Rather, we propose to allow States flexibility to conduct provider access certification reviews, should they choose, provided they have sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria in proposed § 155.1050(d)(2) through (d)(4).

We seek comment on these proposed impact estimates and assumptions.

29. Essential Community Provider Standards (§ 155.1051 and § 156.235)

ECP requirements under the General Standard at § 156.235(a)(2)(i) specify that a plan applying for QHP certification to be offered through a FFE must demonstrate in its QHP application that the issuer's provider network includes as participating providers at least a minimum percentage, as specified by HHS, of available ECPs in each plan's service area collectively across all ECP categories defined under § 156.235(a)(2)(ii)(B), and at least a minimum percentage of available ECPs in each plan's service area within certain individual ECP categories, as specified by HHS. Alternate Standard issuers must demonstrate similar minimum percentage requirements as described at § 156.235(b)(2)(i). For PY 2014, we set this minimum percentage at 20 percent and increased the minimum percentage to 30 percent for PY 2015. For QHP certification for PY 2018 and through the end of PY 2022, we returned to the percentage used in PY 2014, and to again consider the issuer to have satisfied the threshold requirement if the issuer contracted with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network. We increased the minimum percentage to 35 percent starting in PY 2023 and required issuers to separately meet 35 percent minimum percentage requirements within two standalone ECP categories, FQHCs and family

planning providers, as finalized in the PY 2024 Payment Notice. In this proposed rule, we propose to consider medical QHP and SADP issuers to have satisfied minimum percentage requirements under § 156.235(a)(2)(i) and (b)(2)(i) if they contract with at least 20 percent of available ECPs in each plan's service area collectively across all ECP categories defined under § 156.235(a)(2)(ii)(B), they contract with at least 20 percent of available FQHCs that qualify as ECPs in each plan's service area, and they contract with at least 20 percent of available family planning providers that qualify as ECPs in the plan's service area (medical QHPs only) to participate in the plan's provider network. We believe reverting to the previous 20 percent minimum percentage that issuers were accustomed to for PY 2014 and PY 2018 through 2022 would result in minimal disruptions for issuers in adjusting to meet the threshold requirements based on previous analyses of ECP data that have identified that the majority of issuers exceed the minimum percentage requirement within their provider networks. For example, for PY 2026, the average threshold percentage for all FFE issuers, including issuers in States performing plan management, for the overall ECP requirement was 71 percent, for the family planning provider requirement was 85 percent, and for the FQHC requirement was 79 percent despite the minimum percentage being set at 35 percent. We believe that reducing the overall threshold requirement, FQHC threshold requirement, and family planning provider threshold requirement from 35 to 20 percent would minimally impact the majority of QHP issuers, while allowing issuers the opportunity and flexibility to build provider networks that comply with the ECP Standard under § 156.235.

We anticipate several potential impacts associated with these proposed changes to return minimum percentage requirements described under §§ 156.235(a)(2)(i) and (b)(2)(i) back to 20 percent. Less expansive requirements for network size would lead to both costs to consumers and cost savings to issuers. Costs could take the form of increased travel time and wait time for appointments or reductions in continuity of care for those patients whose providers have been removed from their insurance networks. Cost savings for issuers would be associated with reductions in administrative costs of arranging contracts, meeting higher QHP certification requirements for ECP Standards, and, if issuers focus their

networks on relatively fewer providers to the extent possible, reductions in the cost of providing health care. Potential cost savings from reduced administrative burden for issuers may also be passed on to consumers through lower premium rates.

Additionally, we propose to modify the narrative justification requirement under §§ 156.235(a)(3) and 156.235(b) to make the language more consistent with current operations and data submission requirements for ECP certification reviews. As part of the narrative justification requirements, an issuer applying for QHP certification that is not meeting the ECP standard under § 156.235 has to include as part of its QHP application a written open-ended narrative describing how the issuer's provider network as currently designed would provide an adequate level of service for individuals residing in low-income zip codes or Health Professional Shortage Areas within the plan's service area, and how the issuer would strengthen the plan's provider network in future years. We have instituted multiple refinements and modernizations to the justification process over time, and recently in PY 2025, leveraged information technology to embed justification related information (for example, contract statuses) into the new ECP User Interface (UI) in the MPMS. In alignment with this modernization that now allows issuers to easily select and report the contract status of ECPs included within their networks or who are being recruited into their networks, we propose to modify §§ 156.235(a)(3) and 156.235(b) to instead designate that a network plan applying for QHP certification to be offered through a FFE must include as part of its QHP application the status of contract offers to qualified ECPs available in the network plan's service area. A network plan would not need to report on the status of contract offers for all available ECPs in the network plan's service area but should at least report on the status of contract offers for all ECPs which the issuer has either included in its network plan or offered a contract to be included in its network plan within each service area.

We believe these changes to the narrative justification requirements at §§ 156.235(a)(3) and 156.235(b) would not have meaningful impacts to issuers since these amendments would reflect current ECP data submission requirements that have been in place since PY 2025. Issuers would continue to upload ECP data into MPMS and complete required fields within the ECP UI, including selecting or importing

ECPs included within their networks and designating the status of their contract offers. Although this proposed language does not modify current requirements as part of ECP certification reviews, it would reflect modernizations to the ECP data collection process that have introduced significant program efficiencies that have improved data quality, and effectively reduced the time, resources, and administrative costs required by issuers to submit supporting justification documentation for meeting the ECP standard under § 156.235.

Furthermore, we propose at § 155.1051 to allow FFE States, including States performing plan management, to elect to perform their own State reviews of issuer-submitted ECP data provided the State demonstrates it has sufficient legal authority and the technical capacity to conduct these reviews by meeting the applicable criteria determined by HHS to be considered to have an Effective ECP Review Program under proposed § 155.1051. We propose that FFE States must ensure that a QHP with a provider network includes in its provider network a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the Exchange's network adequacy standards. In addition, we propose that FFE States must also ensure that a non-network plan applying for certification as a QHP to be offered through an FFE demonstrates that it provides reasonable and timely access to ECPs that accept the plan's benefit amount as payment in full to ensure that services will be accessible without unreasonable delay. We also propose that FFE States must have established ECP requirements that are set forth in State statute or regulation. And we propose that at a minimum, FFE States must demonstrate that these established ECP requirements are comparable to ECP requirements described under § 156.235 for issuers with a provider network and under proposed § 156.236 for issuers without a provider network to promote a sufficient number and geographic distribution of ECPs, but that those FFE States with alternative ECP requirements must demonstrate how those requirements would promote a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to ECPs. At proposed § 155.1051(e), we also set forth factors that HHS would

consider in its review to determine if an FFE State has an Effective ECP Review Program. Additionally, we clarify that HHS would still be available to provide technical assistance and various resources to FFE States, including that we would continue collecting ECP data from FFE issuers in States with an Effective ECP Review Program with the goal of providing this data in a standardized format to FFE States that could inform additional assessments of access to ECPs across the State and assisting FFE States that may require additional support due to more limited resources.

We anticipate several potential impacts associated with these proposed changes to implement the Effective ECP Review Program provisions at proposed § 155.1051. First, while we believe that predominately collecting and reviewing ECP data on the Federal level as part of QHP certification for issuers across the FFE has helped ensure that issuers include a sufficient number and geographic distribution of ECPs within their networks, we believe providing FFE States more flexibility and authority to conduct their own ECP certification reviews may deliver quality improvements to the review process. We acknowledge that States possess unique knowledge on local and contextual factors, such as on market conditions, geographic constraints, and areas in the State with limited economic resources, provider shortages, workforce issues, and population demographics. FFE States may incorporate these various factors to tailor their ECP certification reviews and apply ECP certification results to more directly address State-specific challenges for consumers as it pertains to ECP access, which is more difficult to accomplish at the Federal level with a one-size-fits all approach for all States. In addition, continuing to leverage Federal infrastructure to collect ECP data from issuers in FFE States with an Effective ECP Review Program would create opportunities for a State-Federal partnership where HHS could provide data in a standardized format to States to inform their ECP certification reviews and provide support to FFE States that require additional assistance.

Additionally, we presume there are several cost related implications of this proposal. We do not anticipate any additional costs to the Federal Government as part of this proposal. While HHS still intends to collect data from QHP issuers in FFE States with Effective ECP Review Programs, there is still the potential for cost savings at the Federal level as it pertains to reviewing such ECP data during QHP certification and taking enforcement actions against

QHP issuers after QHP certification as part of compliance if HHS shifts these responsibilities to FFE States that elect to conduct their own reviews of issuers as part of the Effective ECP Review Program. Though, in turn, this may increase costs among FFE States if they do not already possess the capability and resources to conduct complex, data-intensive ECP certification reviews and enforcement actions against issuers that neglect to meet ECP requirements. For QHP issuers, this proposal may have reduced administrative costs and efficiency gains. While HHS would still collect ECP data from issuers in these FFE States, issuers would not have to undergo intensive ECP certification reviews at the Federal level which often requires coordination with HHS to address corrections in ECP data until ECP requirements are met. Also, many QHP issuers already need to coordinate with FFE States to meet various requirements to operate plans in the State. Thus, redirecting ECP review activities to FFE States that issuers already need to coordinate with could further streamline the efficiency of the QHP certification process. However, requiring issuers to submit ECP data on both the State and Federal levels could potentially duplicate both effort and costs among issuers, but the extent of this administrative burden is uncertain as States likely have different data collection and submission requirements, and it is not yet known how FFE States will implement ECP data collection as part of the Effective ECP Review Program and if existing data collection processes already exist or need to be developed to support requirements under proposed § 155.1051.

Lastly, as it pertains to Federalism implications of this proposal, the Affordable Care Act does not require FFE States to establish and enforce ECP certification criteria and review programs for QHP issuers; if an FFE State elects not to establish any of these programs or is not approved to do so, HHS must establish and operate the programs in that State. As part of this proposal, we would not require that FFE States elect to conduct ECP certification reviews as part of the Effective ECP Review Program. Rather, we propose additional flexibilities to allow FFE States with the desire to conduct ECP certification reviews to have an opportunity to do so, provided they have sufficient authority and the technical capacity to conduct these reviews by meeting the applicable criteria in proposed § 155.1051. Thus, FFE States that elect to perform their ECP certification reviews and undergo

HHS' determination process for assessing if an FFE State has an Effective ECP Review Program would be willingly assuming this responsibility.

30. QHP Certification of Non-Network Plans (§ 156.236)

We propose a number of revisions to part 155 and part 156 to allow plans that do not use a network (non-network plans) to obtain QHP certification by demonstrating sufficient access to a broad range of providers in a manner consistent with sections 1311(c)(1)(B) and (C) of the Affordable Care Act. This proposal would not require States to approve non-network plans for sale nor would it require Exchanges to certify such plans. States that do not approve non-network plans as QHPs would see no impact under this proposal. The following impact analysis applies only to States that decide to approve such plans as QHPs.

Non-network plans may typically attract healthier enrollees who are generally more willing and able to engage in a sufficient number of price negotiations with providers to benefit from the value a non-network plan can provide. Conversely, individuals requiring frequent care may prefer enrolling in network plans to avoid the need to conduct price negotiations for a greater volume of needed care. This, in turn, naturally leads to favorable risk selection in non-network plans. Consequently, under this proposal, non-network plans should anticipate and budget for risk adjustment transfers in their premium calculations, at least to the extent that the issuers of such plans do not already have sufficient reserves at hand to be able to pay an expected high risk adjustment transfer amount.

This dynamic also means that non-network plans may tend to have lower premiums than network plans, so we would expect that they would tend to be among the least expensive plans in a particular area. This could affect premium tax credits to the extent that non-network plans are the lowest and/or second-lowest cost silver plan in that area.

We seek comment on these proposed impact estimates and assumptions.

31. Amendments To Strengthen HHS' Oversight of the Administration of the Advanced Payments of the Premium Tax Credit, Cost-Sharing Reductions, and User Fee Programs and Clarifying HHS' Compliance Review Authority (§ 156.480)

We propose to modify § 156.480 to clarify HHS' authority to audit or conduct a compliance review to assess issuers' compliance with requirements

related to the APTC, CSR, and user fee programs. Specifically, we propose clarifying that under § 156.480(c), HHS or its designee may audit or conduct a compliance review to assess compliance with all requirements related to APTC, CSR, and user fee programs applicable to issuers offering a QHP in an Exchange. For consistency, we also propose to make conforming changes to § 156.480(c)(6) to provide that in instances where HHS enforces compliance with any requirements related to APTC, CSR, and user fee programs with respect to QHP issuers participating in State Exchanges or SBE-FPs, HHS may do so in accordance with § 156.805. We also propose clarifying that the compliance review authority in § 156.480(c) allows for compliance reviews as needed or on an annual basis.

We estimate that the audits that we would conduct under this authority would not impose additional costs beyond what is already accounted for in the audit review process (86 FR 24140, 24281). We estimate that we would conduct compliance reviews under this authority to address systemic issues for approximately 150 issuers each year. We estimate that it would take a business operations specialist 10 hours (at a rate of \$44.41 per hour) to compile and submit data and other information necessary for a compliance review. We estimate it would take a compliance officer (at a rate of \$40.86 per hour) 4 hours to review and sign off on the submission. The cost per issuer to develop and submit the compliance information would be approximately \$607.54.

The total annual cost to issuers undergoing compliance reviews would be approximately \$91,131 (\$607.54 x 150 issuers) beginning in 2026. However, conducting compliance reviews on an as needed or annual basis if determined appropriate by HHS to assess issuer compliance with requirements related to the APTC programs may reduce the amount of APTC overpayments and result in HHS recouping those overpayments. Further, this additional information could assist issuers in correcting their data for APTC payments not received in advance of the three-year window, after which HHS only recoups overpayments.²⁵⁵ While

²⁵⁵ Plan year data inaccuracies described to HHS or the State Exchange (as applicable) before the end of the 3-year period beginning at the end of the plan year are eligible for resolution and payment to the issuer of any confirmed APTC underpayments. Data inaccuracies identified after the 3-year period are not eligible for repayment to the issuer. However, should an issuer identify a payment error after the 3-year period, the issuer must notify HHS or the

there would be some Federal costs to conduct the compliance reviews, we expect benefits of more accurate APTC reconciliation and payment adjustments to outweigh the costs.

We seek comment on these proposed impact estimates and assumptions.

32. Amendments to Factors Considered in Determining the Amount of Civil Money Penalties (CMPs) and HHS' Authority To Impose CMPs Against Issuers in State Exchanges or SBE-FPs (§ 156.805)

We propose to amend § 156.805 to reiterate what HHS considers when imposing CMPs as enforcement remedies against QHP issuers in Exchanges. Specifically, we propose to amend § 156.805(b) to provide that HHS, in determining the amount of CMPs, will identify the lawful purpose or purposes of the CMP.

We also propose to clarify the authority HHS has to impose CMPs against issuers in State Exchanges and SBE-FPs for identified violations. Specifically, we propose to amend § 156.805(f) to clarify that, when HHS' authority to enforce requirements in State Exchanges and SBE-FPs is triggered, HHS may impose CMPs against issuers in State Exchanges and SBE-FPs for violations of requirements applicable to the noncompliant actions described in § 156.805(a) that are applicable to issuers offering a QHP in a State Exchange or SBE-FP.

We do not believe that the proposed amendments would impose substantial additional costs to HHS beyond the costs that are already accounted for as part of the existing bases and process for imposing CMPs in the FFE, State Exchanges, and SBE-FPs. This is an existing policy that already applies broadly to those issuers participating on the Exchange and since this amendment does not independently add any new requirements for any issuer in an Exchange, we believe that the burden associated with it is already covered by existing requirements in § 156.805. Therefore, we do not believe there would be additional burden to issuers under this proposal. The burden associated with these requirements is the time and effort necessary to draft and submit audit reports that form the basis for subsequent CMP assessments. While these requirements do impose burdens, data collection requirements associated with imposing CMPs on QHP issuers in an Exchange are exempt from PRA requirements in accordance with 44 U.S.C. 3518(c)(1)(B)(ii), as effectuated

State Exchange (as applicable) and repay any overpayments. See 45 CFR 156.1210(c).

through 5 CFR 1320.4(a)(2), because this information would be collected during the conduct of an administrative action or investigation involving an agency against specific individuals or entities.

On balance, we anticipate that this proposal would streamline our compliance and enforcement processes and limit the administrative burden for evaluating Exchange standards and requirements applicable to issuers offering QHPs participating in Exchanges.

We seek comment on these proposed impact estimates and assumptions.

33. Amendments to the Administrative Review of QHP Issuer Sanctions (§§ 156.903 and 156.935)

We propose to amend to § 156.903 to provide that an ALJ presiding over an appeal of a sanction imposed in accordance with § 156.805 may issue subpoenas, upon his or her own motion or at the request of a party, if they are reasonably necessary for the full presentation of a case and to add procedures governing the process for issuing subpoenas. We also propose to amend § 156.935 to ensure that the discovery provisions set forth therein do not apply to appeals of proposed CMPs to be assessed under § 156.805 that result from violations identified in audits under § 156.480(c).

We do not believe that the proposed amendments would impose additional costs to HHS beyond what is currently accounted for in appeals to the DAB. The DAB's procedures include subpoena procedures which follow the procedures established by a program's regulations. We also do not believe the proposed amendments to exclude appeals of CMPs to be assessed under § 156.805 that result from violations identified in audits under § 156.480(c) from discovery would impose additional costs on HHS or issuers as both parties would be able to provide and obtain information during the audit and informal refutation process and obtain publicly available information that would help to develop a record for appeal.

We seek comment on these proposed impact estimates and assumptions.

34. Quality Improvement Strategy (§ 156.1130)

As discussed in section IV.U of this proposed rule, there is no information collection associated with this proposed policy and no changes were proposed to the QIS data collection requirements applicable to QHP issuers.

We seek comment on this proposed impact estimate and assumption.

35. Amendments to Netting Regulations To Include Netting of CMPs (§ 156.1215)

We propose to amend the payment and collections processes set forth at § 156.1215(b) to provide that any CMPs assessed against health insurance issuers for violations of any applicable Exchange standards and requirements or PHSA requirements applicable health insurance issuers, would be subject to netting as part of HHS' integrated monthly payment and collections cycle. We also propose to amend § 156.1215(c) to provide that any amount owed to the Federal Government by an issuer and its affiliates for unpaid CMP amounts, after HHS nets amounts owed by the Federal Government under these program affiliates, would be the basis for calculating the determination of the debt.

We do not believe that the proposed amendments would impose additional costs to HHS beyond costs that are already accounted for as part of the existing payment and collections process. The existing payment and collection process uses netting as one means to collect debts from health insurance issuers. The proposed amendments provide that HHS would utilize the existing process to collect unpaid amounts for CMPs assessed against issuers and their affiliates operating under the same tax identification number that are already subject to netting. This proposal also reduces the number of payments and charges flowing back and forth between HHS and issuers, allowing for more efficient collections.

Therefore, we anticipate this proposal would streamline the payments and collections processes and limit the administrative burden for operating our programs.

We seek comment on these proposed impact estimates and assumptions.

36. Regulatory Review Cost Estimation

Due to the uncertainty involved with accurately quantifying the number of entities that would review the rule, we assume that the mid-point between the total number of unique commenters on the 2026 Payment Notice proposed rule (269) and the number of page views on the **Federal Register** website during the comment period for that rule (15,824) would be the approximate number of reviewers (8,046) of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed last year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons,

we thought that the mid-point of unique commenters and page views would be a fair estimate of the number of reviewers of this rule. We welcome any comments on the approach in estimating the number of entities which would review this proposed rule.

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 seek comments on this assumption.

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.²⁵⁶ Assuming an average reading speed of 250 words per minute, we estimate that it would take approximately 6.54 hours for the staff to review half of this proposed rule. For each entity that reviews the rule, the estimated cost is \$741.77 (6.54 hours × \$113.42). Therefore, we estimate that the total cost of reviewing this regulation is approximately \$5,968,281.42 (\$741.77 × 8,046 reviewers).

