DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 153, 155, and 156

[CMS–9899–P]

RIN 0938–AU97

Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024

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

ACTION: Proposed rule.

SUMMARY: This proposed rule includes proposed payment parameters and provisions related to the HHS-operated risk adjustment and risk adjustment data validation programs, as well as proposed 2024 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 proposes requirements related to updating standardized plan options and reducing plan choice overload; re-enrollment hierarchy; plan and plan variation marketing name requirements for QHPs; essential community providers (ECPs) and network adequacy; failure to file and reconcile; special enrollment periods (SEPs); the annual household income verification; the deadline for QHP issuers to report enrollment and payment inaccuracies; requirements related to the State Exchange improper payment measurement program; and requirements for agents, brokers, and web-brokers assisting FFE and SBE–FP consumers.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by no later than 5 p.m. on January 30, 2023.

ADDRESSES: In commenting, please refer to file code CMS–9899–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–9899–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–9899–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, (301) 492–4229, Grace Bristol, (410) 786–8437, for general information.

Jacquelyn Rudich, (301) 492–5211, Bryan Kirk, (443) 745–8999, or Joshua Paul, (301) 492–4347, for matters related to HHS-operated risk adjustment.

Leanne Klock, (410) 786–1045, or Joshua Paul, (301) 492–4347, for matters related to risk adjustment data validation (HHS–RADV).

Aaron Franz, (410) 786–8027, or Leanne Klock, (410) 786–1045, for matters related to FFE and SBE–FP user fees.

Jacob LaGrand, (301) 492–4400, for matters related to actuarial value (AV).

Brian Gubin, (401) 786–1659, for matters related to agent, broker, and web-broker guidelines.

Claire Curtin, (301) 492–4400 or Marisa Beatley, (301) 492–4307, for matters related to failure to file and reconcile.

Grace Bridges, (301) 492–5228, or Natalie Myren, (667) 290–8511, for matters related to the verification process related to eligibility for insurance affordability programs.

Zarah Ghiasuddin, (301) 356–3598, for matters related to re-enrollment in the Exchanges.

Nicholas Eckart, (301) 492–4452, for matters related to enrollment of qualified individuals into QHPs and termination of Exchange enrollment or coverage.

Marisa Beatley, (301) 492–4307, or Dena Nelson, (240) 401–3535, for matters related to qualified individuals losing MEC and qualifying for SEPs.

Samantha Nguyen Kella, (816) 426–6339, for matters related to plan display error SEPs.

Eva LaManna, (301) 492–5565, or Ellen Kuhn, (410) 786–1695, for matters related to the eligibility appeals requirements.

Linus Bicker, (803) 931–6185, for matters related to State Exchange improper payment measurement.

Alexandra Gribbin, (667) 290–9977, for matters related to stand-alone dental plans.

Nikolas Berkobien, (667) 290–9903, for matters related to standardized plan options.

Carolyn Kraemer, (301) 492–4197, for matters related to plan and plan variation marketing name requirements for QHPs.

Emily Martin, (301) 492–4423, or Deborah Hunter, (443) 386–3651, for matters related to network adequacy and ECPs.

Zarin Ahmed, (301) 492–4400, for matters related to termination of coverage or enrollment for qualified individuals.

Nora Simmons, (410) 786–1981 for matters related to reporting enrollment and payment inaccuracies.

Jenny Chen, (301) 492–5156, or Shilpa Gogna, (301) 492–4257, for matters related to State Exchange Blueprint approval timelines.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post 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 individual will take actions to harm the 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.

Table of Contents

I. Executive Summary
II. Background
A. Legislative and Regulatory Overview
B. Summary of Major Provisions
III. Provisions of the Proposed Regulations
A. Part 153—Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment
B. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act
C. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges
IV. Collection of Information Requirements
A. Wage Estimates
B. ICRs Regarding Repeal of Risk Adjustment State Flexibility To Request a Reduction in Risk Adjustment State Transfers (§ 153.320(d))
C. ICRs Regarding Risk Adjustment Issuer Data Submission Requirements (§§ 153.610, 153.700, and 153.710)

D. ICRs Regarding Risk Adjustment Data Validation Requirements When HHS Operates Risk Adjustment (HHS–RADV) (§ 153.630)
E. ICRs Regarding Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210 and 155.225)
F. ICRs Regarding Providing Correct Information to the FFEs (§ 155.220(j))
G. ICRs Regarding Documenting Receipt of Consumer Consent (§ 155.220(j))
H. ICRs Regarding Failure To File and Reconcile Process (§ 155.305(f))
I. ICRs Regarding Income Inconsistencies (§§ 155.315 and 155.320)
J. ICRs Regarding the Improper Payment Pre-Testing and Assessment (IPPTA) for State Exchanges (§§ 155.1500–155.1515)
K. ICRs Regarding QHP Rate and Benefit Information (§ 156.210)
L. ICRs Regarding Establishing a Timeliness Standard for Notices of Payment Delinquency (§ 156.270)
M. Summary of Annual Burden Estimates for Proposed Requirements
N. Submission of PRA-Related Comments
V. Regulatory Impact Analysis
A. Statement of Need
B. Overall Impact
C. Impact Estimates of the Payment Notice Provisions and Accounting Table
D. Regulatory Alternatives Considered
E. Regulatory Flexibility Act (RFA)
F. Unfunded Mandates Reform Act (UMRA)
G. Federalism

I. Executive Summary

We are proposing changes to the provisions and parameters implemented through prior rulemaking to implement the Patient Protection and Affordable Care Act (ACA).[1] These proposals are published under the authority granted to the Secretary by the ACA and the Public Health Service (PHS) Act.[2] In this proposed rule, we propose changes related to some of these ACA provisions and parameters we previously implemented and propose to implement new provisions. Our goal with the proposals is providing quality, affordable coverage to consumers while minimizing administrative burden and ensuring program integrity. The changes proposed in this rule are also intended to help advance health equity and mitigate health disparities.

[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,'' ''Affordable Care Act,'' or ''ACA.''

[2] See sections 1311, 1312, 1313, 1321, and 1343 of the ACA and section 2792 of the PHS Act.

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 ACA. Subtitles A and C of title I of the ACA 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.

Section 2702 of the PHS Act, as added by the ACA, establishes requirements for guaranteed availability of coverage in the group and individual markets.

Section 1301(a)(1)(B) of the ACA directs all issuers of QHPs to cover the essential health benefit (EHB) package described in section 1302(a) of the ACA, including coverage of the services described in section 1302(b) of the ACA, adherence to the cost-sharing limits described in section 1302(c) of the ACA, and meeting the AV levels established in section 1302(d) of the ACA. 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 described in section 1302(c)(1) of the ACA.

Section 1302 of the ACA provides for the establishment of an EHB package that includes coverage of EHBs (as defined by the Secretary of HHS), cost-sharing limits, and AV requirements. The law directs that EHBs be equal in scope to the benefits provided under a typical employer plan, and that they cover at least the following 10 general categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Section 1302(d) of the ACA describes the various levels of coverage based on their AV. Consistent with section 1302(d)(2)(A) of the ACA, AV is calculated based on the provision of EHB to a standard population. Section 1302(d)(3) of the ACA directs the Secretary of HHS to develop guidelines that allow for de minimis variation in AV calculations. Sections 1302(b)(4)(A) through (D) of the ACA establish that the Secretary must define EHB in a manner that: (1) Reflects appropriate balance among the 10 categories; (2) is not designed in such a way as to discriminate based on age, disability, or expected length of life; (3) takes into account the health care needs of diverse segments of the population; and (4) does not allow denials of EHBs based on age, life expectancy, disability, degree of medical dependency, or quality of life.

Section 1311(c) of the ACA provides the Secretary the authority to issue regulations to establish criteria for the certification of QHPs. Section 1311(c)(1)(B) of the ACA requires, among the criteria for certification that the Secretary must establish by regulation that QHPs ensure a sufficient choice of providers. Section 1311(e)(1) of the ACA grants the Exchange the authority to certify a health plan as a QHP if the health plan meets the Secretary's requirements for certification issued under section 1311(c) of the ACA, and the Exchange determines that making the plan available through the Exchange is in the interests of qualified individuals and qualified employers in the State. Section 1311(c)(6)(C) of the ACA directs the Secretary of HHS to require an Exchange to provide for special enrollment periods and section 1311(c)(6)(D) of the ACA directs the Secretary of HHS to require an Exchange to provide for a monthly enrollment period for Indians, as defined by section 4 of the Indian Health Care Improvement Act.

Section 1311(d)(3)(B) of the ACA 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 ACA 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 ACA.

Section 1312(e) of the ACA provides the Secretary with the authority to establish procedures under which a State may allow agents or brokers to (1) enroll qualified individuals and qualified employers in QHPs offered through Exchanges and (2) assist individuals in applying for premium tax credits (PTC) and cost-sharing reductions (CSRs) for QHPs sold through an Exchange.