We seek comment on these estimates and assumptions.

37. Overall Impact of the Proposed Payment Notice Individual Provisions

In the regulatory impact analysis of this proposed rule, we include impact analyses and estimates for each proposal separately, as we intend for each provision to be severable from the rest. Please see section III.G for a more detailed discussion on the severability of the provisions of this rule. However, we anticipate that the provisions of this proposed 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 proposed rule would likely be less than the simple accumulation of the individual provisions' impact analyses. To the best of our ability, we provide overall impact estimates of these provisions with respect to enrollment, premiums, and APTC, that minimize the overlap of individuals affected.

The baseline starts with internal CMS data of enrollment by month, premiums, and APTCs, we summarize the data using average monthly amounts. These

²⁵⁶ 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.

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. While the expiration of enhanced subsidies is considered in baseline enrollment numbers, it is important to note effectuated enrollment numbers are unavailable at this time.

Based on the analysis presented thus far in this section, we expect average enrollment for 2027 to decrease between 1.2 and 2 million enrollees compared to baseline estimates. Many enrollees will lose coverage due to no longer being eligible for subsidies, and we believe it is likely that healthier enrollees are more likely to discontinue coverage. We have assumed a 2 percent increase in premiums in the scenario where 1.2 million enrollees leave the market and a 3 percent premium increase if 2.0 million enrollees exit the market.

These increases are offset by efforts to improve the health of the risk pool by removing opportunities for adverse

selection with removal of an SEP for those under 150 percent FPL and with adding pre-enrollment SEP verification. With loss of enhanced subsidies and an increase in the member shared responsibility payment, an enrollment option always being available encourages healthier individuals to forgo coverage and wait until they are sick to enroll in an Affordable Care Act plan. These policies help mitigate that risk. We assume a 3 percent premium reduction for removal of the under 150 percent FPL SEP and a 0.5 percent reduction for SEP verification in the 1.2 million enrollment scenario. We assume a 4 percent premium reduction for removal of the under 150 percent FPL SEP and a 0.8 percent reduction for SEP verification in the 2 million enrollment scenario. Overall, after accounting for these premium reductions, rates are expected to be 1.5 percent lower in the 1.2 million enrollment scenario and 1.8 percent lower in the 2 million enrollment scenario compared to the baseline scenario before normal premium trends.

For the 1.2 million enrollment scenario, premium trend is estimated to

increase by 4.5 percent for 2027 and increase at 4 percent the following years. Premium trend is estimated to increase 6 percent for 2027 and 4.5 percent in the following years for the 2 million enrollment scenario. Starting with a 2026 premium PMPM of \$736.36 and applying the adjustments mentioned above, we arrive at estimated premium PMPMs of \$758.45 in the 1.2 million enrollment scenario and \$767.29 in the 2 million enrollment scenario $[736.36 * (1 + 0.045 + 0.02 - 0.03 - 0.005) = 758.45$ and $736.36 * (1 + 0.06 + 0.03 - 0.04 - 0.008) = 767.29]$. We assume APTC PMPMs will be approximately 88.5 percent of premium PMPMs, leading to projected 2027 APTC PMPMs of \$671.23 for the 1.2 million enrollment scenario and \$679.05 for the 2 million enrollment scenario $(758.45 * 0.885 = 671.23$ and $767.29 * 0.885 = 679.05)$.

Future enrollment is expected to shrink by 2.3 percent for 2028 as these policies continue to take full effect. We estimate modest enrollment increases of 0.3 percent for 2029 and 0.03 percent for 2030.

TABLE 26: Overall Enrollment and APTC Impacts – Lower Bound Estimates

1.2 Million Enrollment Decrease Scenario							
	Calendar Year	2026	2027	2028	2029	2030	2026- 2030
Baseline	Total Enrollment (Millions)	17.710	17.729	16.484	16.527	16.532	84.981
	APTC Enrollment (Millions)	15.979	15.957	14.701	14.719	14.711	76.067
	Premium (\$Billions)	156.491	162.599	156.873	164.414	172.577	812.954
	APTC (\$Billions)	124.841	125.785	124.434	128.317	134.514	637.891
NBPP Rule	Total Enrollment (Millions)	17.710	16.529	16.149	16.191	16.196	82.775
	APTC Enrollment (Millions)	15.979	14.877	14.402	14.420	14.412	74.090
	Premium (\$Billions)	156.491	150.436	152.855	159.382	165.813	784.978
	APTC (\$Billions)	124.841	119.830	121.247	124.390	129.241	619.551
Changes	Total Enrollment (Millions)	0.000	-1.200	-0.335	-0.336	-0.336	-2.207
	APTC Enrollment (Millions)	0.000	-1.080	-0.299	-0.299	-0.299	-1.977
	Premium (\$Billions)	0.000	-12.163	-4.017	-5.031	-6.764	-27.976
	APTC (\$Billions)	0.000	-5.955	-3.187	-3.927	-5.272	-18.340

TABLE 27: Overall Enrollment and APTC Impacts – Upper Bound Estimates

2 Million Enrollment Decrease Scenario							
Calendar Year		2026	2027	2028	2029	2030	2026– 2030
Baseline	Total Enrollment (Millions)	17.710	17.729	16.484	16.527	16.532	84.981
	APTC Enrollment (Millions)	15.979	15.957	14.701	14.719	14.711	76.067
	Premium (\$Billions)	156.491	162.599	156.873	164.414	172.577	812.954
	APTC (\$Billions)	124.841	125.785	124.434	128.317	134.514	637.891
NBPP Rule	Total Enrollment (Millions)	17.710	15.729	15.367	15.407	15.412	79.626
	APTC Enrollment (Millions)	15.979	14.157	13.705	13.722	13.715	71.278
	Premium (\$Billions)	156.491	144.823	147.859	154.914	161.940	766.027
	APTC (\$Billions)	124.841	115.359	117.285	120.903	126.222	604.610
Changes	Total Enrollment (Millions)	0.000	-2.000	-1.117	-1.119	-1.120	-5.356
	APTC Enrollment (Millions)	0.000	-1.800	-0.996	-0.997	-0.996	-4.789
	Premium (\$Billions)	0.000	-17.776	-9.013	-9.500	-10.638	-46.927
	APTC (\$Billions)	0.000	-10.426	-7.149	-7.414	-8.292	-33.281

38. Regulatory Impact Considerations Regarding *City of Columbus v. Kennedy*

This proposed rule proposes updates to policies that were previously finalized with an earlier effective date in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074), including § 155.305(f)(4) Failure to File and Reconcile (FTR), § 155.320(c)(3)(iii) Income Verification when Data Sources Indicate Income Less than 100 Percent of the FPL, § 155.320(c)(5) Income Verification When Tax Data is Unavailable, and § 155.420(g) Pre-Enrollment Special Enrollment Period Verification. Although these policies were initially finalized in the 2025 Marketplace Integrity and Affordability final rule with a sunset at the end of PY 2026, they are currently stayed by the court.²⁵⁷

While we cannot postulate on active judicial proceedings, we have considered the regulatory impact if this stay was lifted and these provisions from the 2025 Marketplace Integrity and Affordability final rule became effective. If the stay is lifted in PY 2026, these provisions may become effective in PY 2026, but there still may be an operational delay in effectuating the policies. If the provisions become effective in PY 2026, the regulatory impacts that were estimated in the 2025 Marketplace Integrity and Affordability final rule would be in effect for PY 2026. From PY 2027, the ongoing regulatory impacts that are estimated in this proposed rule would be in effect. Any costs to sunset the provisions that were estimated in the 2025 Marketplace Integrity and Affordability final rule would be nullified if this proposed rule is finalized as proposed because the policies would continue beyond PY 2026. We do not anticipate additional

impacts beyond what has been estimated in the 2025 Marketplace Integrity and Affordability final rule and this proposed rule. If the court stay is lifted after PY 2026 and this rule is finalized as proposed, we do not anticipate additional regulatory impacts from the court decision, as the policies in this proposed rule would be in effect, and we have estimated the regulatory impacts under the relevant provisions in this proposed rule.

Due to the uncertainties mentioned above, we are unable to further quantify the impact regarding the active court proceedings. We seek comment on these proposed estimates and assumptions.

D. Regulatory Alternatives Considered

CMS created a Frequently Asked Questions (FAQ) document to help address the issue of what is considered “taking an action” as it relates to regulatory requirements for creating documentation related to eligibility

²⁵⁷ See *City of Columbus v. Kennedy*, 796 F. Supp. 3d at 170.

application review and consumer consent, as per § 155.220(j)(2)(ii)(A) and (j)(3)(iii)(A), respectively. However, adding this language solely to sub-regulatory guidance, such as an FAQ, would not provide HHS with the necessary enforcement authority when we are reviewing documentation submitted by agents/brokers related to documenting consumer eligibility application requirements and consent documentation. Therefore, it was determined that updating the regulations in § 155.220 was necessary.

When developing the proposal to expand the marketing regulations to improve our enforcement authority related to misleading marketing, we considered creating an FAQ document to notify agents, brokers, and web-brokers of certain prohibited behaviors related to marketing practices. However, adding this language solely to sub-regulatory guidance, such as an FAQ document, would not provide HHS with the necessary enforcement authority when we discover misleading marketing. Therefore, it was determined that updating the regulations in § 155.220 was necessary.

In developing the SEIPM policies contained in this proposed rule (§ 155.1600), we considered the lessons learned while implementing IPPTA. During IPPTA, HHS engaged with 19 State Exchanges to test measurement processes. We considered several data collection options and chose the primary option as that which provides the greatest amount of reliability and flexibility in providing the data that supports the payment decisions and calculations of APTC made by State Exchanges.

In regard to the proposed SEIPM, HHS considered several alternative approaches. For the implementation timeline, HHS considered alternative implementation timelines for SEIPM beyond the proposed January 1, 2027 effective date. Alternatives for extending the implementation timeline to 2028 or 2029 were considered as they would have provided HHS the window to evaluate all of the results from IPPTA as well as afford State Exchanges with additional preparation time. Delaying the implementation beyond 2027 would delay HHS' ability to meet PIIA requirements for comprehensive improper payment measurement across all APTC programs. The proposed January 2027 effective date balances the need for adequate State Exchange preparation time with Federal statutory obligations, particularly given the foundational framework established through the IPPTA with the large bulk of operational processes associated with

collecting information from the State Exchanges being completed. IPPTA will continue through the end of 2026 and we will continue to assess lessons learned for incorporation into the SEIPM implementation.

For the data collection requirements, HHS evaluated alternate approaches that would have required more limited data submissions from State Exchanges. One alternative considered was limiting data collection to only basic enrollment and payment information, which would have reduced State Exchange burden but would not have provided sufficient detail to conduct comprehensive improper payment reviews that meet PIIA standards. For sampling methodology, HHS considered alternative approaches to the proposed stratified random sampling methodology. One alternative considered was using a simple random sampling approach without stratification, which would have been easier to implement but would have been less efficient in detecting errors and would have required larger sample sizes to achieve the same level of statistical precision. HHS also considered implementing a static sample size approach that would have applied the same sample size across all State Exchanges regardless of their APTC volume or operational characteristics. While this approach would have simplified program administration and ensured consistent measurement effort across all participating Exchanges, it would have resulted in imprecise estimates for smaller State Exchanges and inefficient resource allocation for larger Exchanges, failing to optimize statistical precision relative to program risk and Federal investment. HHS also evaluated implementing more prescriptive enforcement mechanisms with automatic penalties for noncompliance but determined that the proposed graduated enforcement approach with due process protections and opportunities for corrective action better supports the collaborative relationship necessary for successful program implementation while maintaining appropriate accountability for State Exchange compliance with Federal oversight requirements.

Finally, in considering the proposed SEIPM, we evaluated the option of publishing individual rates for each SBE, rather than an aggregate rate for all State Exchanges. Achieving an appropriate level of precision (that is, a margin of error less than ± 5 percent) for such an approach, however, would require doubling the sample sizes used which would incur an additional \$25

million Federal and \$1.5 million State cost annually. Therefore, we did not adopt this approach.

In considering proposed modifications to the programmatic audit requirements under § 155.1200(c), HHS evaluated several alternatives. These included maintaining the existing audit requirement for State Exchanges that complete the SEIPM for a given benefit year, as well as allowing SEIPM to fully satisfy the audit requirement under § 155.1200. Maintaining the current audit requirement would have resulted in duplicative reviews and increased administrative burden for State Exchanges, while allowing SEIPM to replace the audit entirely would have reduced the comprehensiveness of oversight currently provided.

In developing this proposal to require issuers that make plan-level adjustments to account for unreimbursed CSRs to submit specified CSR data elements in the URRT and Actuarial Memorandum, HHS considered several alternative approaches. One alternative considered was to maintain the current policy as outlined in the 2025 Rate Filing Guidance, which would have continued to rely on reporting of CSR-related information in the Actuarial Memorandum without adding explicit URRT fields. However, this approach would not have achieved the policy goal of ensuring consistency and comparability across issuers and States in the reporting of CSR load methodologies and amounts. HHS also considered permitting issuers to use alternative or simplified methodologies for estimating CSR amounts paid on behalf of enrollees, leveraging existing internal calculations that may vary by issuer. While this approach could have reduced issuer burden, it would have resulted in inconsistent data and limited the ability of State and Federal regulators to assess whether CSR load adjustments are actuarially justified. Finally, HHS considered not requiring submission of CSR data at all, leaving such determinations entirely to State review processes. However, this would not have provided HHS and State regulators with standardized, plan-level information needed to ensure transparency and regulatory oversight of CSR loading practices. The proposed approach—requiring consistent data reporting through the URRT and Actuarial Memorandum using the standard methodology under § 156.430(c)(2)—balances the need for improved data comparability and regulatory oversight with the goal of minimizing additional issuer burden by leveraging existing data and familiar calculation methodologies.

We considered maintaining the vendor program, which would allow the opportunity for approved third-party vendors to facilitate agent and broker annual registration and training in addition to having the training and registration process available through the CMS Marketplace Learning Management System (MLMS), but determined the proposed benefits of terminating the vendor program outweighs the costs of maintaining the existing policy with both programs. As such, we did not consider other regulatory alternatives, as removing § 155.222, which would allow HHS to sunset the vendor program, would maintain agent and broker accessibility to training and registration while reducing costs.

We considered a range of regulatory alternatives for the proposal to discontinue the full suite of standardized plan options policies effective beginning in PY 2027. Under the current proposal, we propose to remove the following from our regulations: the definition of “standardized option” at § 155.20; all requirements pertaining to standardized plan options at § 156.201 (the requirements for FFE and SBE-FP QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one another at paragraph (c)); the differential display of standardized plan options on *HealthCare.gov* at § 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE-FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv), and non-standardized plan option limits and exceptions at § 156.202. Finally, we propose to cease the annual design and publication of these plans in the applicable Payment Notice rulemaking for each plan year.

That said, we considered several regulatory alternatives that could potentially allow us to achieve the same goals of simplifying the plan selection process and reducing burden without discontinuing this suite of policies in its entirety. In particular, we considered continuing to require issuers to offer standardized plan options but only at particular metal levels, such as the bronze and silver metal levels (instead of at every metal level at which they offer non-standardized plan options). We also considered requiring issuers to offer standardized plan options only in certain service areas in which they offer a certain number of non-standardized

plan options. We also considered transitioning from requiring issuers to offer these standardized plan options to once more allowing issuers to voluntarily offer them—as was the approach with the previous iteration of the policy—while we continue to maintain the differential display of these plans on *HealthCare.gov* and the DE pathways. We also considered resuming a revised version of the meaningful difference standard, which was previously codified at § 156.298.

However, based on our experience administering this suite of policies from PY 2023 through PY 2025, we have determined that this suite of policies has failed to meaningfully enhance the consumer experience, increase consumer understanding, and simplify the plan selection process—our originally articulated objectives. Furthermore, imposing these requirements has increased burden for both issuers and HHS (for example, by requiring issuers to create and submit certification applications for additional plans), impeded issuer innovation in plan design, unnecessarily constrained consumer choice, and caused significant market disruption.

Additionally, based on our experience administering the previous iteration of this suite of policies from PY 2017 through 2019 (when standardized plan options were voluntary and when there was no non-standardized plan option limit), we do not believe it would be an effective approach to once more revert to making it voluntary for issuers to offer these plans. This is primarily because when there was no requirement for issuers to offer these plans, few issuers chose to offer them, and fewer consumers chose to enroll in them.

Furthermore, we do not believe HHS is positioned to impose a “one size fits all” approach standardized plan option designs for an environment as heterogeneous as the FFEs (such as in terms of consumer demographics, health care needs, and preferences). We refer readers to the preamble section for the proposal to discontinue standardized plan options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv)) for a detailed discussion of relevant literature we considered in our proposal to discontinue the full suite of standardized plan option limits policies.

Finally, given that we previously discontinued standardized plan options at a time when the individual market was considered to be at risk of destabilization, and given that there are a range of substantive changes in the present environment, we believe that

now is not an appropriate time to once again add to that complexity.

We considered making the provisions requiring income verification when tax data is unavailable and income verification when trusted data sources indicate income less than 100 percent of the FPL optional for State Exchanges that demonstrate improper payment rates (that is, SEIPM) below the Federal rate (that is, FEIPM). Under the current proposal, we propose to impose these requirements on all Exchanges starting in PY 2027. We considered this regulatory alternative in light of the fact that some analysis²⁵⁸ has shown that erroneous or improper enrollments are less widespread in State Exchanges than in Exchanges on the Federal platform and due to the significant annual administrative costs (that is, a combined \$75 million annually) that would be incurred by States in implementing these provisions. Under this regulatory alternative these provisions would be optional for State Exchanges so long as they maintained a SEIPM below the FEIPM in any given year. If a State Exchange’s SEIPM meets or exceeds the FEIPM in any year then, under this regulatory alternative, these integrity provisions would be imposed on that State Exchange in the subsequent year and would remain in effect unless the State Exchange demonstrated a SEIPM below the FEIPM for three subsequent consecutive years (at which point these provisions would revert to being optional for the State Exchange). While this approach could strike a balance between the need to safeguard program integrity and mitigate administrative costs, the SEIPM will not be fully implemented until at least PY 2029. Additionally, we note that implementation of this regulatory alternative would be administratively burdensome and would require a doubling of sample sizes (resulting in an additional \$25 million Federal and \$1.5 million State costs annually) to ensure a sufficiently precise margin of error. Since this regulatory alternative would significantly delay implementation of these vital program integrity measures, would impose additional administrative cost and complexity, and would fail to fully address known program integrity issues, it was determined that to impose these requirements on all Exchanges starting in PY 2027.

E. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small

²⁵⁸ See, for example, Table 14 of the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability final rule.

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. Individuals and States are not included in the definition of a “small entity.”

1. Legislative and Regulatory Overview

Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) added a new title XXVII to the PHS Act to establish various reforms to the group and individual health insurance markets. These provisions of the PHS Act were later augmented by other laws, including the Affordable Care Act. Subtitles A and C of title I of the Affordable Care Act reorganized, amended, and added to the provisions of part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. The term “group health plan” includes both insured and self-insured group health plans. For summarized sections of the PHS Act and Affordable Care Act, please see section II.A of this proposed rule.

These proposed provisions revise current regulations, and HHS does not anticipate any duplication, overlap, or conflict with other rules and regulations associated with these rules.