Sections 1313 and 1321 of the ACA provide the Secretary with the authority to oversee the financial integrity of State Exchanges, their compliance with HHS standards, and the efficient and non-discriminatory administration of State Exchange activities. Section 1313(a)(5)(A) of the ACA 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 ACA provides for State flexibility in the operation and enforcement of Exchanges and related requirements.

Section 1321(a) of the ACA provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs and other components of title I of the ACA, including such other requirements as the Secretary determines appropriate. When operating an FFE under section 1321(c)(1) of the ACA, HHS has the authority under sections 1321(c)(1) and 1311(d)(5)(A) of the ACA to collect and spend user fees. Office of Management and Budget (OMB) Circular 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 general public.

Section 1321(d) of the ACA provides that nothing in title I of the ACA must be construed to preempt any State law that does not prevent the application of title I of the ACA. Section 1311(k) of the ACA specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations issued by the Secretary.

Section 1343 of the ACA establishes a permanent risk adjustment program to provide payments to health insurance issuers that attract higher-than-average risk populations, such as those with chronic conditions, funded by payments from those that attract lower-than-average risk populations, thereby reducing incentives for issuers to avoid higher-risk enrollees. Section 1343(b) of the ACA 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 ACA, the Secretary is responsible for operating the risk adjustment program in any State the fails to do so.[3]

Section 1401(a) of the ACA 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 PTC the taxpayer is allowed for the year.

Section 1402 of the ACA 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 Indians enrolled in QHPs at any metal level.

Section 1411(c) of the ACA requires the Secretary to submit certain information provided by applicants under section 1411(b) of the ACA to other Federal officials for verification, including income and family size information to the Secretary of the Treasury. Section 1411(d) of the ACA provides that the Secretary must verify the accuracy of information provided by applicants under section 1411(b) of the ACA, for which section 1411(c) of the ACA does not prescribe a specific verification procedure, in such manner as the Secretary determines appropriate.

Section 1411(f) of the ACA requires the Secretary, in consultation with the Treasury and Homeland Security Department Secretaries 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 ACA 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 advance payments of the premium tax credit (APTC) and CSRs.

Section 1411(g) of the ACA allows the use of applicant information only for the limited purposes of, and to the extent necessary to, ensure 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 5000A of the Code, as added by section 1501(b) of the ACA, 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 age 30 and above qualify to enroll in catastrophic coverage under §§ 155.305(h) and 156.155(a)(5).

1. Premium Stabilization Programs

The premium stabilization programs refer to the risk adjustment, risk corridors, and reinsurance programs established by the ACA.[4] 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-operated methodology related to community rating States.
- In the November 6, 2013 **Federal Register** (78 FR 66653), we published a correcting amendment to the 2014 Payment Notice final rule to address how an enrollee's age for the risk score calculation would be determined under the HHS-operated 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 established payment parameters in those programs.
- In the May 27, 2014 **Federal Register** (79 FR 30240), we announced

[3] In the 2014 through 2016 benefit years, HHS operated the risk adjustment program in every State and the District of Columbia, except Massachusetts. Beginning with the 2017 benefit year, HHS has operated the risk adjustment program in all 50 States and the District of Columbia.

[4] See ACA section 1341 (transitional reinsurance program), ACA section 1342 (risk corridors program), and ACA section 1343 (risk adjustment program).

the 2015 fiscal year sequestration rate for the 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 established 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 established 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 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 methodology for HHS–RADV adjustments to transfers.

• In the May 11, 2018 **Federal Register** (83 FR 21925), we published a correction to the 2019 risk adjustment coefficients in the 2019 Payment Notice final rule.

• On July 27, 2018, consistent with 45 CFR 153.320(b)(1)(i), we updated the 2019 benefit year final risk adjustment model coefficients to reflect an additional recalibration related to an update to the 2016 enrollee-level EDGE dataset.[5]

• In the July 30, 2018 **Federal Register** (83 FR 36456), we adopted the 2017 benefit year risk adjustment methodology as established in the final rules published in the March 23, 2012 (77 FR 17220 through 17252) and March 8, 2016 editions of the **Federal Register** (81 FR 12204 through 12352). The final rule set forth an additional explanation of the rationale supporting the use of Statewide average premium in the HHS-operated risk adjustment State payment transfer formula for the 2017 benefit year, including the reasons why the program is operated in a budget-neutral manner. The final rule also permitted HHS to resume 2017 benefit year 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-operated risk adjustment methodology as established in the final rules published 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 HHS-operated risk adjustment State payment transfer formula for the 2018 benefit year, including the reasons why the program is operated 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 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 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 published the 2021 Benefit Year Final HHS Risk Adjustment Model Coefficients on the CCIIO website.[6]

• In the May 14, 2020 **Federal Register** (85 FR 29164) (2021 Payment Notice), we finalized the benefit and payment parameters for 2021 benefit year, as well as adopted updates to the risk adjustment models' hierarchical condition categories (HCCs) to transition to ICD–10 codes, approved the request from Alabama to reduce risk adjustment transfers by 50 percent in 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 September 2, 2020 **Federal Register** (85 FR 54820), we issued an interim final rule containing certain policy and regulatory revisions in response to the COVID–19 public health emergency (PHE), wherein we set forth risk adjustment reporting requirements for issuers offering temporary premium credits in the 2020 benefit year.

• In the May 5, 2021 **Federal Register** (86 FR 24140), we issued part 2 of the 2022 Payment Notice final rule (2022 Payment Notice) finalizing a subset of proposals from the 2022 Payment Notice proposed rule, including policy and regulatory revisions related to the risk adjustment program, finalization of the benefit and payment parameters for the 2022 benefit year, and approval of the request from Alabama to reduce 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 risk adjustment adult model coefficients.[7]

• In the May 6, 2022 **Federal Register** (87 FR 27208) (2023 Payment Notice), we finalized revisions related to the risk adjustment program, including the benefit and payment parameters for the 2023 benefit year, risk adjustment model recalibration, and collection and extraction of enrollee-level EDGE data.

[5] 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.*

[6] 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.*

[7] *See* 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.*

We also finalized the adoption of the interacted HCC count specification for the adult and child models, along with modified enrollment duration factors for the adult model models, beginning with the 2023 benefit year.[8] We also repealed the ability for States, other than prior participants, to request a reduction in risk adjustment State transfers starting with the 2024 benefit year. In addition, we approved a 25 percent reduction to 2023 benefit year transfers in Alabama's individual market and a 10 percent reduction to 2023 benefit year transfers in Alabama's small group market. We also finalized further refinements to the HHS–RADV error rate calculation methodology beginning with the 2021 benefit year and beyond.

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'' published in the August 30, 2013 **Federal Register** (78 FR 54069), and the ''second Program Integrity Rule'' published in the October 30, 2013 **Federal Register** (78 FR 65045). We also refer readers to the 2019 Patient Protection and Affordable Care Act; Exchange Program Integrity rule published in the December 27, 2019 **Federal Register** (84 FR 71674).

3. Market Rules

For past rulemaking related to the market rules, we refer readers to the following rules:

- In the April 8, 1997 **Federal Register** (62 FR 16894), HHS, with the Department of Labor and Department of the Treasury, published an interim final rule relating to the HIPAA health insurance reforms. In the February 27, 2013 **Federal Register** (78 FR 13406) (2014 Market Rules), we published the health insurance market rules.
- In the May 27, 2014 **Federal Register** (79 FR 30240) (2015 Market Standards Rule), we published the Exchange and Insurance Market Standards for 2015 and Beyond.
- In the December 22, 2016 **Federal Register** (81 FR 94058), we provided additional guidance on guaranteed availability and guaranteed renewability.
- In the April 18, 2017 **Federal Register** (82 FR 18346) (Market Stabilization final rule), we further interpreted the guaranteed availability provision.
- In the April 17, 2018 **Federal Register** (83 FR 17058) (2019 Payment Notice final rule), we clarified that certain exceptions to the special enrollment periods only apply to coverage offered outside of the Exchange in the individual market.
- In the June 19, 2020 **Federal Register** (85 FR 37160) (2020 section 1557 final rule), in which HHS discussed section 1557 of the ACA, HHS removed nondiscrimination protections based on gender identity and sexual orientation from the guaranteed availability regulation.
- In part 2 of the 2022 Payment Notice final rule in the May 5, 2021 **Federal Register** (86 FR 24140), we made additional amendments to the guaranteed availability regulation regarding special enrollment periods and finalized new special enrollment periods related to untimely notice of triggering events, cessation of employer contributions or government subsidies to COBRA continuation coverage, and loss of APTC eligibility.
- In the September 27, 2021 **Federal Register** (86 FR 53412) (part 3 of the 2022 Payment Notice final rule), which was published by HHS and the Department of the Treasury, we finalized additional amendments to the guaranteed availability regulations regarding special enrollment periods.
- In the May 6, 2022 **Federal Register** (87 FR 27208), we finalized a revision to our interpretation of the guaranteed availability requirement to prohibit issuers from applying a premium payment to an individual's or employer's past debt owed for coverage and refusing to effectuate enrollment in new coverage.