2. Need for Regulatory Action and Objectives

For the purposes of the RFA, we believe the following provisions could impact smaller agent, broker, and web broker firms.

a. Mandating the HHS-Approved and -Created Consumer Consent Form—Eligibility Application Review and Documenting Receipt of Consumer Consent (§ 155.220(j))

We propose amendments to §§ 155.220(j)(2)(ii)(A) and (j)(2)(iii)(A) to require agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review requirements and consent documentation requirements. Our proposal would eliminate the current broad allowances for meeting these requirements. The language in the regulation would also be changed to clarify what types of actions constitute “taking an action” to meet the regulatory requirements. The goal of this policy is to reduce confusion among

agents, brokers, and web-brokers on what constitutes compliant eligibility application review documentation and what constitutes compliant consumer consent by ensuring objective standards, which protects consumers ultimately. These proposals also greatly improve HHS’ investigative abilities into agent, broker, and web-broker eligibility application review and consumer consent review by creating a clear and objective standard for all applications clearly outlining what HHS deems complaint. More information about this provision is available in section VI.C.8 of this proposed rule.

b. Misleading Marketing (§ 155.220(j)(3))

The proposed regulatory amendments would create a new standards of conduct section in § 155.220(j) describing marketing requirements. These requirements would list certain prohibited practices, provide HHS audit authority, and put agents, brokers, and web-brokers on notice that they are responsible for marketing created by their downstream entities. This proposal would allow HHS to increase its efforts to engage in compliance actions for misleading marketing by providing agents, brokers, and web-brokers notice of the types of activities that are prohibited, allowing HHS to review marketing materials for compliance, and ensure agents, brokers, and web-brokers are not able to push responsibility to third-parties. Creating a marketing standards of conduct section is necessary to protect consumers and maintain the integrity of the Exchanges. More information about this provision is available at section VI.C.9 of this proposed rule.

For the purposes of the RFA, we believe the following provisions could impact smaller insurers.

c. Submission of Rate Filing Justification (§ 154.215)

The proposed rule would require issuers to report actual CSR amounts paid in the Market Experience section (2 years prior, using the standard methodology), projected CSR amounts in the current filing year in the Projections section, and CSR load factors in a new dedicated line item, among other proposed requirements. Issuers would also be required to provide an explanation of how these data points were used to determine the CSR load as part of the Actuarial Memorandum.

The proposed provisions would primarily affect health insurance issuers offering qualified health plans in the individual market, Federal and State regulators in their review capacity, and

indirectly, Marketplace enrollees who receive cost-sharing reductions. The enhanced CSR reporting would enable issuers to more accurately determine their CSR payment amounts and improve future projections for rate setting. This could result in more appropriate premium levels if current CSR load factors are inaccurate or unreasonable, enabling issuers to better calibrate their load factors to adequately cover actual CSR costs, potentially leading to more stable and accurate premium pricing over time. More information is available at section VI.C.3 of this proposed rule.

d. Amendments To Strengthen HHS’ Oversight of the Administration of the Advanced Payments of the Premium Tax Credit, Cost-Sharing Reductions, and User Fee Programs and Clarifying HHS’ Compliance Review Authority (§ 156.480)

We propose to modify § 156.480 to clarify HHS’ authority to audit or conduct a compliance review to assess issuers’ compliance with requirements related to the APTC, CSR, and user fee programs. Specifically, we propose clarifying that under § 156.480(c), HHS or its designee may audit or conduct a compliance review to assess compliance with all requirements related to APTC, CSR, and user fee programs applicable to issuers offering a QHP in an Exchange. For consistency, we also propose to make conforming changes to § 156.480(c)(6) to provide that in instances where HHS enforces compliance with any requirements related to APTC, CSR, and user fee programs with respect to QHP issuers participating in State Exchanges or SBE-FPs, HHS may do so in accordance with § 156.805. We also propose clarifying that the compliance review authority in § 156.480(c) allows for compliance reviews as needed or on an annual basis. More information about this provision is available at section VI.C.31 of this proposed rule.

3. Number of Affected Small Entities

For purposes of the RFA, we believe that health insurance issuers and group health plans would be classified under the North American Industry Classification System (NAICS) code 524114 (Direct Health and Medical Insurance Carriers) or possibly be classified in 621491 (HMO Medical Centers). Based on latest available Statistics of U.S. Businesses (SUSB) data, 1,071 and 146 total firms fall under NAIC codes 524114 and 621491,

respectively.²⁵⁹ According to SBA size standards, entities with average annual receipts of \$47 million or less would be considered small entities for NAICS code 524114 and \$44.5 million or less for NAICS code 621491.²⁶⁰ However, 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) 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.²⁶¹ Furthermore, it should be noted 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.²⁶² Therefore, 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 seek comment on these estimates.

For purposes of the RFA, the Departments consider agents, brokers, and web brokers classified under NAICS code 524210 (Insurance Agencies and Brokerages) that have annual receipts of \$15 million or less to be small entities. According to the 2022 Statistics of U.S. Businesses data²⁶³, there are 120,434 firms in the Insurance Agencies and Brokerages industry, of which 119,114, or approximately 99 percent, had annual receipts below the \$15 million size standard. Nearly all agents, brokers, and web brokers affected by this

proposed rule would therefore be small entities.²⁶⁴

4. Regulatory Impacts and Alternatives

For the purposes of this RFA, the costs per agent, broker, and web broker summarized in sections VI.C.8 and VI.C.9 are expected to be representative of the average costs that would be incurred by small agents, brokers, and web brokers to comply with the provisions in this proposed rule. We outline those proposed assumptions and estimates later in this section.

Regarding the costs related to requiring small agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review documentation requirements and the consumer consent documentation requirements, we estimate it would take approximately 10 minutes of time for an enrolling agent, broker or web-broker to meet eligibility application review documentation requirements and to obtain consumer, or their authorized representative, affirmation of their consent. Using the current adjusted hourly wage rate of \$58.04²⁶⁵ for an insurance sales agent, each enrollment using the HHS-approved and -created consumer consent form would have approximately \$9.87 (10 minutes, or 0.17 hours, at an hourly wage rate of \$58.04) in additional cost associated with it based on the extra time commitment from these proposed policy changes. The total cost for small agents, brokers, and web-brokers would be contingent on the number of policies enrolled by each small firm, with the upper bound estimate being 9.8 million policies estimated for all agents, brokers, and web brokers regardless of firm size. Please see sections IV.C and VI.C.8 of this proposed rule for more information.

As stated in IV.D of this proposed rule, we do not anticipate many costs for the agents, brokers, or web-brokers we investigate for misleading marketing. We believe responding to HHS requests to provide confirmation they removed the ads and/or reviewed the marketing guidelines would not be overly time-consuming or burdensome. Our notifications to the agents, brokers, or web-brokers detail what response is required and provide hyperlinks to the noncompliant ad(s). We estimate it would take each agent, broker, or web-

broker one hour to remove any noncompliant ad(s), and/or review the marketing guidelines, and respond to HHS via email. This estimate incorporates the potential of HHS asking these agents, brokers, and web-brokers to provide advertisements for HHS' review. Using the hourly wage rate for an insurance sales agent from Table 12 in section IV.A of this proposed rule (\$58.04), the cost of responding to HHS would be \$58.04 per response. The total cost for small agents, brokers, and web-brokers would be contingent on the number of responses from these smaller firms, with the upper bound estimate being 24 responses estimated for all agents, brokers, and web brokers regardless of firm size. Please see sections IV.D and VI.C.9 of this proposed rule for more information.

For the purposes of this RFA, the costs per issuer summarized in sections VI.C.3 and VI.C.31 of this proposed rule are expected to be representative of the average costs that would be incurred by small issuers to comply with the provisions in this proposed rule. We outline those proposed assumptions and estimates later in this section.

As discussed in section III.C of this proposed rule, this rule proposes to change the instructions for the URRT so that issuers would enter the actual amount of CSRs they paid for enrollees (2 years prior), the amount of CSRs they expect to provide to enrollees, and add a new field to gather the "load amount." Issuers would incur ongoing burden to gather the three required values and enter them into the URRT in their appropriate places. The annual cost and burden per issuer to update and run the standard methodology calculations is \$572,118 at 5,700 hours. The annual cost and burden per issuer to provide CSR related information in the URRT is \$429.47 at 3.6 hours. The annual cost and burden per issuer to provide CSR calculation explanations in the Actuarial Memorandum is \$1,718.27 at 14.2 hours. The total annual ongoing cost for 16 small issuers is \$9,188,251.84 at 91,488 hours. We estimate that each issuer would incur an initial one-time cost of \$1,114,236 at 11,400 burden hours in 2026 to develop and implement a claim-level re-adjudication process using the standard methodology set forth in § 156.430 to produce the required values, which totals \$17,827,776 at 182,400 for 16 small issuers. Please see sections IV.B and VI.C.3 of this proposed rule for more information.

In regard to modifying § 156.480 to clarify HHS' authority to audit or conduct a compliance review to assess issuers' compliance with requirements

²⁵⁹ United States Census Bureau. (April 2025). *2022 SUB Annual Data Tables by Establishment Industry*. <https://www.census.gov/data/tables/2022/econ/susb/2022-susb-annual.html>.

²⁶⁰ SBA. (n.d.). *Table of size standards*. <https://www.sba.gov/document/support-table-size-standards>.

²⁶¹ CMS. (n.d.). *Medical Loss Ratio Data and System Resources*. <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

²⁶² Based on internal calculations. Source: CMS, Medical Loss Ratio Data and System Resources, available at: <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

²⁶³ U.S. Census Bureau (April 2025). *2022 SUB Annual Data Tables by Establishment Industry, Data by Enterprise Receipts Size*. <https://www.census.gov/data/tables/2022/econ/susb/2022-susb-annual.html>.

²⁶⁴ Previously, in 86 FR 51730, 51756, the Departments noted that a total of 55,541 agents and brokers work with issuers.

²⁶⁵ See the 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.

related to the APTC, CSR, and user fee programs, we estimate that the audits that we would conduct under this authority would not impose additional costs beyond what is already accounted for in the audit review process (86 FR 24140, 24281). We estimate that it would take a business operations specialist 10 hours (at a rate of \$44.41 per hour) to compile and submit data and other information necessary for a compliance review. We estimate it would take a compliance officer (at a rate of \$40.86 per hour) 4 hours to review and sign off on the submission. The cost per issuer to develop and submit the compliance information would be approximately \$607.54. The total cost for small issuers is contingent on the number of small issuers selected for a compliance review each year (out of the 150 estimated regardless of firm size in section VI.C.31 of this proposed rule). Please see section VI.C.31 of this proposed rule for more information. We anticipate small issuers could be impacted by other provisions in this proposed rule. However, 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 would not be a significant change in revenue for issuers as a reduction in APTC payments would mean consumers would be responsible for the balance of the premium not covered by APTC. Yet, we also acknowledge that due to the reductions in enrollment anticipated to result from the policies in this proposed rule, including the potential reduction in APTC to consumers resulting in increased premiums and choose not to maintain coverage due to affordability constraints, 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.

The data and conclusions presented in this section, along with the rest of the RIA, amount to our initial regulatory flexibility analysis under the RFA.

We seek comment on the proposed estimates and assumptions.

As discussed in section VI.C.36 of this proposed rule, we anticipate that entities such as issuers, including small issuers and agents/brokers, would face regulatory review costs as a result of needing to familiarize themselves with this proposed rule. The cost per entity to review this proposed rule is estimated to be \$741.77. The total cost

for 16 small issuers to review this rule is estimated to be \$11,868.32. We anticipate that agents, brokers, and web brokers would also incur costs to review this proposed rule, however, we do not have reliable data on the number of agents, brokers, and web brokers that would review this rule and therefore do not estimate the total burden for these entities. We seek comment on the number of agents, brokers, and web brokers that may review this rule and the associated costs.

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

5. Impact on Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. While this proposed rule is not subject to section 1102 of the Act, we have determined that this rule would not affect small rural hospitals. Therefore, we anticipate this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

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 this proposed rule would not impose a mandate that would result in the expenditure by State, local, and Tribal Governments, in the aggregate, or by the private sector, of more than \$187 million in any 1 year.

G. 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 E.O. 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 proposed 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 E.O. 13132.

Because States have flexibility in designing their Exchange and Exchange-related programs, State decisions would ultimately influence both administrative expenses and overall premiums. States are not required to establish an Exchange or risk adjustment program. 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, while this proposed rule will not impose substantial direct requirement costs on State and local governments, 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 coverage that is offered in the individual and small group markets.

We have examined the federalism implications involved in proposing to revise § 155.170(a) to provide that any State-required benefits would be considered "in addition to EHB" (and thus not an EHB) if they are: required by a State action taking place after December 31, 2011; applicable to the small group and/or individual markets; specific to required care, treatment, or services; and not required by State action for purposes of compliance with Federal requirements. While developing this proposal, we considered our longstanding engagement with States regarding their benefit mandates and the operation and impact of the statutory defrayal requirement, including discussions with State insurance

officials over time about how State mandates affect affordability and Federal and State financial impacts. In developing this proposal, we sought to balance States' interests in regulating health insurance issuers with the need to promote market stability and affordability, and we believe this approach appropriately respects State authority while advancing the objectives of the Affordable Care Act. If finalized, we expect that there would be increased costs to any States that would have to defray the cost of benefits that would be considered "in addition to EHB".

In addition, we believe this proposed rule does have Federalism implications due to system and operation costs associated with requiring the four State Exchanges that process their own hardship exemptions to process the additional hardship exemptions expected due to the amendment to § 155.605(d)(1) in this proposed rule. However, the Federalism implications are mitigated as this proposed rule would not preempt state law, as it provides states with flexibility to either process hardship exemptions themselves or delegate this function to HHS under existing regulatory provisions at § 155.605(d), thereby avoiding any Federalism implications that would trigger the requirements of Executive Order 13132.

Additionally, in this proposed rule, HHS proposes new State flexibilities for provider access reviews and/or ECP certification reviews, which have federalism implications for FFE States, including States performing plan management. Specifically, CMS proposes that FFE States may elect to conduct their own provider access reviews and/or ECP certification reviews of issuers' plans, with or without a provider network, that apply for QHP certification to be offered through an FFE (including States that perform plan management), provided that CMS determines the State has sufficient authority and the technical capacity to conduct such reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program for provider access certification reviews, and/or an Effective ECP Review Program for ECP certification reviews. An FFE State would have the choice to elect to conduct their own provider access certification reviews, ECP certification reviews, or both reviews provided the FFE State satisfies the applicable criteria for each effective review program it wishes to administer. For additional detailed information on the federalism

impacts of these proposals, please reference the discussions in sections VI.C.19 for Modification of Exchange Network Adequacy Standards, VI.C.28. for Provider Access Standards for Network Plans, and VI.C.29. Essential Community Provider Standards of this proposed rule.

Additionally, we believe this proposed rule also has Federalism implications for both policies related to income verification in cases where a consumer attests to an income at or above 100 percent of the FPL but the IRS returns data below 100 percent of the FPL as well as in cases where the IRS returns no income data for a household. Specifically, states will incur one-time implementation costs as well as annual operating costs for the policies, and, in the case of the Under 100 percent FPL policy, requiring State Exchanges to set continue the income verification when IRS returns data below 100 percent of the FPL but households attest to income at or above 100 percent of the FPL. However, this is mitigated by no longer requiring Exchanges to accept attestations in cases where the IRS returns no income for a household. Additionally, the Federalism implications are mitigated by the benefits to ensuring Marketplace stability, particularly through addressing continued potential fraud.

We also believe this proposed rule has Federalism implications for the amendment of the failure to file and reconcile policy at § 155.305(f)(4) in this proposed rule. Specifically, States will incur one-time implementation costs as well as annual operating costs for their failure to file and reconcile policies. Federalism implications are mitigated by the benefits to the Marketplace by removing unauthorized enrollments and lessening the potential for consumers to generate potentially large tax liabilities.

Executive Order 14192, entitled "Unleashing Prosperity Through Deregulation" was issued on January 31, 2025, and requires that "any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations." This proposed rule, if finalized as proposed, is expected to be exempt from otherwise-applicable requirements under E.O. 14192, per footnote 1 of OMB's Accounting Methods.²⁶⁶

²⁶⁶ See Accounting Methods under Executive Order 14192. https://www.reginfo.gov/public/pdf/eo14192/Accounting_Methods_under_EO_14192.pdf.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on February 5, 2026.

List of Subjects

42 CFR Part 600

Administrative practice and procedure, Health care, Health insurance, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 150

Administrative practice and procedure, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interests, Consumer protection, Eligibility criteria, Exemptions, Grants administration, Grant programs—health, 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, Technical assistance, Women and 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, the Department of Health and Human Services and the Centers for Medicare & Medicaid Services propose to amend 42 CFR part 600 and 45 CFR subtitle A, subchapter B, as set forth below.

Title 42

PART 600—ADMINISTRATION, ELIGIBILITY, ESSENTIAL HEALTH BENEFITS, PERFORMANCE STANDARDS, SERVICE DELIVERY REQUIREMENTS, PREMIUM AND COST SHARING, ALLOTMENTS, AND RECONCILIATION

■ 1. The authority citation for part 600 continues to read as follows:

Authority: Section 1331 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148, 124 Stat. 119), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, 124 Stat. 1029).

■ 2. Section 600.5 is amended by adding the definition of “Eligible noncitizen” in alphabetical order as follows:

§ 600.5 Definitions and use of terms.

Eligible noncitizen has the meaning given in 45 CFR 155.20.

Title 45

PART 150—CMS ENFORCEMENT IN GROUP AND INDIVIDUAL INSURANCE MARKETS

■ 3. The authority citation for part 150 continues to read as follows:

Authority: 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92, as amended.

■ 4. Section 150.317 is amended by revising the introductory text to read as follows:

§ 150.317 Factors CMS uses to determine the amount of penalty.

In determining the amount of any civil money penalty, CMS will identify the lawful purpose or purposes of the penalty, and take into account the following factors as appropriate to the circumstances of the case:

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

■ 5. 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.

■ 6. Section 155.20 is amended by—
 ■ a. Adding the definition “Eligible noncitizen” in alphabetical order; and
 ■ b. Removing the definition “Standardized option”.

The addition reads as follows:

§ 155.20 Definitions.

Eligible noncitizen means an “eligible alien,” as defined in 26 U.S.C. 36B(e)(2)(B).

§ 155.105 [Amended]

■ 7. Section 155.105 is amended by removing paragraph (b)(4).

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

§ 155.106 Election to operate an Exchange after 2014.

(a) * * *
 (2) Submit an Exchange Blueprint application for HHS approval at least 15 months prior to the date on which the Exchange proposes to begin open enrollment as a State Exchange.

(i) *Public notice.* Upon submission of an Exchange Blueprint application to operate a State Exchange, the State shall issue a public notice of its Exchange Blueprint application submission through its website and include a copy of the Exchange Blueprint application, a description of the Plan Year for which the State seeks to transition to a State Exchange, language indicating that the State is seeking approval from HHS to transition to a State Exchange, and information about when and where the State will conduct public engagements regarding the State’s Exchange Blueprint application, as described in paragraph (a)(2)(ii) of this section.

(ii) *Public engagements.* After a State issues its public notice as described in paragraph (a)(2)(i) of this section and until HHS approves, or conditionally approves, the State’s Exchange Blueprint application, a State must conduct at least one public engagement (such as a townhall meeting or public hearing) either in-person or virtually, regarding the State’s Exchange Blueprint application progress, in a timeline and manner considered effective by the State and with HHS’ concurrence. A State shall provide public notice of the public engagement. Such public engagement shall also provide interested parties the opportunity to learn about the State’s progress in transitioning to a State Exchange and offer input on that transition. Following the initial public engagement described in this paragraph and until HHS approves or conditionally approves the State Exchange Blueprint application, a State shall conduct periodic public engagements, either in-person or virtually, in a timeframe and manner considered effective by the State.

■ 9. Section 155.170 is amended by revising paragraphs (a)(1) and (2) to read as follows:

§ 155.170 Additional required benefits.

(a) * * *
 (1) A State may require a QHP to cover benefits in addition to the essential health benefits, which are any State-required benefits that are:
 (i) Required by a State action taking place after December 31, 2011;
 (ii) Applicable to the small group and/or individual markets;
 (iii) Specific to required care, treatment, or services; and
 (iv) Not required by State action for purposes of compliance with Federal requirements.