4. Exchanges

We published a request for 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 18309) (Exchange Establishment Rule), we implemented the Affordable Insurance Exchanges (''Exchanges''), consistent with title I of the ACA, to provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of 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 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, published 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, published 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 an interim final rule, published in the May 11, 2016 **Federal Register** (81 FR 29146), we made amendments to the parameters of certain special enrollment periods (2016 Interim Final Rule). We finalized these in the 2018 Payment Notice final rule, published in the December 22, 2016 **Federal Register** (81 FR 94058).

In the April 18, 2017 Market Stabilization final rule **Federal Register** (82 FR 18346), we amended standards relating to special enrollment periods and QHP certification. In the 2019 Payment Notice final rule, published in the April 17, 2018 **Federal Register** (83 FR 16930), we modified parameters around certain special enrollment periods. In the April 25, 2019 **Federal Register** (84 FR 17454), the final 2020 Payment Notice established a new special enrollment period.

We published the final rule in the May 14, 2020 **Federal Register** (85 FR 29164) (2021 Payment Notice).

In the January 19, 2021 **Federal Register** (86 FR 6138), we finalized part 1 of the 2022 Payment Notice final rule that 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 published part 2 of the 2022 Payment Notice final rule. In the September 27, 2021 **Federal Register** (86 FR 53412) part 3 of the 2022 Payment Notice final rule, in conjunction with the Department of the Treasury, we finalized amendments to certain policies in part 1 of the 2022 Payment Notice final rule.

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. 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

[8] On May 6, 2022, we also published the *2023 Benefit Year Final HHS Risk Adjustment Model Coefficients* at *https://www.cms.gov/files/document/2023-benefit-year-final-hhs-risk-adjustment-model-coefficients.pdf.*

Exchanges conduct special enrollment period verifications.

5. Essential Health Benefits

On December 16, 2011, HHS released a bulletin that outlined an intended regulatory approach for defining EHB, including a benchmark-based framework. We established requirements relating to EHBs in the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule, which was published in the February 25, 2013 **Federal Register** (78 FR 12833) (EHB Rule). In the 2019 Payment Notice, published in the April 17, 2018 **Federal Register** (83 FR 16930), we added § 156.111 to provide States with additional options from which to select an EHB-benchmark plan for plan years (PYs) 2020 and beyond.

B. Summary of Major Provisions

The regulations outlined in this proposed rule would be codified in 45 CFR parts 153, 155, and 156.

1. 45 CFR Part 153

In accordance with the OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2023, the permanent risk adjustment program is subject to the fiscal year 2023 sequestration.[9] Therefore, the risk adjustment program will be sequestered at a rate of 5.7 percent for payments made from fiscal year 2023 resources (that is, funds collected during the 2023 fiscal year). The funds that are sequestered in fiscal year 2023 from the risk adjustment program will become available for payment to issuers in fiscal year 2024 without further Congressional action. HHS did not receive any requests from States to operate risk adjustment for the 2024 benefit year; therefore, HHS will operate risk adjustment in every State and the District of Columbia for the 2024 benefit year.

We propose to recalibrate the 2024 benefit year risk adjustment models using the 2018, 2019, and 2020 benefit year enrollee-level EDGE data, with an exception for the use of the 2020 benefit year to recalibrate the adult model age-sex coefficients. We propose to use only 2018 and 2019 benefit year enrollee-level EDGE data in the recalibration of the adult age-sex coefficients to account for the observed anomalies in the 2020 benefit year enrollee-level EDGE data for older adult enrollees, especially older adult female enrollees.

For the 2024 benefit year, we propose to continue applying a market pricing adjustment to the plan liability associated with Hepatitis C drugs in the risk adjustment models (see, for example, 84 FR 17463 through 17466). In addition, we are soliciting comment on whether to consider adding a new payment HCC for gender dysphoria to the risk adjustment models for future years.