(2) A State must make payments in accordance with paragraph (b) of this section to defray the cost of any State-required benefits in addition to the EHB.

■ 10. Section 155.205 is amended by revising paragraphs (b)(1) introductory text, and (b)(4) and (5) to read as follows:

§ 155.205 Consumer assistance tools and programs of an Exchange.

(b) * * *
 (1) Provides standardized comparative information on each available QHP and at a minimum includes:

(4)(i) Allows for an individual seeking coverage to submit an approved single streamlined eligibility application to the Exchange, in accordance with § 155.405(b), and allows for the Exchange to make all determinations of eligibility for enrollment in a QHP and insurance affordability programs, in accordance with subpart D of this part.

(ii) As an alternative to paragraph (4)(i) of this section, allows a non-Exchange web-broker entity to implement and operate a consumer website that allows an individual seeking coverage to submit an approved single streamlined eligibility application, in accordance with § 155.405(b), on the non-Exchange web-broker consumer website. Such non-Exchange web-broker websites must interface with the State Exchange to transmit eligibility application information such that the State Exchange may make determinations of eligibility for enrollment in a QHP and insurance affordability programs and communicate such eligibility determinations to applicants.

(iii) If the Exchange is a State-based Exchange on the Federal platform, directs an individual seeking coverage to submit a single streamlined eligibility

application through the Federal eligibility and enrollment platform.

(5)(i) Allows a qualified individual to select a QHP, and allows the Exchange to maintain records of all enrollments in the QHPs offered by the Exchange, in accordance with subpart E of this part.

(ii) As an alternative to paragraph (5)(i) of this section, a State Exchange may allow a non-Exchange web-broker entity to implement and operate a consumer website that allows an individual to select and enroll in a QHP on the web-broker's consumer website. Such non-Exchange web-broker websites must interface with the State Exchange to transmit individual QHP plan selection and enrollment information to the State Exchange so that the State Exchange is able to fulfill its requirement to maintain records of all enrollments in the QHPs offered by the State Exchange and meet all other applicable requirements under subpart E of this part.

(iii) If the Exchange is a State-based Exchange on the Federal platform, directs an individual seeking coverage to select a QHP through the Federal eligibility and enrollment platform.

* * * * *

■ 11. Section 155.220 is amended by—

- a. Removing paragraph (c)(3)(i)(H);
- b. Redesignating paragraphs (c)(3)(i)(I) through (M) as paragraphs (c)(3)(i)(H) through (L), respectively;
- c. Revising paragraph (j)(2)(i);
- d. Revising paragraph (j)(2)(ii)(A) introductory text;
- e. Redesignating paragraph (j)(2)(ii)(A)(2) as paragraph (j)(2)(ii)(A)(3);
- f. Adding new paragraph (j)(2)(ii)(A)(2);
- g. Revising paragraph (j)(2)(iii)(A);
- h. Redesignating paragraph (j)(2)(iii)(C) as paragraph (j)(2)(iii)(D);
- i. Adding new paragraph (j)(2)(iii)(C);
- j. Redesignating paragraph (j)(3) as paragraph (j)(4); and
- k. Adding new paragraph (j)(3).

The revisions and additions 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.

* * * * *

(j) * * *

(2) * * *

(i) Provide consumers with correct information, without omission of material fact, regarding the Federally-facilitated Exchanges, QHPs offered through the Federally-facilitated Exchanges, and insurance affordability programs, and refrain from conduct that is misleading (including by having a

direct enrollment website that HHS determines could mislead a consumer into believing they are visiting *HealthCare.gov*), coercive, or discriminates based on race, color, national origin, disability, age, or sex;

(ii) * * *

(A) Documenting that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or the consumer's authorized representative is effectuated by having the consumer or the consumer's authorized representative take an action to execute the HHS-approved and -created consumer consent form.

* * * * *

(2) The action the consumer or the consumer's authorized representative took to confirm the eligibility application information has been reviewed and confirmed to be accurate must be clear to HHS on the face of the documentation. This may include a hand-written or electronic written signature or initials, an email from the consumer, a recorded verbal conversation, or other means. A signature that is simply typed on the documentation or a filled-in check box does not clearly indicate the eligibility application information was reviewed and confirmed accurate by the consumer or the consumer's authorized representative.

* * * * *

(iii) * * *

(A) Obtaining and documenting the receipt of consent is effectuated by having the consumer or the consumer's authorized representative take an action to execute the HHS-approved and -created consumer consent form.

* * * * *

(C) The action the consumer or the consumer's authorized representative took to provide consent must be clear to HHS on the face of the documentation. This may include a hand-written or electronic written signature or initials, an email from the consumer, a recorded verbal conversation, or other means. A signature that is simply typed on the documentation or a filled-in check-box does not properly indicate consent was provided by the consumer or the consumer's authorized representative.

* * * * *

(3) Marketing Requirements. An individual or entity described in paragraph (j)(1) of this section must additionally:

- (i) Comply with the standards of conduct under § 155.220(j)(2); and
- (ii) Provide consumers with correct information, without omission of material fact, regarding the Federally-

facilitated Exchanges, QHPs offered through the Federally-facilitated Exchanges, and insurance affordability programs, and refrain from marketing that is misleading, materially inaccurate, coercive, or discriminates based on race, color, national origin, disability, age, or sex.

(iii) Examples of prohibited misleading marketing practices agents, brokers, and web-brokers may not include in their marketing of FFE plans include, but are not limited to:

(A) Providing cash, monetary rebates, gift cards, travel vouchers, or cash equivalents as an inducement for enrollment or otherwise.

(B) Offering gifts to consumers, unless the gifts are of nominal value, are offered to similarly situated consumers without regard to whether or not the consumers enroll, and are not in the form of cash or cash equivalents.

(C) Falsely asserting or suggesting that consumers will always qualify for zero-dollar insurance/zero-dollar premiums.

(D) Falsely using identical or facsimiles of government or other official logos and notations.

(E) Miscommunicating enrollment timelines and deadlines.

(F) Misconstruing legislation, regulations, or Executive Orders, including listing fake or incorrect references or citations.

(G) Utilizing the image or likeness and/or utilize a quote from a notable figure, such as a celebrity or politician, in an advertisement claiming that figure has endorsed you or your agency when that endorsement is not truthful.

(iv) An individual or entity described in paragraph (j)(1) of this section must produce any marketing material upon request, within the specified timeframe HHS mandates, in response to monitoring, audit, and enforcement activities conducted consistent with paragraphs (c)(5), (g), (h), and (k) of this section.

(v) An individual or entity described in paragraph (j)(1) of this section is responsible to ensure that all marketing-related materials created, written, released, or otherwise produced by the individual or entity or on their behalf adhere to the requirements of § 155.220(j)(3)(ii)–(iii), and to make all such marketing-related materials available upon request in accordance with § 155.220(j)(3)(iv) of this section.

* * * * *

■ 12. Section 155.221 is amended by adding paragraph (k) to read as follows:

§ 155.221 Standards for direct enrollment entities and for third parties to perform audits of direct enrollment entities.

* * * * *

(k) *Direct Enrollment Option for a State Exchange.* Subject to HHS approval, and in lieu of the Exchange operating its own consumer-facing eligibility application and enrollment website, a State may elect for the State Exchange to select one or more web-brokers described in paragraph (a)(2) of this section to make available a non-Exchange online website to enroll qualified individuals in a QHP offered through the Exchange in the State in a manner that constitutes enrollment through the Exchange, as specified in paragraph (k) of this section. A newly transitioning or approved State Exchange that wishes to implement this option must submit an Exchange Blueprint, or a Blueprint revision, at least 15 months prior to the date on which the State Exchange pursuing this option proposes to begin open enrollment using this option, after which HHS would have up to 90 days to review and render a decision to approve or deny the Blueprint, and in accordance with § 155.105(b) and (e), and § 155.106(a). HHS will approve a State Exchange to make available a non-Exchange online website to enroll qualified individuals in a QHP offered through the Exchange, as described in this paragraph only if the State Exchange:

(1) Demonstrates to HHS operational readiness for the State Exchange to enroll qualified individuals in a QHP through approved direct enrollment entity websites in a manner that constitutes enrollment through the Exchange, including enabling individuals to apply for, and receive eligibility determinations for, QHP enrollment and advance payments of the premium tax credit and cost-sharing reductions, as well as receive assessments or determinations of Medicaid and CHIP eligibility from the Exchange as described in § 155.302, using the eligibility application described in § 155.405;

(2) Provides HHS with an implementation plan and timeline that details the key activities, milestones, and communication and outreach strategy to support the transition of enrollment operations to direct enrollment entities; and

(3) Demonstrates to HHS that a minimum of one direct enrollment entity selected by the State meets minimum Federal requirements to participate in the Federally-facilitated Exchange enhanced direct enrollment program, including requirements at §§ 155.220 and 155.221, particularly § 155.220(c)(3)(i)(A) and (D); displays detailed information for all available QHPs; meets accessibility requirements

under § 155.205(c); and is capable of enrolling all consumers in the State, including those who present complex eligibility scenarios.

(i) If at any point there is no direct enrollment entity selected by the State that meets such minimum Federal requirements or possesses the capability to enroll all consumers in the State, as soon as practicable, the State Exchange must offer its consumer-facing website and ensure that it meets such requirements and possesses such capability.

(ii) [Reserved]

§ 155.222 [Removed]

■ 13. Remove § 155.222.

■ 14. Section 155.302 is amended by revising paragraph (a)(1) to read as follows:

§ 155.302 Options for conducting eligibility determinations.

(a) * * *

(1) Directly, through which the Exchange carries out all eligibility determinations for QHP coverage and related insurance affordability programs; or if the Exchange is a State-based Exchange on the Federal platform, through a Federal platform agreement under which HHS carries out eligibility determinations and other requirements contained within this subpart.

* * * * *

■ 15. Section 155.305 is amended by—

■ a. Revising paragraph (f)(1)(ii) introductory text;

■ b. Adding paragraph (f)(1)(ii)(C);

■ c. Removing and reserving paragraph (f)(2); and

■ d. Revising paragraph (f)(4).

The addition and revision read as follows:

§ 155.305 Eligibility Standards.

* * * * *

(f) * * *

(1) * * *

(ii) One or more applicants who is expected to be a member of the tax filer's family within the meaning of 26 CFR 1.36B-1(d) for the benefit year—

(A) * * *

(B) * * *

(C) He or she is a U.S. citizen, U.S. national, or an eligible noncitizen as defined in § 155.20.

* * * * *

(4) *Compliance with tax filing requirement.*

(i) APTC eligibility. (A) For plan year 2027, an Exchange must implement one of two policies where it may not determine a tax filer eligible for APTC if the tax filer and their spouse, if the tax filer is married, has either failed to file and reconcile for 1 year, as

described in paragraph (f)(4)(ii)(A) (“1 tax year FTR policy”) or has failed to file and reconcile for 2 consecutive tax years, as described in paragraph (f)(4)(ii)(B) (“2 tax-year policy”) of this section. Exchanges must apply any such policy uniformly to all tax filers (and their spouses, if married).

(B) For plan year 2028 and beyond, an Exchange must implement a 1-tax year FTR policy described in paragraph (f)(4)(ii)(A) of this section.

(ii) *Failure to file and reconcile.* For purposes of paragraph (f)(4)(i) of this section:

(A) A tax filer and their spouse, if the tax filer is married, is considered to have failed to file and reconcile for 1 tax year 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 the tax filer's spouse, if the tax is a married couple, for the most recent 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 in 26 CFR chapter I, and reconcile APTC for that period.

(B) A tax filer and their spouse, if the tax filer is married, is considered to have failed to file and reconcile for 2 tax years 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 the tax filer's spouse, if the tax filer is a married couple, for the 2 most recent consecutive tax 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 those years as required by 26 U.S.C. 6011, 6012, and in 26 CFR chapter I, and reconcile APTC for that period.

(iii) *Notice Requirements.* For purposes of paragraph (f)(4)(ii) of this section, the following notice requirements apply.

(A) An Exchange that implements a 2-tax year FTR policy as described in paragraph (f)(4)(ii)(B) of this section must:

(1) For tax filers failing to file and reconcile for 1 tax year as described in paragraph (f)(4)(ii)(A) of this section:

(i) Send a notification to the tax filer, consistent with the standards applicable to the protection of Federal Tax Information, that 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 for a second consecutive tax year; or

(ii) 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 in the future. 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 the tax filer's spouse, if the tax filer is married, has failed to file and reconcile.

(2) For tax filers failing to file and reconcile for 2 consecutive tax years as described in paragraph (f)(4)(ii)(B) of this section:

(i) Send a direct notification to the tax filer, consistent with the standards applicable to the protection of Federal Tax Information, that explicitly 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 their Federal income taxes and reconcile APTC, and educate the tax filer of the need to file and reconcile or risk being determined ineligible for APTC after 2 consecutive tax years of failing to file and reconcile; or

(ii) Send an indirect 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 after 2 consecutive tax years of failing to file and reconcile. These notices must educate tax filers or their enrollees on the requirement to file and reconcile, while not directly stating that the Internal Revenue Service indicates the tax filer or the tax filer's spouse, if the tax filer is married, has failed to file and reconcile.

(B) An Exchange that implements 1-tax year FTR policy as described in paragraph (f)(4)(ii)(A) of this section must:

(1) Send a notification to the tax filer, consistent with the standards applicable to the protection of Federal Tax Information, that 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 of the need to file and reconcile, and of the risk of being determined ineligible for APTC if they fail to file and reconcile immediately; 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 in the future. 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 the tax filer's spouse, if the tax filer is married, has failed to file and reconcile.

* * * * *

■ 16. Section 155.320 is amended by—

■ a. Revising paragraphs (c)(3)(iii)(A) and (c)(3)(vi)(C)(2);

■ b. Removing the second occurrence of paragraph (c)(3)(viii);

■ c. Revising paragraphs (c)(3)(vii) and (viii);

■ d. Adding paragraph (c)(3)(ix); and

■ e. Removing paragraph (c)(5).

The revisions and addition read as follows:

§ 155.320 Verification process related to eligibility for insurance affordability programs.

* * * * *

(c) * * *

(3) * * *

(iii) * * *

(A) 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 under 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). 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) 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 taxpayer 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.

* * * * *

(vii) *Definition of Household Income.* For the purposes of paragraph (c)(3) of this section, “household income” means household income as specified in 26 CFR 1.36B–1(e).

(viii) *Definition of Family Size.* For purposes of paragraph (c)(3) of this section, “family size” means family size as specified in section 26 CFR 1.36B–1(d).

(ix) *Verification of Eligible Noncitizen Status.* (A) Verification with the records of the Department of Homeland Security. For an applicant who has information or documentation of immigration status that can be verified through the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) program, and who attests to having an eligible noncitizen immigration status as defined at § 155.20, the Exchange must transmit information from the applicant or document to the Department of Homeland Security for verification.

(B) Inconsistencies and inability to verify information. For an applicant who attests to having an eligible noncitizen status as defined at § 155.20, and for whom the Exchange cannot verify such attestation through the Department of Homeland Security, the Exchange must follow the procedures specified in § 155.315(f)(1) through (4). The date on which the notice is received means 5 days after the date on the notice, unless the applicant demonstrates that he or she did not receive the notice within the 5 day period as described in § 155.315(b) (2).

(C) If, at the conclusion of the period specified in paragraph (c)(3)(ix)(B) of this section, the Exchange remains unable to verify the applicant's attestation, the Exchange must determine the applicant ineligible for advance payments of the premium tax credit and cost-sharing reductions, notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(g), and discontinue any advance payments of the premium tax credit and cost-sharing reductions in

accordance with the effective dates specified in § 155.330(f).

* * * * *

- 17. Section 155.420 is amended by—
- a. Removing paragraph (a)(4)(ii)(D);
- b. Revising paragraph (a)(4)(iii) introductory text;
- c. Removing paragraph (b)(2)(vii);
- d. Revising paragraph (d)(13);
- e. Removing paragraph (d)(16); and
- f. Revising paragraph (g).

The revisions read as follows:

§ 155.420 Special enrollment periods.

(a) * * *

(4) * * *

(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:

* * * * *

(d) * * *

(13) At the option of the Exchange, the qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in § 155.315.

* * * * *

(g) *Special enrollment period verification.* Beginning January 1, 2027, unless a request for modification is granted in accordance with § 155.315(h), Exchanges on the Federal platform must conduct pre-enrollment verification of new 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 such individuals are not eligible for enrollment through that special enrollment period. In accordance with § 155.505(b)(1)(iii), individuals have the right to appeal the eligibility determination.

- 18. Section 155.605 is amended by—
- a. Revising the end of paragraph (d)(1)(ii) to remove “or” and revising paragraph (d)(1)(iii) to add at the end “; or”; and

- b. Adding new paragraph (d)(1)(iv). The addition reads as follows:

§ 155.605 Eligibility standards for exemptions.

(d) * * *

(1) * * *

(iv) The applicant, or their claiming tax filer in the case of a tax dependent, has a projected household income that does not qualify them as an applicable taxpayer according to 26 CFR 1.36B–2(b) or does not qualify them for cost-sharing reductions according to 45 CFR 155.305(g)(1)(i)(C).

* * * * *

- 19. Section 155.1050 is amended by—

- a. Revising the section heading and paragraphs (a)(1) and (2); and
- b. Adding paragraph (d).

The revisions and addition read as follows:

§ 155.1050 Establishment of Exchange provider access standards.

(a) * * *

(1) A Federally-facilitated Exchange or a State on the Federally-facilitated Exchanges with an Effective Provider Access Review Program (as defined in paragraph (d) of this section) must ensure that each QHP provides sufficient access to providers in a manner that meets the standards specified in § 156.230(a)(1)(ii) and (iii) for network plans, or § 156.236(a) for non-network plans, as applicable.

(2) State Exchanges and State-based Exchanges on the Federal Platform must ensure that each QHP provides sufficient access to providers in a manner that meets applicable standards specified in § 156.230(a)(1)(ii) and (iii) for network plans, or § 156.236(a) for non-network plans, as applicable.

* * * * *

(d) *Effective Provider Access Review Program.* (1) FFE States may elect to conduct their own provider access certification reviews of issuers' plans, with or without a provider network, applying for certification as a QHP to be offered through a Federally-facilitated Exchange provided that the State has demonstrated sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program under paragraphs (d)(2) through (d)(4) of this section. This option applies to Federally-facilitated Exchange States, including States performing plan management. If States do not satisfy the criteria established under paragraphs (d)(2) through (d)(4) of this section, CMS will continue to perform reviews of QHP issuer provider access in those States consistent with

requirements listed at § 156.230(a)(1), (a)(2), and (a)(3) for network plans and § 156.236 for non-network plans.

(2) FFE States with an Effective Provider Access Review Program must ensure that a QHP issuer that uses a network of providers ensures that the in-network providers, as available to all enrollees, include essential community providers (ECPs) in accordance with § 156.235, and maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay. The QHP issuer's provider network consisting of in-network providers, as available to all enrollees, must be consistent with the rules for network plans of section 2702(c) of the PHS Act.

(3) FFE States with an Effective Provider Access Review Program must ensure that a QHP issuer that does not use a network of providers (a non-network plan) provides access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full, including ECPs and providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay.

(4) A State operating on the Federally-facilitated Exchanges that elects to conduct its own provider access reviews has an Effective Provider Access Review Program if it meets the following requirements:

(i) The FFE State has established provider access standards that are set forth in State statute or regulation, which are consistent with provider access standards as set forth in § 156.230(a)(1)(ii) and (iii), and reports to CMS whether the State has delegated authority to some entity other than the State Department of Insurance to perform any or all provider access review activities.