We propose under § 153.320(d) to repeal the flexibility for States to request reductions of risk adjustment State transfers calculated by HHS under the State payment transfer formula in all State market risk pools, including prior participant States that previously requested a reduction, for the 2025 benefit year and beyond. We also seek comment on the requests from Alabama to reduce risk adjustment State transfers in its individual and small group markets by 50 percent for the 2024 benefit year.

Additionally, we propose, beginning with the 2023 benefit year, to collect and extract from issuers' EDGE servers through issuers' EDGE Server Enrollment Submission (ESES) files and risk adjustment recalibration enrollment files a new data element, a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) indicator. In addition, we propose to extract the plan identifier and rating area data elements from issuers' EDGE servers for benefit years prior to the 2021 benefit year. We also propose a risk adjustment user fee for the 2024 benefit year of $0.21 per member per month (PMPM).

Beginning with the 2022 benefit year HHS–RADV, we propose to change the materiality threshold established under § 153.630(g)(2) for random and targeted sampling from $15 million in total annual premiums Statewide to 30,000 total billable member months (BMM) Statewide, calculated by combining an issuer's enrollment in a State's individual non-catastrophic, catastrophic, small group, and merged markets, as applicable, in the benefit year being audited.

Beginning with the 2021 benefit year HHS–RADV, we propose to no longer exempt exiting issuers from adjustments to risk scores and risk adjustment transfers when they are negative error rate outliers in the applicable benefit year's HHS–RADV. Thus, HHS would apply HHS–RADV results to adjust the plan liability risk scores and State transfers of all issuers. We also solicit comments on discontinuing the use of the lifelong permanent condition list and the use of Non-EDGE Claims in HHS–RADV.

We propose to shorten the window to confirm the findings of the second validation audit (SVA) (if applicable),[10] or file a discrepancy report to dispute the SVA findings, to within 15 calendar days of the notification by HHS, beginning with the 2022 benefit year HHS–RADV.

We propose to amend the EDGE discrepancy materiality threshold set forth at § 153.710(e) to align with and mirror the policy finalized in preamble in part 2 of the 2022 Payment Notice (86 FR 24194 through 24195). That is, the materiality threshold at § 153.710(e) would be revised to provide that the amount in dispute must equal or exceed $100,000 or one percent of the total estimated transfer amount in the applicable State market risk pool, whichever is less.

2. 45 CFR Part 155

In part 155, we propose to revise the Exchange Blueprint approval timelines for States transitioning from either a FFE to a SBE–FP or to a State-based Exchange (SBE), or from a SBE–FP to a SBE. We propose to remove the deadlines for when HHS provides approval, or conditional approval, on an Exchange Blueprint, and instead propose to require that such approval is provided at some point prior to the date on which the Exchange proposes to begin open enrollment either as an SBE or SBE–FP.

We propose a change to address the standards applicable to Navigators and other assisters and their consumer service functions. At § 155.210(d)(8), we propose to remove the prohibition on Navigators from going door-to-door or using other unsolicited means of direct contact to help provide consumers with enrollment assistance. The proposal would also apply to non-Navigator assistance personnel in FFEs and in State Exchanges if funded with section 1311(a) Exchange Establishment grants, through the reference to § 155.210(d) in § 155.215(a)(2)(i). In § 155.225(g)(5), we propose to remove the prohibition on certified application counselors from going door-to-door or using unsolicited means of direct contact to help consumers fill out applications or enroll in health coverage. We believe that these proposals would allow Navigators and other assisters in the FFEs to help more consumers.

In part 155, we propose changes to address certain agent, broker, and web-

[9] OMB. (2022, March 28). OMB Report to the Congress on the BBEDCA 251A Sequestration for Fiscal Year 2023. *https://www.whitehouse.gov/wpcontent/uploads/2022/03/BBEDCA_251A_Sequestration_Report_FY2023.pdf.*

[10] Only those issuers who have insufficient pairwise agreement between the Initial Validation Audit (IVA) and SVA receive SVA findings. See 84 FR 17495; 86 FR 24201.

broker practices. We propose to allow HHS up to an additional 15 calendar days to review evidence submitted by agents, brokers, or web-brokers to rebut allegations that led to suspension of their Exchange agreement(s). We also propose to allow HHS up to an additional 30 calendar days to review evidence submitted by agents, brokers, or web-brokers that led to termination of their Exchange agreement(s). The proposal would provide HHS with up to 45 or 60 calendar days to review and respond to such evidence or requests for reconsideration submitted by agents, brokers, or web-brokers stemming from the suspension or termination of their Exchange agreement(s), respectively.

Further, we propose to require agents, brokers, or web-brokers assisting consumers with completing eligibility applications through the FFEs and SBE–FPs or assisting an individual with applying for APTC and CSRs for QHPs to document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or their authorized representative prior to application submission. We propose that the documentation would be required to include: the date the information was reviewed; the name of the consumer or their authorized representative; an explanation of the attestations at the end of the eligibility application; and the name of the assisting agent, broker, or web-broker. Furthermore, the documentation would be required to be maintained by the agent, broker, or web-broker for a minimum of 10 years and produced upon request in response to monitoring, audit, and enforcement activities.

We also propose to require agents, brokers, or web-brokers assisting consumers with applying and enrolling through FFEs and SBE–FPs, making updates to an existing application, or assisting an individual with applying for APTC and CSRs for QHPs to document the receipt of consent from the consumer or their authorized representative seeking assistance prior to providing assistance, which would include the consumer taking an action that produces a record of consent and the maintenance of that record by the agent, broker, or web-broker. We also propose standards for the content of the documentation of consent, including that it would be required to include a description of the scope, purpose, and duration of the consent provided by the consumer or their authorized representative, the date consent was given, name of the consumer or their authorized representative, and the name of the agent, broker, web-broker, or agency being granted consent, as well as the process by which the consumer or their authorized representative may rescind consent. Further, we propose that agents, brokers, or web-brokers would be required to maintain the consent documentation for a minimum of 10 years and produced upon request in response to monitoring, audit, and enforcement activities.

We propose to revise the failure to file and reconcile (FTR) process at § 155.305(f)(4). First, we are proposing codify CMS's guidance that, for plan year 2023 coverage, the Exchanges on the Federal platform would not act on data from the IRS for consumers who have failed to file tax returns and reconcile a previous year's APTC with the PTC allowed for the year. Second, we propose to provide that, beginning on January 1, 2024, Exchanges must once again determine enrollees ineligible for APTC when HHS notifies the Exchange that a taxpayer (or a taxpayer's spouse, if married) has failed to file a Federal income tax return and reconcile their past APTC. However, we propose that an Exchange may only determine enrollees ineligible for APTC after a taxpayer (or a taxpayer's spouse, if married) has failed to file a Federal income tax return and reconcile their past APTC for two consecutive years. We also propose a technical correction to § 155.305(f)(4) to clarify that HHS receives data from the IRS for consumers who have failed to file tax returns and reconcile a previous year's APTC.

We propose to amend § 155.320 to require Exchanges to accept an applicant's attestation of projected annual household income when the Exchange requests tax return data from the IRS to verify attested projected annual household income, but the IRS confirms there is no such tax return data available. Further, we propose to revise § 155.315 to add that an enrollee with income inconsistencies must receive a 60-day extension in addition to the 90 days currently provided in § 155.315(f)(2)(ii). These changes would ensure consumers are treated equitably, ensure continuous coverage, and strengthen the risk pool.

In the 2023 Payment Notice proposed rule (87 FR 584, 652), we solicited comments on revising the re-enrollment hierarchy at § 155.335(j) at a later date, and, after considering comments, we now propose amending and adding several provisions to this regulation to provide Exchanges (including Exchanges on the Federal platform and SBEs) with the option to make certain changes to the re-enrollment hierarchy beginning for PY 2024. Specifically, we propose to allow Exchanges to direct re-enrollment for CSR-eligible enrollees from a bronze QHP to a silver QHP with a lower or equivalent net premium under the same product and QHP issuer, regardless of whether the enrollee's current plan is available. We believe directing re-enrollment into lower or same cost, high generosity plans would place enrollees in more affordable plans with lower out-of-pocket costs, which would lower health insurance costs for those lower-income (CSR-eligible) individuals. We also propose to allow the Exchange to incorporate provider network considerations into the Exchange re-enrollment hierarchy.

We are proposing changes related to SEPs at § 155.420. First, we propose two technical corrections to § 155.420(a)(4)(ii)(A) and (B) to align the text with § 155.420(a)(d)(6)(i) and (ii). The proposed revisions would clarify that only one person in a tax household applying for coverage or financial assistance through the Exchange must qualify for an SEP in order for the entire tax household to qualify for the SEP. Second, we propose to change the current coverage effective date requirements at § 155.420(b)(2)(iv) to permit Exchanges to offer earlier coverage effective start dates for consumers attesting to a future loss of MEC. These changes would ensure qualifying individuals are able to seamlessly transition from other forms of coverage to Exchange coverage as quickly as possible with minimal coverage gaps.