(ii) The FFE State's provider access review process includes reporting systems for State required provider access metrics and documentation of methodology and the State provides descriptions of all data collection systems, resources, templates, and methodologies used by the State, or the State's delegated entity to collect and review provider access data; and the State receives from issuers data and documentation in connection with provider access standards that are sufficient to conduct the examination.

(iii) The FFE State's provider access review process includes procedures to ensure full and ongoing compliance

with State provider access standards and enforcement frameworks applicable to issuers that fail to meet provider access standards so that those issuers come into compliance with State provider access standards, including standardized processes to assess efforts the issuer is pursuing to come into compliance with State provider access standards and implementing any justification and exception processes for issuers that have not yet or cannot meet provider access requirements.

(iv) The FFE State establishes and maintains clear procedures and timeline requirements for regular provider access reviews, including processes that ensure reviews occur prior to each plan year's QHP certification cycle.

(v) The FFE State has a process for monitoring and addressing consumer-related provider access complaints to ensure sufficient access to providers consistent with section 1311(c)(1)(B) of the Affordable Care Act and as set forth in State statute.

(vi) The FFE State has a process to collect and review information capable of demonstrating whether non-network plans provide access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full.

(5) CMS will determine whether a State has an Effective Provider Access Review Program based on information available to CMS that demonstrates whether the program meets the criteria described in paragraph (d)(4) of this section.

(6) CMS may grant an exception to the requirements in paragraph (d) of this section if it determines that making such an exception is in the interests of qualified individuals in the State or States in which such Exchange operates.

(7) CMS will notify the FFE State electing to conduct provider access certification reviews of its decision in writing whether the State is determined to have an Effective Provider Access Review Program and can therefore conduct its own provider access certification reviews. CMS reserves the right to evaluate at any time whether, and to what extent, a FFE State's circumstances have changed such that it has begun to or has ceased to satisfy the criteria established by CMS under this section. Such evaluations may result in CMS assuming provider access review responsibilities or transitioning such responsibilities back to the State.

* * * * *

■ 20. Part 155 is amended by adding § 155.1051 to subpart K to read as follows:

§ 155.1051 Effective Essential Community Provider Review Program.

(a) FFE States may elect to conduct their own ECP certification reviews of issuers' plans with or without a provider network applying for certification as a QHP to be offered through a Federally-facilitated Exchange provided that the State demonstrates it has sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective Essential Community Provider Review Program under this section. This option applies to all FFE States, including States performing plan management. An FFE State must demonstrate it meets applicable criteria established under paragraphs (b) through (c) of this section for both network plans and non-network plans, and the sufficient authority and technical capacity to conduct reviews of such plans (as assessed by CMS under § 155.1051(e)), to be considered to have an Effective Essential Community Provider Review Program, if they decide to certify such plans. If FFE States do not satisfy the criteria established by CMS under paragraphs (b) through (e) of this section or do not elect to conduct such reviews, then CMS will continue to perform ECP certification reviews consistent with § 156.235 for network plans and § 156.236 for non-network plans.

(b) FFE States with an Effective ECP Review Program must ensure that a QHP issuer with a provider network includes in their provider network a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the Exchange's network adequacy standards. FFE States with an Effective ECP Review Program must also ensure that a non-network plan applying for certification to be offered as a QHP through a Federally-facilitated Exchange demonstrates that it provides reasonable and timely access to ECPs that accept the plan's benefit amount as payment in full to ensure that services will be accessible without unreasonable delay.

(c) FFE States with an Effective ECP Review Program must have established ECP requirements that are set forth in State statute or regulation. FFE States must demonstrate that these established ECP requirements ensure that plans meet all the following requirements that promote a sufficient number and geographic distribution of ECPs:

(1) The minimum percentage requirements under § 156.235(a)(2)(i) for network plans, and under § 156.236(b)(1) for non-network plans.

(2) The Indian health care provider requirement under § 156.235(a)(2)(ii)(A) for network plans and under § 156.236(b)(3) for non-network plans.

(3) The category per county requirements, including for each of the eight ECP category types under § 156.235(a)(2)(ii)(B) for network plans and under § 156.236(b)(2) for non-network plans.

(d) FFE States with an Effective ECP Review Program that have alternative ECP requirements compared to those described under paragraph (c)(1) through (3) of this section must demonstrate how their requirements would continue to promote a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to ECPs, and an adequate level of service for low-income enrollees or individuals residing in Health Professional Shortage Areas.

(e) CMS will consider all the following factors in its review to determine if a FFE State has an Effective ECP Review Program:

(1) The State's legal authority to review whether plans applying for QHP certification meet ECP requirements, including relevant State regulations and statutes.

(2) Evidence that the State's requirements are consistent with ECP requirements under paragraph (c)(1) through (3) of this section that promote a sufficient number and geographic distribution of ECPs, or the State provides a rationale to describe how its alternative requirements promote a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to ECPs.

(3) A description of the State's definition of an ECP, if different from the definition under § 156.235(c), including relevant categories and eligibility criteria that the State uses to determine whether a facility qualifies as an ECP.

(4) Whether the State utilizes the Federal ECP List or has a process it uses to identify qualified ECPs that may be included within a network plan's provider network.

(5) Whether the State utilizes the Federal ECP List or has a process it uses to identify qualified ECPs that may accept a non-network plan's benefit amount as payment in full.

(6) A description of data collection systems, resources, templates, or methodologies used by the State to collect and review ECP data.

(7) Whether the State generally collects information from QHP issuers regarding the status of contract offers for network plans or offers of benefit amounts as payment in full to an ECP for non-network plans.

(8) Whether the State has delegated authority to some other entity other than the State Department of Insurance to perform any or all ECP review activities.

(9) Whether the State has compliance reviews, follow-up procedures, and enforcement frameworks applicable to issuers that demonstrate inadequate networks of ECPs or inadequate access to ECPs that accept benefit amounts as payment in full, so that those issuers come into compliance with State ECP requirements, including standardized processes to assess efforts the issuer is pursuing to come into compliance with State ECP requirements and any justification and exception processes for issuers that have not yet or cannot meet ECP requirements.

(10) Whether the State has a process for monitoring and addressing consumer-related complaints regarding access to ECPs to ensure sufficient access to ECPs consistent with section 1311(c)(1)(C) of the Affordable Care Act and set forth in State statute.

(f) CMS will notify the FFE State electing to conduct ECP certification reviews of its decision in writing whether the State is determined to have an Effective ECP Review Program and can therefore conduct its own ECP certification reviews. CMS reserves the right to evaluate at any time whether, and to what extent, an FFE State's circumstances have changed such that it has begun to or has ceased to satisfy the criteria established by CMS under this section, and consequently no longer has an Effective ECP Review Program.

■ 21. Section 155.1200 is amended by revising paragraph (d) introductory text and adding paragraph (e) to read as follows:

§ 155.1200 General program integrity and oversight requirements.

* * * * *

(d) *External audit standard.* The State Exchange must ensure that independent audits of State Exchange financial activities and program activities under paragraph (c) of this section address the following requirements, unless a State Exchange is satisfying certain programmatic audit requirements for a given benefit year, as identified by HHS in sub-regulatory guidance, under paragraph (e) of this section:

* * * * *

(e) *State Exchange Improper Payment Measurement (SEIPM) program.* For a given benefit year, a State Exchange may

satisfy certain requirements of the independent external programmatic audit, particularly the review of compliance with subparts D and E, as identified by HHS in sub-regulatory guidance, as outlined in paragraph (d), by completing the SEIPM process established through 45 CFR part 155, subpart Q.

* * * * *

■ 22. Part 155 is amended by adding subparts Q to read as follows:

Subpart Q—State Exchange Improper Payment Measurement (SEIPM)

Sec.

- 155.1600 Purpose and scope.
- 155.1605 Effective date and implementation.
- 155.1610 Definitions.
- 155.1615 Information submission.
- 155.1620 Sampling procedures.
- 155.1625 Determining payment errors.
- 155.1630 Difference Resolution and appeal process.
- 155.1635 Corrective action plan (CAP).
- 155.1640 SEIPM preparation phase.
- 155.1645 Minimizing potential duplicate audit requirements.
- 155.1650 Failure to comply.

§ 155.1600 Purpose and scope.

(a) This subpart sets forth the requirements of the State Exchange Improper Payment Measurement (SEIPM) program. SEIPM is an initiative through which HHS will measure improper payments of advance payment of the premium tax credit (APTC) that are administered by State Exchanges, as described in more detail in § 155.1610. HHS will use the SEIPM program results to produce an estimate of improper payments of APTC aggregated across State Exchanges.

(b) Unless otherwise specified by HHS, all State Exchanges must submit information on an annual basis that is necessary to support the SEIPM processes.

(c) HHS will publish in the Agency Financial Report an estimate of improper payments that is aggregated across all State Exchanges.

§ 155.1605 Applicability date and implementation.

(a) *Applicability date.* The requirements of this subpart are applicable beginning January 1, 2027.

§ 155.1610 Definitions.

As used in this subpart—

Annual Program Schedule means the document issued by HHS to each State Exchange that prescribes the dates for which key program milestones must be met for each SEIPM Cycle.

Administrative Appeal means the process by which a State Exchange may

request HHS to review and reconsider a Difference Resolution Decision. The appeal is the second and last level for a State Exchange to contest findings of error or improper payment as it relates to APTC.

Administrative Appeal decision means the HHS final appeal decision resulting from a State Exchange's request for an appeal of one or more error or improper payment findings in a Sampled Unit Assessment Package.

Corrective action plan (CAP) means the plan a State Exchange develops in order to correct errors resulting in improper payments of APTC identified through SEIPM.

Difference Resolution means the process by which a State Exchange may initially request HHS to reconsider one or more errors or improper payment findings documented in a Sampled Unit Assessment Package. The Difference Resolution is the first level of appeal.

Difference Resolution Decision means the HHS decision resulting from a State Exchange's request for a difference resolution or an appeal of any Sampled Unit Assessment Package.

Error means a finding by HHS that a State Exchange did not correctly apply a requirement of subparts D and E of this part related to:

- (1) Eligibility for and enrollment in a Qualified Health Plan (QHP);
- (2) Eligibility for APTC, and calculated amount of APTC;
- (3) Redeterminations of eligibility during a plan year;
- (4) Eligibility redeterminations for purposes of re-enrollment.

Measurement Year means the calendar year in which the processes described in § 155.1625 are initiated. The Measurement Year immediately follows the Plan Year and is the second year of the SEIPM Cycle.

Reporting Year means the calendar year in which HHS reports the improper payment rate for State Exchanges as required under § 155.1625(c), following completion of the measurement processes for the applicable Plan Year. The Reporting Year immediately follows the Measurement Year and is the last year of the SEIPM Cycle.

Sampled Unit Assessment Package means the collection of findings and supporting documentation that HHS prepares in order to record errors at the tax household level using the process described § 155.1625.

State Exchange Improper Payment Measurement or SEIPM means the process for determining estimated improper payments of APTC that are administered by State Exchanges as required under the Payment Integrity Information Act of 2019, which includes

a review of a State Exchange's APTC-related determinations regarding:

(1) Eligibility for and enrollment in a QHP;

(2) Eligibility for APTC, and calculated amount of APTC;

(3) Redeterminations of eligibility during a Plan Year;

(4) Annual eligibility redeterminations.

SEIPM Cycle means the 3-year period consisting of the Plan Year, Measurement Year, and Reporting Year, during which the improper payment measurement process occurs for the Plan Year that is subject to review.

Tax household means the applicant, the applicant's spouse if the applicant is married and files a joint return, and all individuals who are dependents of the applicant or spouse as defined in 26 U.S.C. 152.

§ 155.1615 Information submission

(a) HHS will issue an Annual Program Schedule to each State Exchange no later than January 5th of the Measurement Year. The Annual Program Schedule will specify the deadlines for all information submissions required under this section.

(b) On an annual basis, each State Exchange must submit or make available to HHS the following information:

(1) *Program documentation*. Policy, operational and technical documentation concerning business rules and APTC calculations that pertain to consumer eligibility and enrollment processes of the State Exchange as well as information that describes the data system architecture of the State Exchange such as entity relationship diagrams and data dictionaries.

(2) *Universe*. For the Plan Year being reviewed, a listing of the population of tax households that have associated QHP enrollments and payments of APTC. For each tax household within the universe, the State Exchange must submit the following information:

- (i) Exchange assigned policy identifier;
- (ii) Tax household grouping identifier;
- (iii) SSN inconsistency indicator;
- (iv) Citizenship inconsistency indicator;
- (v) Lawful presence inconsistency indicator;
- (vi) Annual income inconsistency indicator;
- (vii) Non-employer sponsored minimum essential coverage inconsistency indicator;
- (viii) Employer sponsored minimum essential coverage inconsistency indicator;

(ix) Incarceration inconsistency indicator;

(x) Residency inconsistency indicator;

(xi) Number of tax household

members; and

(xii) APTC amount paid over the duration of the benefit year.

(3) *Tax household Data*. For each of the sampled tax households and in a format specified by HHS:

(i) Information pertaining to the calculation of the APTC benefits paid that includes monthly enrollment premium amounts, monthly APTC payment amounts, monthly Second Lowest Cost Silver Plan Premium amounts, and the amount of each monthly premium that is attributable to essential health benefits.

(ii) Information relevant to enrollment that includes dates and amounts of effectuation payments, premium payment amount, and policy start and end dates.

(iii) Information relevant to the determination of eligibility for a special enrollment period (where applicable), which would include (where applicable) information collected by the State Exchange about consumer attestations and representations regarding special enrollment period eligibility criteria, copies of documentary evidence submitted by applicants, electronic verification information, and timing information.

(iv) Information about the timing of QHP certification or approval, the coverage area of the associated QHP, and the timing of any QHP decertification or suppression.

(v) To the extent applicable, for each person who is included in the APTC payment calculation:

(A) Information collected by the State Exchange about consumer attestations regarding QHP and APTC eligibility factors and demographic information relevant to initial QHP enrollment and eligibility.

(B) APTC eligibility and payment determinations which includes evidence of required data verifications, the electronic sources consulted, the timing of required verifications, and the results of the verification.

(C) Information relevant to QHP and APTC manual eligibility verifications and the resolution of electronic verification inconsistencies, which would include copies of documentary evidence submitted by QHP enrollees, the timing of submissions, the timing of adjudication, and information about good faith extensions.

(D) Information relevant to QHP and APTC eligibility redeterminations such as information about automatic annual redeterminations, the timing and results

of periodic examinations of data sources, and policy or application changes initiated by the consumer and resultant electronic or manual eligibility verifications.

(vi) Any consumer submitted documents that were used to establish new or continued eligibility for enrollment in a QHP and APTC.

§ 155.1620 Sampling procedures.

(a) *Sample size*. At the beginning of each SEIPM cycle, HHS will calculate a sample size in aggregate across all State Exchanges.

(1) *Statistical Methodology*. The sample size will be calculated to estimate an improper payment rate.

(2) *State-specific sample sizes*. HHS will develop sample sizes specific for each State Exchange. HHS may take into consideration the following factors in determining each State Exchange's sample size for the current SEIPM cycle:

(i) Overall APTC expenditures associated with the State Exchange.

(ii) State-level precision goals for the current SEIPM cycle.

(iii) The improper payment rate from the State Exchange's previous SEIPM cycle.

(3) *Sample size parameters*. HHS will establish minimum and maximum sample sizes to ensure statistical validity while maintaining operational feasibility across State Exchanges of varying sizes.

(b) *Sample selection procedures*. On an annual basis, HHS will select samples of tax households from the data provided by each State Exchange as described in § 155.1615(b)(2).

(c) *State Exchange coordination and notification*.

(1) *Sampled records notification*.

Following receipt of the universe data from State Exchanges as described in § 155.1615(b)(2), HHS will notify each State Exchange of the specific records selected for review. This notification will include:

(i) The total number of sampled tax households selected for the State Exchange.

(ii) A unique identifier for each sampled tax household.

(iii) Any specific instructions or requirements that HHS determines are needed to facilitate HHS' review of the sampled records.

(2) *Timing of sampled records notification*. HHS will provide the sampled records notification described in paragraph (c)(1) of this section no later than 60 days after receipt of complete universe data from all State Exchanges.

(3) *Extension of sampling notification timeline*.

(i) HHS may extend the 60-day timeline specified in paragraph (c)(2) of this section if:

(A) Technical issues prevent completion of the sampling process within the standard timeframe;

(B) Data quality issues require additional coordination with State Exchanges before sampling can be completed; or

(C) Other circumstances beyond HHS's control necessitate additional time to ensure accurate sampling methodology.

(ii) If HHS determines an extension is necessary, HHS will:

(A) Notify all affected State Exchanges in writing of the extension and the revised notification date;

(B) Provide the reason for the extension; and

(C) Confirm the impact, if any, on subsequent SEIPM cycle timelines.

§ 155.1625 Determining payment errors.

(a) *Review of records and error identification.* (1) *Systematic review process.* For each sampled record, HHS will conduct a comprehensive review of all information provided by the State Exchange using standardized review criteria.

(2) *Data sources.* HHS will conduct reviews using the tax household information provided under § 155.1615(b)(3), supplemented by any relevant consumer-submitted documents that were gathered by the State Exchange as part of the enrollment and eligibility process and provided to HHS.

(3) *Error identification.* The review will identify whether the State Exchange made any errors related to the following resulting in improper payments of APTC:

(i) Enrolling or re-enrolling a consumer into a QHP for which APTC was paid.

(ii) Consumer eligibility for APTC being paid on the consumer's behalf.

(iii) Calculating the APTC amount that was paid on the consumer's behalf.

(iv) Taking required actions upon changes to a consumer's status that would affect their APTC-related eligibility or payment amount.

(4) *Review standards and criteria.* HHS will apply consistent review standards based on the APTC-related determination requirements established in subparts D and E of this part, and other applicable provisions of this part.

(b) *Error evaluation.* HHS will evaluate each error to determine an improper payment amount. For each error identified, HHS will:

(1) Calculate the correct APTC amount based on the requirements of

section 36B of the Internal Revenue Code and applicable implementing regulations.

(2) Determine an improper payment amount.

(3) Document the error and improper payment amount within a Sampled Unit Assessment Package and provide the Sampled Unit Assessment Package to the State Exchange.

(4) Extrapolate the identified improper payments from the sample to estimate the total improper payment amount for the State Exchange's entire universe of APTC payments, using statistically valid methodologies that comply with OMB guidance on improper payment estimation.

(c) *Reporting.* HHS will report annually in the Agency Financial Report, which is made available to the public:

(1) The estimated aggregate improper payment rate for Federal and State Exchanges combined.

(2) The estimated aggregate improper payment rate for State Exchanges; and

(3) HHS will provide to each State Exchange a report that documents the State-specific improper payment rate and error analysis.

§ 155.1630 Difference Resolution and appeal process.

(a) *Difference Resolution.*

(1) The State Exchange may make a written Difference Resolution request to HHS within 30 days after the issuance of the Sampled Unit Assessment Package to dispute HHS' error and improper payment findings.

(2) Upon receipt of a Difference Resolution request, HHS will do the following:

(i) Engage with the State Exchange in a collaborative process to examine the disputed findings and any additional documentation provided by the State Exchange.

(ii) Evaluate the disputed findings by applying the same protocol used in the original review while considering whether the State Exchange's position is supported by the existing or newly provided evidence.

(iii) Prepare the Difference Resolution Decision.

(3) The Difference Resolution Decision will be communicated to the State Exchange within 90 days of receipt of the written request for a Difference Resolution. The Difference Resolution Decision will include a summary of the analysis and rationale that informed the decision.

(b) *Administrative Appeal.*

(1) To dispute a Difference Resolution Decision, the State Exchange may make a written request for an administrative

appeal within 15 business days after the issuance of the Difference Resolution Decision.

(i) The State Exchange may not submit new evidence; it may use evidence that was previously submitted during Difference Resolution.

(ii) The State Exchange may provide additional context regarding information that was submitted during Difference Resolution.

(2) Upon receipt of an appeal request, HHS will do the following:

(i) Assign the appeal request to one or more administrative appeal reviewers who were not involved in the original review;

(ii) Conduct a comprehensive review of the disputed findings using the administrative record established during the Difference Resolution process;

(iii) Independently evaluate the disputed findings by applying the same protocol used in the original review while considering whether the State Exchange's position is supported by the evidence; and

(iv) Prepare an appeal decision for the completed review based on a preponderance of the evidence.

(3) HHS will issue the appeal decision within 90 days of receipt of the written request for appeal. The appeal decision will include a summary of the analysis and rationale that informed the decision.

(c) *Difference Resolution and administrative appeal submission requirements.* All Difference Resolution and appeal requests must be filed in a form and manner specified by HHS and contain the following:

(1) A clear statement of the specific finding(s) being challenged.

(2) All factual and legal bases for filing the request.

(3) Evidence directly related to the finding(s), which may include:

(i) Clarifying information regarding data interpretation.

(ii) Legal citations supporting the State Exchange's position.

(d) *Timing of Difference Resolution and Administrative Appeal decisions.*

(1) For Difference Resolution Requests or administrative appeals resolved in favor of the State Exchange during the current SEIPM cycle:

(i) HHS will adjust the affected improper payment rate calculations for the SEIPM cycle.

(ii) Updated aggregate rates will be reflected in current cycle reporting.

(2) For Difference Resolution Requests or administrative appeals resolved in favor of the State Exchange after completion of the SEIPM cycle:

(i) If Difference Resolution or administrative appeal decisions result

in material changes to aggregate rates, HHS will publish amended aggregate improper payment rates in subsequent Agency Financial Reports or other appropriate public reporting mechanisms as well as notify affected State Exchanges of any amendments to previously published rates.

(ii) If HHS determines, at its discretion, that the Difference Resolution or administrative appeal decisions do not result in material changes to aggregate rates, no action will be taken to publish amended aggregated improper payment rates or notify affected State Exchanges.

(e) *Good cause exception.* For good cause, HHS may extend the timelines for accepting a Difference Resolution request or administrative appeal request or for issuing a Difference Resolution Decision or Administrative Appeal Decision. The failure of HHS to timely issue a Difference Resolution or Administrative Appeal decision does not indicate an acceptance of the State Exchange's position and is not a basis to decide in favor of the State Exchange.

§ 155.1635 Corrective action plan (CAP).

(a) *CAP.* HHS may require the State Exchange to develop and submit a proposed CAP to correct errors resulting in improper payments.

(b) *Development of proposed CAP.* A State Exchange's proposed CAP must address errors that are included in the State Exchange improper payment report described in § 155.1625(c)(2) and must be developed in accordance with HHS requirements.

(1) In developing a proposed CAP, the State Exchange must conduct an error analysis such as reviewing causes, characteristics, and frequency of errors that are associated with improper payments. The State Exchange must review the findings of the analysis to determine the causes of the errors included in the State Exchange improper payment rate, if any, and to identify the root causes of the resulting improper payments.

(i) If a State Exchange has a pending Difference Resolution request or administrative appeal and HHS requests a CAP, HHS may provide a new timeline for CAP submission after the Difference Resolution or Administrative Appeal Decision and calculation of the final improper payment rate.

(2) The State Exchange must determine the corrective actions to be implemented to correct causes of the errors included in the State Exchange improper payment rate and to prevent them from occurring again.

(3) The proposed CAP must include measurable milestones, accountability

mechanisms, regular monitoring and validation of progress, documentation of implemented corrective actions, and regular status updates. The CAP must include all the following for each identified error:

- (i) The specific corrective action.
- (ii) Status of the corrective action.
- (iii) Scheduled or actual

implementation date of the corrective action.

(iv) Key personnel responsible for implementing each corrective action.

(v) A plan for monitoring the effectiveness of the corrective action.

(c) *Implementation and evaluation of CAP.* A State Exchange must develop an implementation schedule for its CAP, implement the plan in accordance with that schedule, and regularly evaluate whether the initiatives are effective at reducing or eliminating error causes. The State Exchange must provide updates on CAP implementation progress in a manner and frequency specified by HHS, but at least annually.

(d) *Failures in the CAP process.* If a State Exchange does not submit a CAP when one has been required, submits an incomplete CAP that does not address all the required parts of a CAP as specified in paragraph (b)(3) of this section, fails to follow the implementation schedule referenced in paragraph (c), or submits a CAP that is otherwise unacceptable following technical assistance from HHS, HHS may take actions consistent with § 155.1650.

§ 155.1640 SEIPM preparation phase.

(a) Any State Exchange in its first year of operation must participate in a 1-year SEIPM preparation phase prior to participating in SEIPM in the subsequent year.

(b) To satisfy the requirements of the SEIPM preparation phase, a State Exchange must:

(1) Complete the information submission requirements in § 155.1615(b)(1) and (3) using information from the most current Plan Year for a sample size not to exceed 10 unique tax households that address scenarios specified by HHS.

(2) Undergo the review procedures in § 155.1625(a) and (b).

(3) Participate in technical assistance activities provided by HHS, which may include:

- (i) Training on SEIPM requirements and procedures;
- (ii) System readiness assessments;
- (iii) Data quality validation exercises; and

(iv) Process improvement recommendations.

(c) At the beginning of each calendar year, HHS will provide any State

Exchange that meets either of the conditions in paragraphs (a)(1) and (2) of this section with a schedule that spans a 12-month period that specifies when the requirements of this section must be completed.

§ 155.1645 Minimizing potential duplicate audit requirements.

HHS will minimize potential duplicate requirements of the annual independent external programmatic audit described at § 155.1200(c) and (d) and SEIPM, such that, as determined by HHS, a State Exchange may be deemed to satisfy certain requirements of § 155.1200(c) and (d), particularly the review of compliance with subparts D and E, as identified in HHS sub-regulatory guidance, for a particular plan year by successfully completing the SEIPM process.

§ 155.1650 Failure to comply.

(a) *General principle.* For purposes of improper payment measurement under this subpart, HHS will classify APTC payments as improper when a State Exchange fails to provide adequate documentation demonstrating that such payments were made in accordance with applicable Federal requirements.

(b) *Determination of substantial noncompliance.* HHS will determine that a State Exchange has failed to substantially comply with this subpart if the State Exchange:

(1) Fails to submit required data or documentation within the timelines specified in the Annual Program Schedule.

(2) Submits data or documentation that is incomplete, inaccurate, or in a format that would reasonably prevent effective review.

(3) Fails to implement the CAP process as set out in § 155.1635(d).

(4) A pattern, that is more than five instances during a SEIPM cycle, of non-response within 30 calendar days to HHS requests for clarification or additional information.

(c) *Notice and opportunity to cure.* Before implementing measures under paragraph (d) of this section, HHS will:

(1) Provide written notice to the State Exchange specifying the nature of the noncompliance and the potential consequences.

(2) Allow the State Exchange a reasonable opportunity, not less than 30 days, to cure the noncompliance or demonstrate that compliance has been achieved.

(d) *Remedial measures.* If a State Exchange fails to substantially comply with the data collection requirements, the CAP provisions contained in this subpart, or HHS requests for

clarification or additional information, and HHS finds that such failures undermine or prohibit HHS's efficient administration of Exchange improper payment measurement activities, HHS may implement measures or procedures for:

(1) Enhanced monitoring and reporting.

(2) Mandatory implementation of specific operational procedures or controls.

(3) On-site visits to State Exchange facilities to assess operational procedures, data systems, and compliance with program requirements.

(e) *Escalation procedures.* If a State Exchange continues to fail to comply after implementation of initial remedial measures under paragraph (d) of this section, HHS may initiate proceedings to revoke the State Exchange's authority to operate in accordance with applicable law.

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

■ 23. 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.

■ 24. Section 156.80 is amended by revising the heading of paragraph (d) and paragraph (d)(2)(ii) to read as follows:

§ 156.80 Single risk pool.

* * * * *

(d) *Index rate.*

* * * * *

(2) * * *

* * * * *

(ii) The plan's provider network, delivery system characteristics, utilization management practices, and for catastrophic plans with terms of multiple consecutive years, the length of the entire term, to account for such plans' benefit characteristics, such as their deductible and maximum out-of-pocket cost structure.

* * * * *

■ 25. Section 156.115 is amended by—

■ a. Redesignating paragraphs (a)(2) through (a)(6) as paragraphs (a)(3) through (a)(7);

■ b. Adding new paragraph (a)(2); and

■ c. Revising paragraph (d).

The addition and revision read as follows:

§ 156.115 Provision of EHB.

(a) * * *

(2) Are required by a State action taking place on or before December 31, 2011.

* * * * *

(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 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.

* * * * *

■ 26. Section 156.130 is amended by—

■ a. Revising paragraph (a)(2);

■ b. Redesignating paragraphs (c) through (h) as paragraphs (d) through (i); and

■ c. Adding new paragraph (c).

The revision and addition read as follows:

§ 156.130 Cost-sharing requirements.

(a) * * *

(2) Except as permitted in § 156.136, for a plan year beginning in a calendar year after 2014, cost sharing may not exceed the following:

* * * * *

(c) *Special rule for catastrophic plans with consecutive multi-year terms.* In the case of a catastrophic plan with a consecutive multi-year term, the annual limitation on cost sharing for the initial plan year of the contract may apply on an annual basis, or on average over the life of the contract.

* * * * *

■ 27. Part 156 is amended by adding § 156.136 to subpart B to read as follows:

§ 156.136 Expanded cost-sharing parameters.

For plan years beginning on or after January 1, 2027, if an issuer offers a bronze plan (as defined at § 156.140(b)(1)) in the individual market that complies with the cost-sharing

requirements at § 156.130 and the levels of coverage requirements at § 156.140, it may also offer, within the same service area, bronze plans that utilize a cost-sharing design that exceeds the maximum annual limitation on cost sharing at § 156.130 by amounts in increments of 50 dollars in order to achieve an AV within the standard bronze de minimis variation at § 156.140(c), calculated as described in § 156.135 of this subpart.

■ 28. Section 156.155 is amended by—

■ a. Revising paragraphs (a)(1) and (3); and

■ b. Adding paragraph (a)(6).

The revisions and addition read as follows:

§ 156.155 Enrollment in catastrophic plans.

(a) * * *

(1) Meets all applicable requirements for health insurance coverage in the individual market other than as permitted under paragraph (a)(6) of this section or as required under § 156.80 (including but not limited to those requirements described in parts 147 and 148 of this subchapter), and is offered only in the individual market.

* * * * *

(3)(i) For plan years beginning before January 1, 2027, provides coverage of the essential health benefits under section 1302(b) of the Affordable Care Act, except that the plan provides no benefits for any plan year (except as provided in paragraphs (a)(4), (b), and (c) of this section) until the annual limitation on cost sharing in section 1302(c)(1) of the Affordable Care Act is reached.

(ii) For plan years beginning on or after January 1, 2027, provides coverage of the essential health benefits under section 1302(b) of the Affordable Care Act, except that the plan provides no benefits for any plan year (except as provided in paragraphs (a)(4), (b), and (c) of this section) until an amount equal to 130 percent of the annual limitation on cost sharing in section 1302(c)(1) of the Affordable Care Act, rounded down to the next lowest multiple of 50 dollars, is reached.

* * * * *

(6) Has a plan term of either 1 year, or of multiple consecutive years not to exceed 10 years. Such a plan with a plan term of at least 2 consecutive years may utilize value-based insurance designs to provide benefits for preventive services under section 2713 of the Public Health Service Act beyond those specified in section 2713(a)(1)-(5) prior to the enrollee's satisfaction of the plan's deductible and prior to satisfying

the plan's annual limitation on cost sharing.

* * * * *

§ 156.201 [Removed]

■ 29. Remove § 156.201.

§ 156.202 [Removed]

■ 30. Remove § 156.202.

■ 31. Section 156.230 is amended by revising the section heading, paragraphs (a)(1) introductory text, (a)(2)(i) introductory text, (a)(2)(ii), and (a)(3) and (4) to read as follows:

§ 156.230 Provider access standards for network plans.

(a) * * *

(1) A QHP that uses a network of providers must ensure that the provider network consisting of in-network providers, as available to all enrollees, meets the following standards:

* * * * *

(2) * * *

(i) *Standards.* A QHP issuer in a Federally-facilitated Exchange in a State that CMS has not determined to have an Effective Provider Access Review Program as described in § 155.1050(d) must comply with the requirement in paragraph (a)(1)(ii) of this section by:

* * * * *

(ii) *Justification.* If a plan applying for QHP certification to be offered through a Federally-facilitated Exchange in a State that CMS has not determined to have an Effective Provider Access Review Program as described in § 155.1050(d) does not satisfy the network adequacy standards described in paragraphs (a)(2)(i)(A) and (B) of this section, the issuer must include as part of its QHP application a justification describing how the plan's provider network provides an adequate level of service for enrollees and how the plan's provider network will be strengthened and brought closer to compliance with the network adequacy standards prior to the start of the plan year. The issuer must provide information as requested by the FFE to support this justification.

(3) When CMS is conducting provider access reviews under paragraph (a)(2)(i)(A) and (B) of this section, the Federally-facilitated Exchange may grant an exception to the requirements in paragraphs (a)(2)(i)(A) and (B) of this section if the Exchange determines that making such health plan available through such Exchange is in the interests of qualified individuals in the State or States in which such Exchange operates.

(4) A limited exception to the requirement described under *paragraph (a)(1)* of this section is available to stand-alone dental plans issuers that sell

plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers; this exception is not available to medical QHP issuers. Under this exception, an area is considered "prohibitively difficult" for the stand-alone dental plan issuer to establish a network of dental providers based on attestations from State departments of insurance in States with at least 80 percent of counties classified as Counties with Extreme Access Considerations (CEAC) that at least one of the following factors exists in the area of concern: a significant shortage of dental providers, a significant number of dental providers unwilling to contract with Exchange issuers, or significant geographic limitations impacting consumer access to dental providers.

* * * * *

■ 32. Section 156.235 is amended by revising the section heading, and paragraphs (a)(1), (a)(2) introductory text, (a)(2)(i), (a)(2)(ii) introductory text, (a)(3), (a)(5), and (b) to read as follows:

§ 156.235 Essential community provider standards for network plans.

(a) * * *

(1) A QHP issuer that uses a provider network consisting of in-network providers must ensure that the provider network of each of its QHPs includes a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the Exchange's network adequacy standards.

(2) A network plan applying for QHP certification to be offered through a Federally-facilitated Exchange has a sufficient number and geographic distribution of ECPs if it demonstrates in its QHP application that—

(i) The QHP issuer's provider network includes as participating providers at least a minimum percentage, as specified by HHS, of available ECPs in each network plan's service area collectively across all ECP categories defined under paragraph (a)(2)(ii)(B) of this section, and at least a minimum percentage of available ECPs in each network plan's service area within certain individual ECP categories, as specified by HHS. Multiple providers at a single location will count as a single ECP toward both the available ECPs in the network plan's service area and the issuer's satisfaction of the ECP participation standard. For network plans that use tiered networks, to count

toward the issuer's satisfaction of the ECP standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. For network plans with two network tiers (for example, participating providers and preferred providers), such as many preferred provider organizations (PPOs), where cost-sharing is lower for preferred providers, only preferred providers will be counted towards ECP standards; and

(ii) The issuer of the network plan offers contracts to—

* * * * *

(3) A network plan applying for QHP certification to be offered through a Federally-facilitated Exchange must include as part of its QHP application the status of contract offers to qualified ECPs available in the network plan's service area. A network plan does not need to report on the status of contract offers for all available ECPs in the network plan's service area, but must at least report on the status of contract offers for all ECPs which the issuer has either included in its network plan or offered a contract to be included in its network plan within each service area.

* * * * *

(5) A network plan that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section.

(b) Alternate ECP standard.

(1) A network plan described in paragraph (a)(5) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities, to ensure reasonable and timely access for low-income individuals or individuals residing in Health Professional Shortage Areas within the network plan's service area, in accordance with the Exchange's network adequacy standards.

(2) A network plan described in paragraph (a)(5) of this section applying for QHP certification to be offered through a Federally-facilitated Exchange has a sufficient number and geographic distribution of employed or contracted providers if it demonstrates in its QHP application that—

(i) The number of its providers that are located in Health Professional Shortage Areas or five-digit zip codes in which 30 percent or more of the population falls below 200 percent of the Federal poverty level satisfies a minimum percentage, specified by HHS,

of available ECPs in each network plan's service area collectively across all ECP categories defined under paragraph (a)(2)(ii)(B) of this section, and at least a minimum percentage of available ECPs in each network plan's service area within certain individual ECP categories, as specified by HHS.

Multiple providers at a single location will count as a single ECP toward both the available ECPs in the network plan's service area and the issuer's satisfaction of the ECP participation standard. For network plans that use tiered networks, to count toward the issuer's satisfaction of the ECP standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. For network plans with two network tiers (for example, participating providers and preferred providers), such as many PPOs, where cost sharing is lower for preferred providers, only preferred providers would be counted towards ECP standards; and

(ii) The issuer's integrated delivery system provides all of the categories of services provided by entities in each of the ECP categories in each county in the network plan's service area as outlined in the general ECP standard, or otherwise offers a contract to at least one ECP outside of the issuer's integrated delivery system per ECP category in each county in the network plan's service area that can provide those services to low-income, medically underserved individuals.

(3) A network plan applying for QHP certification to be offered through a Federally-facilitated Exchange must include as part of its QHP application the status of contract offers to qualified ECPs available in the network plan's service area. A network plan does not need to report on the status of contract offers for all available ECPs in the network plan's service area, but must at least report on the status of contract offers for all ECPs which the issuer has either included in its network plan or offered a contract to be included in its network plan within each service area.

* * * * *

■ 33. Part 156 is amended by adding § 156.236 to subpart C to read as follows:

§ 156.236 Provider access and essential community providers standards for non-network plans.

(a) A QHP that does not use a network of providers (a non-network plan) must ensure access to a range of providers that accept the non-network plan's benefit amount as payment in full, including essential community providers (ECPs) and providers that specialize in mental health and

substance use disorder services, to ensure that services will be accessible without unreasonable delay. A non-network plan does not provide access to a range of providers in this manner by simply providing some benefit amount for covered services rendered by any provider without providing the Exchange any other contextual information.

(b) A non-network plan applying for QHP certification to be offered as a QHP through a Federally-facilitated Exchange must submit the following information to the Federally-facilitated Exchange for a determination that it provides access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full, and reasonable and timely access to ECPs that accept the plan's benefit amount as payment in full:

(1) The non-network plan's assessed percentage of providers in each plan's service area that accepts the plan's benefit amount as payment in full; and for ECPs, whether the non-network plan meets at least a minimum percentage, as specified by HHS, of available ECPs that accept the plan's benefit amount as payment in full in each plan's service area collectively across all ECP categories defined under § 156.235(a)(2)(ii)(B), and at least a minimum percentage of available ECPs that accept the plan's benefit amount as payment in full in each plan's service area within certain individual ECP categories, as specified by HHS;

(2) For ECPs, whether the non-network plan offers the benefit amount as payment in full to at least one ECP in each of the eight (8) ECP categories per county in the plan's service area described in § 156.235(a)(2)(ii)(B);

(3) For ECPs, whether the non-network plan offers the benefit amount as payment in full to all available Indian health care providers in the plan's service area;

(4) The non-network plan's strategy for conducting continuous outreach to available providers (including ECPs) in a particular area to determine whether they would accept the plan's benefit amount as payment in full;

(5) The non-network plan's strategy for making benefit amounts available publicly to the public, including plan enrollees, potential enrollees, and providers (including ECPs), in an easily accessible and understandable format;

(6) The non-network plan's methodology for determining benefit amounts;

(7) The non-network plan's strategy for providing consumer-friendly and public information about potential balance billing scenarios and expected

out-of-pocket costs, including historical data on actual out-of-pocket costs incurred by its enrollees while accessing providers (including ECPs) in the area;

(8) The availability of an exceptions process under the non-network plan for enrollees who cannot find providers (including ECPs) willing to accept the benefit amount as payment in full; and

(9) The non-network plan's strategy for providing adequate customer service or online provider directory assistance resources to assist plan enrollees and potential enrollees in finding providers (including ECPs) in their area who will accept the plan's benefit amount as payment in full.

§ 156.265 [Amended]

■ 34. Section 156.265 is amended by removing paragraph (b)(3)(iv).

■ 35. Section 156.275 is amended by revising paragraphs (a)(1)(viii) and (c)(2)(iv) to read as follows:

§ 156.275 Accreditation of QHP issuers.

(a) * * *

(1) * * *

(viii) Provider access; and

* * * * *

(c) * * *

(2) * * *

(iv) *Provider access.* The provider access standards for accreditation used by the recognized accrediting entities must, at a minimum, be consistent with the general requirements for network plans codified in § 156.230(a)(2) and (3) and the general requirements for non-network plans codified in § 156.236(a).

* * * * *

■ 36. Section 156.480 is amended by revising paragraph (c) introductory text and paragraph (c)(6) to read as follows:

§ 156.480 Oversight of the administration of the advance payments of the premium tax credit, cost-sharing reductions, and user fee programs.

* * * * *

(c) *Audits and compliance reviews.*

HHS or its designee may audit or conduct a compliance review of an issuer offering a QHP through an Exchange to assess its compliance with the applicable requirements related to administration of the advance payments of the premium tax credit, cost-sharing reductions, and user fee programs. Compliance reviews conducted under this section will follow the standards set forth in § 156.715.

* * * * *

(6) *Circumstances requiring HHS enforcement.* If HHS determines that the State Exchange or State-based Exchange on the Federal platform is not enforcing or fails to substantially enforce compliance with the applicable

requirements related to administration of the advance payments of the premium tax credit, cost-sharing reductions, and user fee programs, then HHS may do so and may pursue the imposition of civil money penalties as specified in § 156.805 for noncompliance by QHP issuers participating in the State Exchange or State-based Exchange on the Federal platform.

■ 37. Section 156.800 is amended by revising paragraph (b) to read as follows:

§ 156.800 Available remedies; Scope.

* * * * *

(b) *Scope.* Sanctions under subpart I are applicable for noncompliance with QHP issuer participation standards and other standards applicable to issuers offering QHPs in a Federally-facilitated Exchange. Sanctions under paragraph (a)(1) of this section are also applicable for noncompliance by QHP issuers participating in State Exchanges and State-based Exchanges on the Federal platform when HHS is responsible for enforcement of any of the requirements applicable to the actions identified in § 156.805(a) that are applicable to issuers offering a QHP in a State Exchange or State-based Exchange on the Federal platform.

* * * * *

■ 38. Section 156.805 is amended by revising paragraphs (b) introductory text and (f) to read as follows:

§ 156.805 Bases and process for imposing civil money penalties in Federally-facilitated Exchanges.

* * * * *

(b) *Factors in determining the amount of civil money penalties assessed.* In determining the amount of civil money penalties, HHS will identify the lawful purpose or purposes of the civil money penalty, and take into account the following factors as appropriate to the circumstances of the case:

* * * * *

(f) *Circumstances requiring HHS enforcement in State Exchanges and State-based Exchanges on the Federal platform.* (1) HHS will enforce the requirements applicable to the actions identified in paragraph (a) of this section that are applicable to issuers offering a QHP in a State Exchange or State-based Exchange on the Federal platform, if the State with enforcement authority over such Exchange notifies HHS that it is not enforcing these requirements or if HHS makes a determination using the process set forth at 45 CFR 150.201, *et seq.* that such State is failing to substantially enforce these requirements.

(2) If HHS is responsible under paragraph (f)(1) of this section for enforcement of the requirements applicable to the actions identified in paragraph (a) of this section that are applicable to issuers offering a QHP in a State Exchange or State-based Exchange on the Federal platform, HHS may impose civil money penalties on an issuer in such Exchange, in accordance with the bases and process for imposing civil money penalties set forth in this section.

■ 39. Section 156.810 is amended by revising paragraph (a)(8) to read as follows:

§ 156.810 Bases and process for decertification of a QHP offered by an issuer through a Federally-facilitated Exchange.

(a) * * *

(8) The QHP issuer substantially fails to meet the requirements under § 156.230 related to provider access standards for network plans, § 156.235 related to essential community provider access standards for network plans, or § 156.236 related to provider access and essential community providers standards for non-network plans, as applicable;

* * * * *

■ 40. Section 156.903 is amended by adding paragraph (d) to read as follows:

§ 156.903 Scope of Administrative Law Judge's (ALJ) authority.

* * * * *

(d) The ALJ, upon his or her own motion or at the request of a party, may issue subpoenas if they are reasonably necessary for the full presentation of a case.

(1) The party must file a written request for a subpoena with the ALJ at least 5 calendar days before the date set for the hearing.

(2) The request must:

- (i) Identify the witnesses or documents to be produced;
- (ii) Describe their addresses or location with sufficient particularity to permit them to be found; and
- (iii) Specify the pertinent facts the party expects to establish by the witnesses or documents, and indicate why those facts could not be established without use of a subpoena.

(3) Subpoenas are issued in the name of the Secretary.

■ 41. Section 156.935 is amended by adding paragraph (f) to read as follows:

§ 156.935 Discovery.

* * * * *

(f) This section does not apply to appeals of civil money penalties imposed under § 156.805 for violations

identified during audits or compliance reviews conducted in accordance with § 156.480(c).

■ 42. Section 156.1215 is amended by revising paragraphs (b) and (c) to read as follows:

§ 156.1215 Payment and collections processes.

* * * * *

(b) *Netting of payments and charges for later years.* As part of its payment and collections process, HHS may net payments owed to issuers and their affiliates operating under the same tax identification number against amounts due to the Federal Government from the issuers and their affiliates under the same taxpayer identification number for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, payment of Federally facilitated Exchange user fees, payment of State Exchanges utilizing the Federal platform user fees, HHS risk adjustment, reinsurance, and risk corridors payments and charges, administrative fees for utilizing the Federal Independent Dispute Resolution process in accordance with § 149.510(d)(2) of this subchapter, and civil money penalties assessed for violations of any applicable Exchange standards and requirements or Public Health Service Act standards and requirements applicable to issuers.

(c) *Determination of debt.* Any amount owed to the Federal Government by an issuer and its affiliates for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, Federally-facilitated Exchange user fees, including any fees for State-based Exchanges utilizing the Federal platform, HHS risk adjustment, reinsurance, risk corridors, unpaid administrative fees for utilizing the Federal Independent Dispute Resolution process in accordance with § 149.510(d)(2), and civil money penalties assessed for violations of any applicable Exchange standards and requirements or Public Health Service Act standards and requirements applicable to issuers, after HHS nets amounts owed by the Federal Government under these programs, is a determination of a debt.

■ 43. Section 156.1220 is amended by revising paragraph (b)(1) as follow:

§ 156.1220 Administrative appeals.

* * * * *

(b) * * *

(1) *Manner and timing for request.* A request for an informal hearing must be made in writing and filed with HHS

within 30 calendar days of the date of the reconsideration decision under paragraph (a)(6) of this section. If the last day of this period is not a business

day, the request for an informal hearing

must be made in writing and filed by the next applicable business day.

* * * * *

Robert F. Kennedy, Jr.,
Secretary, Department of Health and Human Services.

[FR Doc. 2026-02769 Filed 2-9-26; 4:15 pm]

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Part III

The President

Proclamation 11009—Unleashing American Commercial Fishing in the Atlantic

Executive Order 14382—Addressing Threats to the United States by the Government of Iran

Executive Order 14383—Establishing an America First Arms Transfer Strategy

Executive Order 14384—Modifying Duties To Address Threats to the United States by the Government of the Russian Federation

Executive Order 14385—Protecting the National Security and Welfare of the United States and Its Citizens From Criminal Actors and Other Public Safety Threats

Presidential Documents

Title 3—

Proclamation 11009 of February 6, 2026

The President

Unleashing American Commercial Fishing in the Atlantic

By the President of the United States of America

A Proclamation

On September 15, 2016, pursuant to the Antiquities Act (54 U.S.C. 320301), President Obama issued Proclamation 9496 (Northeast Canyons and Seamounts Marine National Monument), which designated approximately 4,913 square miles of waters and submerged lands where the Atlantic Ocean meets the continental shelf as the Northeast Canyons and Seamounts Marine National Monument.

On June 5, 2020, I issued Proclamation 10049 (Modifying the Northeast Canyons and Seamounts Marine National Monument), to remove the restrictions on commercial fishing within the Northeast Canyons and Seamounts Marine National Monument. In that proclamation, I noted that many of the fish species that Proclamation 9496 identifies are highly migratory and not unique to the monument. I further noted that a host of other laws enacted after the Antiquities Act provide specific protection for other plant and animal resources both within and outside the monument.

Subsequently, on October 8, 2021, President Biden issued Proclamation 10287 (Northeast Canyons and Seamounts Marine National Monument), finding that commercial fishing activity has the potential to significantly degrade the monument's objects of historic and scientific interest and reinstating the prohibitions on commercial fishing within the Northeast Canyons and Seamounts Marine National Monument.

As explained herein, following further consideration of the nature of the objects identified in Proclamation 9496 and the protection of those objects already provided by Federal law, I find that appropriately managed commercial fishing would not put the objects of historic and scientific interest that the monument protects at risk.

All of the fish species described in Proclamation 9496 are subject to Federal protections under existing laws and executive department and agency management designations. For example, the Magnuson-Stevens Fishery Conservation and Management Act (16 U.S.C. 1801 *et seq.*) (Magnuson-Stevens), regulates commercial fishing to ensure long-term biological and economic sustainability for our Nation's marine fisheries, taking into account the protection of associated marine ecosystems. Magnuson-Stevens establishes regional fishery management councils, supervised by the Secretary of Commerce in coordination with the States and affected stakeholders, that develop fishery management plans to regulate our Nation's fisheries, using the best available science and observing strict conservation and management requirements. Magnuson-Stevens requires a similar process of scientific fisheries management for highly migratory species, including the tunas referenced in Proclamation 9496. In addition, Magnuson-Stevens provides that fishery management plans may include, among other measures, management measures to conserve target and non-target species and habitats, including measures to protect deep-sea corals. Moreover, many of the fish species that Proclamation 9496 identifies are highly migratory and not unique to the monument.

A host of other laws enacted after the Antiquities Act provide specific protection for other plant and animal resources (including coral species) both within and outside the monument. These laws include the Endangered

Species Act (16 U.S.C. 1531 *et seq.*), the Migratory Bird Treaty Act (16 U.S.C. 703–712), the National Wildlife Refuge System Administration Act (16 U.S.C. 668dd–668ee), the Refuge Recreation Act (16 U.S.C. 460k *et seq.*), the Marine Mammal Protection Act (16 U.S.C. 1361 *et seq.*), the Clean Water Act (33 U.S.C. 1251 *et seq.*), the Oil Pollution Act (33 U.S.C. 2701 *et seq.*), the National Marine Sanctuaries Act (16 U.S.C. 1431 *et seq.*), and Title I of the Marine Protection, Research and Sanctuaries Act (33 U.S.C. 1401 *et seq.*) (Ocean Dumping Act). For example, the Endangered Species Act generally prohibits the taking of fish and wildlife species listed as endangered, and also generally ensures that Federal actions, including fisheries management, are not likely to jeopardize the continued existence of any such species. The Marine Mammal Protection Act provides protections for marine mammals, and prohibits their taking, subject to some exceptions. Numerous other statutes, including the Clean Water Act, the Oil Pollution Act, and the Ocean Dumping Act, address both land-based and ocean-based sources of pollution and help ensure that water quality continues to support plankton and other pelagic organisms.

After further consideration of the nature of the objects identified in Proclamation 9496 and the protection of those objects already provided by Magnuson-Stevens and other applicable legal authorities, I find, for all the reasons previously stated in Proclamation 10049 and provided herein, that a prohibition on commercial fishing is not, at this time, necessary for the proper care and management of the Northeast Canyons and Seamounts Marine National Monument or the objects of historic or scientific interest therein.

WHEREAS, Proclamation 9496 designated the Northeast Canyons and Seamounts Marine National Monument in the Atlantic Ocean and reserved approximately 4,913 square miles of water and submerged lands in and around certain deep-sea canyons and seamounts situated upon lands and interests in lands owned or controlled by the Federal Government as the smallest area compatible with the proper care and management of objects of historic and scientific interest;

WHEREAS, Proclamation 10049 modified the conditions of the Northeast Canyons and Seamounts Marine National Monument to allow commercial fishing activities;

WHEREAS, Proclamation 10287 modified the conditions of the Northeast Canyons and Seamounts Marine National Monument to prohibit commercial fishing activities;

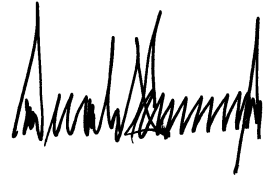
WHEREAS, for the reasons set forth in Proclamation 10049 and provided herein, I find that removing the restrictions on commercial fishing set forth in Proclamation 9496 and Proclamation 10287 to allow for well-regulated commercial fishing use, in accordance with and pursuant to existing statutory authorities, is in the public interest and that the objects in the monument can be, and are currently, protected pursuant to carefully tailored regulation and management under existing Federal law;

NOW, THEREFORE, I, DONALD J. TRUMP, President of the United States of America, by the authority vested in me by the Constitution and the laws of the United States, including section 320301 of title 54, United States Code, hereby proclaim that Proclamation 10287 is revoked and the Northeast Canyons and Seamounts Marine National Monument shall be managed in accordance with Proclamation 10049, which allows for commercial fishing within the monument.

To the extent any provision of Proclamation 10049 is inconsistent with Proclamation 9496, the terms of this proclamation and Proclamation 10049 shall govern.

If any provision of this proclamation, including its application to a particular parcel of land, is held to be invalid, the remainder of this proclamation and its application to other parcels of land shall not be affected thereby.

IN WITNESS WHEREOF, I have hereunto set my hand this sixth day of February, in the year of our Lord two thousand twenty-six, and of the Independence of the United States of America the two hundred and fiftieth.

A handwritten signature in black ink, appearing to be "Donald Trump", located in the lower right quadrant of the page.

Presidential Documents

Executive Order 14382 of February 6, 2026

Addressing Threats to the United States by the Government of Iran

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the International Emergency Economic Powers Act (50 U.S.C. 1701 *et seq.*) (IEEPA), the National Emergencies Act (50 U.S.C. 1601 *et seq.*), section 604 of the Trade Act of 1974, as amended (19 U.S.C. 2483), and section 301 of title 3, United States Code, I hereby determine and order:

Section 1. Background. Executive Order 12957 of March 15, 1995 (Prohibiting Certain Transactions With Respect to the Development of Iranian Petroleum Resources), found that the actions and policies of the Government of Iran constitute an unusual and extraordinary threat to the national security, foreign policy, and economy of the United States and declared a national emergency to deal with that threat. Numerous subsequent Executive Orders—including Executive Order 13059 of August 19, 1997 (Prohibiting Certain Transactions With Respect to Iran); Executive Order 13590 of November 20, 2011 (Authorizing the Imposition of Certain Sanctions With Respect to the Provision of Goods, Services, Technology, or Support for Iran’s Energy and Petrochemical Sectors); Executive Order 13622 of July 30, 2012 (Authorizing Additional Sanctions With Respect to Iran); Executive Order 13902 of January 10, 2020 (Imposing Sanctions With Respect to Additional Sectors of Iran); and others—have further described the threat posed by the Government of Iran and taken additional action to deal with the national emergency declared in Executive Order 12957. For example, Executive Order 13553 of September 28, 2010 (Blocking Property of Certain Persons With Respect to Serious Human Rights Abuses by the Government of Iran and Taking Certain Other Actions), took additional steps with respect to the national emergency declared in Executive Order 12957, including authorizing the blocking of property to address serious human rights abuses against persons in Iran. Executive Order 13846 of August 6, 2018 (Reimposing Certain Sanctions With Respect to Iran), also took additional steps with respect to the national emergency declared in Executive Order 12957, including imposing sanctions to advance the goal of applying financial pressure on the Iranian regime in pursuit of a comprehensive and lasting solution to the full range of the threats posed by the Government of Iran.

I have received additional information from various senior officials on, among other things, the actions and policies of the Government of Iran, including the circumstances related to the national emergency declared in Executive Order 12957 and expanded on in subsequent orders. After considering this additional information, among other things, I find that the national emergency declared in Executive Order 12957 and further described in subsequent orders continues and that the actions and policies of the Government of Iran continue to pose an unusual and extraordinary threat, which has its source in whole or substantial part outside the United States, to the national security, foreign policy, and economy of the United States.

To deal with the national emergency described in Executive Order 12957 and subsequent orders, I determine that it is necessary and appropriate to impose an additional *ad valorem* duty on imports of articles that are products of foreign countries that directly or indirectly purchase, import, or otherwise acquire any goods or services from Iran. In my judgment,

the tariff regime, as described below, in addition to maintaining the other measures taken to address the national emergency described in Executive Order 12957 and subsequent orders, will more effectively deal with the national emergency described in those orders.

Sec. 2. Imposition of Tariffs. (a) Beginning on the effective date of this order, an additional *ad valorem* rate of duty—for example, 25 percent—may be imposed on goods imported into the United States that are products of any country that directly or indirectly purchases, imports, or otherwise acquires any goods or services from Iran, in accordance with subsections (b) and (c) of this section.

(b)(i) The Secretary of Commerce, in consultation with the Secretary of State and any senior official the Secretary of Commerce deems appropriate, shall determine whether, after the effective date of this order, a foreign country directly or indirectly purchases, imports, or otherwise acquires any goods or services from Iran. After the Secretary of Commerce finds that a foreign country directly or indirectly purchases, imports, or otherwise acquires any goods or services from Iran, the Secretary of Commerce shall inform the Secretary of State of his finding, including any information relevant to that finding.

(ii) The Secretary of Commerce may issue rules, regulations, and guidance necessary or appropriate to implement this order. The Secretary of Commerce may also make any other determinations or take any other actions necessary or appropriate to implement this order.

(c)(i) After the Secretary of Commerce makes an affirmative finding pursuant to subsection (b)(i) of this section and informs the Secretary of State of his finding, the Secretary of State, in consultation with the Secretary of the Treasury, the Secretary of Commerce, the Secretary of Homeland Security, and the United States Trade Representative, shall determine whether and to what extent an additional *ad valorem* rate of duty should be imposed on goods that are products of the foreign country found to directly or indirectly purchase, import, or otherwise acquire goods or services from Iran.

(ii) If the Secretary of State determines that an additional *ad valorem* rate of duty should be imposed on goods that are products of the country found to directly or indirectly purchase, import, or otherwise acquire goods or services from Iran, the Secretary of State shall inform me of his recommendation, and the Secretary of Commerce shall inform me of his finding related to that recommendation. I will then consider the recommendation and finding, among other relevant things, in determining whether and to what extent to impose an additional *ad valorem* rate of duty on goods that are products of the country in question.

(iii) The Secretary of State may issue rules, regulations, and guidance necessary or appropriate to implement this order. The Secretary of State may also make any other determinations or take any other actions necessary or appropriate to implement this order.

Sec. 3. Modification Authority. (a) To ensure that the national emergency described in section 1 of this order is dealt with, I may modify this order, including in light of additional information, recommendations from senior officials, or changed circumstances.

(b) Should a foreign country retaliate against the United States in response to this order or any action taken pursuant to this order, I may modify this order or actions taken pursuant to this order to ensure the efficacy of this order and the actions taken pursuant to this order to deal with the national emergency described in section 1 of this order.

(c) Should the Government of Iran or a foreign country affected by this order take significant steps to address the national emergency described in section 1 of this order and align sufficiently with the United States on national security, foreign policy, and economic matters, I may modify this order.

Sec. 4. *Monitoring and Recommendations.* (a) The Secretary of State, in consultation with any senior official the Secretary of State deems appropriate, shall monitor the circumstances involving the national emergency described in section 1 of this order. The Secretary of State shall inform me of any circumstance that, in his opinion, might indicate the need for further Presidential action.

(b) The Secretary of State, in consultation with the Secretary of the Treasury, the Secretary of Commerce, the Secretary of Homeland Security, the United States Trade Representative, and any other senior official the Secretary of State deems appropriate, shall recommend to me additional action, if necessary, if the actions in this order or taken pursuant to this order are not effective in dealing with the national emergency described in section 1 of this order.

(c) The Secretary of Commerce shall monitor whether a foreign country directly or indirectly purchases, imports, or otherwise acquires any goods or services from Iran. The Secretary of Commerce shall continue such monitoring after a foreign country has been found to do so.

Sec. 5. *Delegation.* Consistent with applicable law, the Secretary of State, the Secretary of Commerce, and the United States Trade Representative are directed and authorized to take all actions necessary to implement and effectuate this order—including through temporary suspension or amendment of regulations or through notices in the *Federal Register* and by adopting rules, regulations, or guidance—and to employ all powers granted to the President, including by IEEPA, as may be necessary to implement this order. The head of each executive department and agency (agency) is authorized to and shall take all appropriate measures within the agency's authority to implement this order. The head of each agency may, consistent with applicable law, including section 301 of title 3, United States Code, redelegate the authority to take such appropriate measures within the agency.

Sec. 6. *Definitions.* For the purposes of this order:

(a) The term “goods or services from Iran” shall be construed consistent with 31 CFR 560.306, and the term shall include only goods or services for which United States persons are prohibited from trading in with respect to Iran.

(b) The term “indirectly” includes purchases, imports, or other acquisitions of Iranian goods and services through intermediaries or third countries where the origin of the good or service can reasonably be traced to Iran, as determined by the Secretary of Commerce.

(c) The term “Iran” means the Islamic Republic of Iran, its territory, and any other territory or marine area, including the exclusive economic zone and continental shelf, over which the Government of Iran claims sovereignty, sovereign rights, or jurisdiction, provided that the Government of Iran exercises partial or total de facto control over the area or derives a benefit from economic activity in the area pursuant to international arrangements.

(d) The term “Government of Iran” includes the Government of the Islamic Republic of Iran, any political subdivision, agency, or instrumentality thereof, including the Central Bank of Iran and the Islamic Revolutionary Guard Corps, and any person owned or controlled by, or acting for or on behalf of, the Government of Iran.

Sec. 7. *Effective Date.* This order is effective at 12:01 a.m. eastern standard time on February 7, 2026.

Sec. 8. *Severability.* If any provision of this order or the application of any provision of this order to any individual or circumstance is held to be invalid, the remainder of this order and the application of its provisions to any other individuals or circumstances shall not be affected. If the action in this order or any action taken pursuant to this order is held invalid, the other actions imposed to deal with the national emergencies declared

with respect to the Government of Iran shall not be affected and shall remain in effect.

Sec. 9. General Provisions. (a) Nothing in this order shall be construed to impair or otherwise affect:

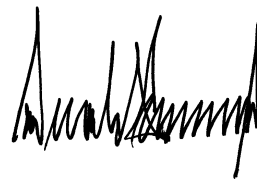
(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order 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.

(d) The costs for publication of this order shall be borne by the Department of Commerce.

A handwritten signature in black ink, appearing to be a stylized representation of a name, possibly 'Donald Trump', with a large, sweeping initial 'D' and a series of connected loops and strokes.

THE WHITE HOUSE,
February 6, 2026.

Presidential Documents

Executive Order 14383 of February 6, 2026

Establishing an America First Arms Transfer Strategy

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered:

Section 1. Purpose. American-manufactured military equipment is the best in the world, resulting in American dominance across international defense exports. It is critical that the United States fully use this comparative advantage in arms transfers as both a tool of foreign policy and a tool to expand domestic production and transfer.

To maintain our military dominance and technological superiority, the time has come to establish, implement, and execute an America First Arms Transfer Strategy. As the first strategy of its kind, it will ensure that future arms sales prioritize American interests by using foreign purchases and capital to build American production and capacity. This strategy will advance a technologically superior, ready, and resilient national security industrial enterprise. It will strengthen the United States defense industrial base to ensure it has the capacity to support our military and our allies and partners, especially as we increase burden-sharing.

Sec. 2. Policy. It is the policy of the United States to intentionally use arms transfers as a tool of American foreign policy and to expand strategically relevant industrial production capacity in the United States by:

(a) establishing an America First Arms Transfer Strategy that provides clear direction and implementation guidance to arms transfer stakeholders; and

(b) streamlining processes across executive departments and agencies (agencies) to strengthen effectiveness and create efficiencies in our defense sales enterprise.

Sec. 3. An America First Arms Transfer Strategy. (a) An America First Arms Transfer Strategy shall accomplish the following objectives:

(i) The United States will use arms sales and transfers to increase production and build production capacity for weapons and platforms the Secretary of War determines to be the most operationally relevant for executing the National Security Strategy (NSS);

(ii) The United States will use foreign purchases and capital to support domestic reindustrialization, expand production capacity, and improve the resilience of the United States defense industrial base. Arms sales and transfers will support Department of War (DoW) efforts to promote innovation and competition by incentivizing new entrants and nontraditional defense companies to contribute to the defense industrial base;

(iii) The United States will use arms sales and transfers to reinforce DoW acquisition and sustainment activities, including by building critical supply chain resilience and avoiding adding to backlogs on priority components and end-items that impact United States or ally and partner readiness;

(iv) Consistent with Executive Order 14268 of April 9, 2025 (Reforming Foreign Defense Sales to Improve Speed and Accountability), the United States will prioritize arms sales and transfers to partners that have invested in their own self-defense and capabilities, have a critical role or geography in United States plans and operations, or contribute to our economic security.

(b) Within 120 days of the date of this order, the Secretary of War, in coordination with the Secretary of State and the Secretary of Commerce, shall submit to the President, through the Assistant to the President for National Security Affairs, a sales catalog of prioritized platforms and systems that the United States shall encourage our allies and partners to acquire. The sales catalog shall be based on criteria identified in the America First Arms Transfer Strategy.

(c) Within 120 days of the date of this order, the Secretary of Commerce, in coordination with the Secretary of State and the Secretary of War, shall provide recommendations to enhance advocacy efforts encouraging foreign procurement of defense articles produced in America for the purpose of supporting an America First Arms Transfer Strategy.

(d) Within 120 days of the date of this order, the Secretary of State and the Secretary of War, in coordination with the Secretary of Commerce, shall identify Foreign Military Sales (FMS) and Direct Commercial Sales opportunities that will support the strategic objectives of the America First Arms Transfer Strategy and the growth of the United States defense industrial base.

(e) Within 60 days of the date of this order, the Secretary of State and the Secretary of War, in coordination with the Secretary of Commerce, shall develop an industry engagement plan and submit it to the President, through the Assistant to the President for National Security Affairs, to enable the United States Government to fully coordinate with American stakeholders while executing the America First Arms Transfer Strategy.

Sec. 4. *Eliminating Inefficiencies in American Arms Transfers.* In order to fully implement an America First Arms Transfer Strategy and streamline our defense sales process, the United States Government shall undertake the following actions:

(i) Within 90 days of the date of this order, the Secretary of War, in coordination with the Secretary of State, shall develop clear criteria for determining which weapons, platforms, or capabilities require Enhanced End Use Monitoring. Additionally, the Secretary of State, the Secretary of War, and the Secretary of Commerce shall establish an End Use Monitoring coordination group, consisting of designees from each respective department, which will meet to improve the effectiveness and coordination of their respective department's end-use monitoring activities. These actions will improve information sharing and efficiencies to ensure allies and partners are complying with United States requirements and to reduce risk of diversion.

(ii) Within 60 days of the date of this order, the Secretary of State, in coordination with the Secretary of War, shall review Third-Party Transfer (TPT) processes and submit a plan to the President through the Assistant to the President for National Security Affairs to reduce and potentially realign the onerous TPT process, with due consideration to technology security risks.

(iii) Within 90 days of the date of this order, the Secretary of War, in coordination with the Secretary of State, shall develop a process to provide advanced notice, as appropriate, to allies and partners of upcoming contracting actions and associated deadlines for FMS Letter of Offer and Acceptance implementation.

(iv) The Secretary of State, the Secretary of War, and the Secretary of Commerce shall ensure effective coordination when assessing the impacts of Direct Commercial Sales to the defense industrial base.

(v) To streamline Congressional notifications, Executive Order 13637 of March 8, 2013 (Administration of Reformed Export Controls) is hereby amended by revising section 1(j) and (k) to read as follows:

“(j) Those under sections 36(a) Act (22 U.S.C. 2776(a)) to the Secretary of War. The Secretary of War, in the implementation of the delegated functions under sections 36(a), shall consult with the Secretary of State. With

respect to those functions under sections 36(a)(5) and (6) (22 U.S.C. 2776(a)(5) and (6)), the Secretary of War shall also consult with the Director of the Office of Management and Budget.

(k) Those under section 36(b)(1), (c) and (d) of the Act (22 U.S.C. 2776(b)(1), (c), and (d)) to the Secretary of State. To ensure coordination, the Secretary of State shall notify the Secretary of War of the intent to formally notify the Congress of proposed arms transfers.”

Sec. 5. *Enhancing Accountability and Transparency.* (a) Within 30 days of the date of this order, the Secretary of State, the Secretary of War, and the Secretary of Commerce shall establish the Promoting American Military Sales Task Force (Task Force) to coordinate efforts to implement the America First Arms Transfer Strategy and enhance accountability and transparency throughout the arms transfer enterprise. The Task Force shall:

(i) be chaired by the Assistant to the President for National Security Affairs or his designee, and be composed of the Under Secretary of Defense for Acquisition and Sustainment, the Under Secretary of State for Arms Control and International Security, the Under Secretary of Commerce for International Trade;

(ii) develop a charter to clearly define the specific objectives and structure of the Task Force;

(iii) include as ex officio members the Service Acquisition Executives of the military departments and representatives of other non-military implementing agencies as appropriate to report on actions taken by the military departments and other implementing agencies to accelerate the contracting of priority FMS cases and ensure exportability of identified priority systems; and

(iv) convene quarterly, or as required, to review progress implementing the America First Arms Transfer Strategy, including whether targeted defense sales align with the Strategy’s objectives.

(b) Within 120 days of the date of this order, and to further the reforms directed in Executive Order 14268, and to improve transparency for United States industry and partners and allies, the Secretary of State, the Secretary of War, and the Secretary of Commerce shall begin to publish aggregate quarterly performance metrics on FMS case development and execution, and on the adjudication of Commerce and State export licenses.

Sec. 6. *General Provisions.* (a) Nothing in this order shall be construed to impair or otherwise effect:

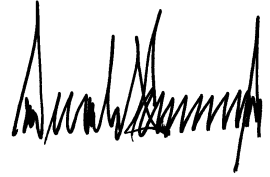
(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order 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.

(d) The costs for publication of this order shall be borne by the Department of War.

A handwritten signature in black ink, appearing to be a stylized name with a long, sweeping horizontal stroke at the end.

THE WHITE HOUSE,
February 6, 2026.

Presidential Documents

Executive Order 14384 of February 6, 2026

Modifying Duties To Address Threats to the United States by the Government of the Russian Federation

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the International Emergency Economic Powers Act (50 U.S.C. 1701 *et seq.*) (IEEPA), the National Emergencies Act (50 U.S.C. 1601 *et seq.*), section 604 of the Trade Act of 1974, as amended (19 U.S.C. 2483), and section 301 of title 3, United States Code, I hereby determine and order:

Section 1. Background. Executive Order 14066 of March 8, 2022 (Prohibiting Certain Imports and New Investments With Respect to Continued Russian Federation Efforts To Undermine the Sovereignty and Territorial Integrity of Ukraine), expanded the scope of the national emergency declared in Executive Order 14024 of April 15, 2021 (Blocking Property With Respect To Specified Harmful Foreign Activities of the Government of the Russian Federation), to include the actions taken against Ukraine by the Government of the Russian Federation. To address that unusual and extraordinary threat to the national security and foreign policy of the United States, Executive Order 14066 prohibited, among other things, the importation into the United States of certain products of Russian Federation origin, including crude oil; petroleum; and petroleum fuels, oils, and products of their distillation.

In Executive Order 14329 of August 6, 2025 (Addressing Threats to the United States by the Government of the Russian Federation), I found that the national emergency described in Executive Order 14066 has continued and that the actions and policies of the Government of the Russian Federation continue to pose an unusual and extraordinary threat to the national security and foreign policy of the United States. To deal with that threat, I determined that it was necessary and appropriate to impose an additional *ad valorem* rate of duty of 25 percent on imports of articles of India, which, at that time, was directly or indirectly importing Russian Federation oil.

I have received additional information and recommendations from senior officials regarding India's efforts to address the national emergency described in Executive Order 14066. Specifically, India has committed to stop directly or indirectly importing Russian Federation oil, has represented that it will purchase United States energy products from the United States, and has recently committed to a framework with the United States to expand defense cooperation over the next 10 years.

After considering the information and recommendations these officials have provided to me, among other things, I have determined that India has taken significant steps to address the national emergency described in Executive Order 14066 and to align sufficiently with the United States on national security, foreign policy, and economic matters. Accordingly, I have determined to eliminate the additional *ad valorem* rate of duty imposed on imports of articles of India pursuant to Executive Order 14329. In my judgment, this modification is necessary and appropriate to deal with the national emergency declared in Executive Order 14066.

Sec. 2. Tariff Modifications. Effective with respect to goods entered for consumption, or withdrawn from the warehouse for consumption, on or after 12:01 a.m. eastern standard time on February 7, 2026, products of India imported into the United States shall no longer be subject to the

additional *ad valorem* rate of duty of 25 percent imposed pursuant to Executive Order 14329. Accordingly, effective 12:01 a.m. eastern standard time on February 7, 2026, headings 9903.01.84 through 9903.01.89 and subdivision (z) of U.S. Note 2 to subchapter III of chapter 99 of the Harmonized Tariff Schedule of the United States are hereby terminated. To the extent that implementation of this order requires a refund of duties collected, refunds shall be processed pursuant to applicable law and the standard procedures of U.S. Customs and Border Protection for such refunds.

Sec. 3. *Implementation.* (a) The Secretary of State, in consultation with the Secretary of the Treasury, the Secretary of Commerce, the Secretary of Homeland Security, the United States Trade Representative, the Assistant to the President for National Security Affairs, the Assistant to the President for Economic Policy, and the Assistant to the President and Senior Counselor for Trade and Manufacturing, is hereby authorized to take such actions, including adopting rules and regulations, and to employ all powers granted to the President by IEEPA as may be necessary to implement this order. The Secretary of State may, consistent with applicable law, redelegate any of these functions within the Department of State. Each executive department and agency shall take all appropriate measures within its authority to carry out this order.

(b) The Secretary of Homeland Security, in consultation with the United States International Trade Commission, shall determine whether modifications to the Harmonized Tariff Schedule of the United States are necessary to effectuate this order and may make such modifications through notice in the *Federal Register*.

Sec. 4. *Monitoring and Recommendations.* The Secretary of Commerce, in coordination with the Secretary of State, the Secretary of the Treasury, and any other senior official the Secretary of Commerce deems appropriate, shall monitor whether India resumes directly or indirectly importing Russian Federation oil, as defined in section 7 of Executive Order 14329. If the Secretary of Commerce finds that India has resumed directly or indirectly importing Russian Federation oil, the Secretary of State, in consultation with the Secretary of the Treasury, the Secretary of Commerce, the Secretary of Homeland Security, the United States Trade Representative, the Assistant to the President for National Security Affairs, the Assistant to the President for Economic Policy, and the Assistant to the President and Senior Counselor for Trade and Manufacturing, shall recommend whether and to what extent I should take additional action as to India, including whether I should reimpose the additional *ad valorem* rate of duty of 25 percent on imports of articles of India.

Sec. 5. *General Provisions.* (a) Nothing in this order shall be construed to impair or otherwise affect:

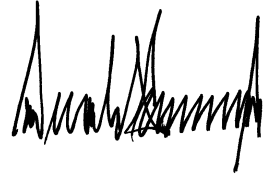
(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order 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.

(d) The costs for publication of this order shall be borne by the Department of State.

A handwritten signature in black ink, appearing to be a stylized name, possibly "Donald Trump", written in a cursive, slanted style.

THE WHITE HOUSE,
February 6, 2026.

Presidential Documents

Executive Order 14385 of February 6, 2026

Protecting the National Security and Welfare of the United States and Its Citizens From Criminal Actors and Other Public Safety Threats

By the authority vested in me as President by the Constitution and the laws of the United States of America, including 6 U.S.C. 122(a)(2), it is hereby ordered:

Section 1. *Policy.* It is the policy of the United States to protect its welfare and security, and the welfare and security of its citizens, from criminal actors. Such criminal actors may include foreign nationals with criminal histories who have entered or remained in the United States in violation of the immigration laws of the United States or who otherwise seek to violate the criminal laws of the United States. It is also the policy of the United States to cooperate with trusted foreign governments by sharing information concerning convicted felons on a reciprocal basis for border security and immigration purposes. The Department of Homeland Security (DHS) is responsible for safeguarding the borders of the United States by interdicting persons and goods illegally entering the United States; protecting against the entry of dangerous goods, narcotics, and firearms; and detecting, responding to, and interdicting terrorists, drug smugglers, human smugglers, and other persons who seek to harm the United States. To fulfill these responsibilities, and consistent with the policy described above, DHS immigration authorities must access criminal history record information (CHRI) in the custody of Federal criminal justice agencies to the maximum extent permitted by law.

Sec. 2. *Providing CHRI to DHS.* The Attorney General shall provide DHS with access, for purposes related to DHS's screening and vetting missions and to the maximum extent permitted by law, to CHRI available to or maintained by the Department of Justice.

Sec. 3. *Exchanging Felony Conviction Records with Visa Waiver Program and Other Countries for Border Security and Immigration Purposes.* (a) The Secretary of Homeland Security may exchange, to the maximum extent permitted by law, CHRI with the border security and immigration authorities of Visa Waiver Program (VWP) countries, countries that have entered into a Preventing and Combating Serious Crime or similar agreement with the United States, and other trusted allies, under an agreement or arrangement described in subsection (b) of this section. The Secretary of Homeland Security may provide this information to these countries for the sole purpose of screening travelers and immigrants seeking to enter or stay in the VWP or other country.

(b) Any exchange of CHRI by the Secretary of Homeland Security with foreign countries shall be on the basis of reciprocity and under a bilateral or multilateral agreement or arrangement entered into by DHS that contains appropriate safeguards to protect the privacy of United States persons and other individuals consistent with applicable law.

Sec. 4. *General Provisions.* (a) Nothing in this order shall be construed to impair or otherwise affect:

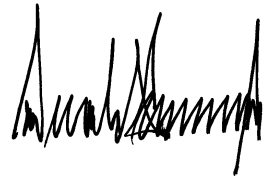
- (i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order 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.

(d) The costs for publication of this order shall be borne by the Department of Homeland Security.

A handwritten signature in black ink, appearing to be a stylized name with a long, sweeping horizontal stroke at the end.

THE WHITE HOUSE,
February 6, 2026.

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