Third, to mitigate coverage gaps, we are proposing to add § 155.420(c)(6) in which Exchanges would have the option to implement a new special rule for consumers eligible for a SEP under § 155.420(d)(1) due to loss of Medicaid or CHIP coverage which would give consumers up to 90 days after their loss of Medicaid or CHIP coverage to select a plan for Exchange coverage. Fourth, we are proposing to revise § 155.420(d)(12) to align the policy of the Exchanges on the Federal platform for granting SEPs to persons who are adversely affected by a plan display error with current plan display error SEP operations. The proposal would remove the burden from the consumer to solely demonstrate to the Exchange that a material plan display error has influenced the consumer's decision to purchase a QHP through the Exchange.

We propose to add § 155.430(b)(3) to explicitly prohibit issuers participating in Exchanges on the Federal platform from terminating coverage for a dependent child prior to the end of the plan year because the dependent child has reached the applicable maximum

age. This change would provide clarity to issuers participating in Exchanges on the Federal platform regarding their obligation to maintain coverage for dependent children, as well as to enrollees regarding their ability to maintain coverage for dependent children. This proposal would be optional for State Exchanges.

We propose to revise § 155.505(g) to acknowledge the ability of the CMS Administrator to review Exchange eligibility appeals decisions prior to judicial review. This change would provide appellants and other parties with accurate information about the availability of administrative review by the CMS Administrator if they are dissatisfied with their eligibility appeal decision.

HHS proposes to implement a new Improper Payment Pre-Testing and Assessment (IPPTA) program under which State Exchanges will be required to participate in pre-audit activities that will prepare State Exchanges for complying with audits required under the Payment Integrity Information Act of 2019 (PIIA). Activities under the proposed IPPTA program would provide State Exchanges experience helpful to preparing for future PIIA audits and will help HHS design and refine appropriate requirements for future PIIA audits of State Exchanges.

3. 45 CFR Part 156

In part 156, we propose user fee rates for the 2024 benefit year for all issuers participating on the Exchanges using the Federal platform. For the 2024 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. HHS will issue the 2024 benefit year premium adjustment percentage index and related payment parameters in guidance, consistent with the policy finalized in part 2 of the 2022 Payment Notice.

For PY 2024 and subsequent PYs, HHS would maintain a large degree of continuity with the approach to standardized plan options finalized in the 2023 Payment Notice and proposes only minor updates in this proposed rule. In particular, in contrast to the policy finalized in the 2023 Payment Notice, we are proposing to no longer include a standardized plan option for the non-expanded bronze metal level, mainly due to AV constraints. Thus, for PY 2024 and subsequent PYs, we propose standardized plan options for the following metal levels: one bronze plan that meets the requirement to have an AV up to five percentage 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 would continue to differentially display standardized plan options, including those standardized plan options required under State action that took place on or before January 1, 2020, on *HealthCare.gov,* and would continue enforcement of the standardized plan options display requirements for approved web-brokers and QHP issuers using a direct enrollment pathway to facilitate enrollment through an FFE or SBE–FP—including both the Classic Direct Enrollment (DE) and Enhanced Direct Enrollment (EDE) Pathways.

To mitigate the risk of choice overload, HHS proposes to limit the number of non-standardized plan options that QHP issuers may offer through the Exchanges using the Federal platform to two non-standardized plan options per product network type and metal level (excluding catastrophic plans), in any service area for PY 2024 and beyond. In addition, HHS proposes, as an alternative to the proposal to limit the number of non-standardized plan options that an FFE or SBE–FP issuer may offer on the Exchange, to apply a meaningful difference standard which would be more stringent than the previous standard. HHS proposes to strengthen the standard by modifying the criteria and difference thresholds used to determine whether plans are ''meaningfully different'' from one another.

We propose to require stand-alone dental plan (SADP) issuers to use age on effective date as the sole method to calculate an enrollee's age for rating and eligibility purposes beginning with Exchange certification for PY 2024. Requiring SADPs to use the age on effective date methodology to calculate an enrollee's age as a condition of QHP certification, and consequently removing the less commonly used and more complex age calculation methods, would reduce consumer confusion and promote operational efficiency. We propose that this policy would apply to Exchange-certified SADPs as a requirement of certification, whether they are sold on- or off-Exchange.

In addition, we propose to require Exchange-certified SADP issuers to submit guaranteed rates as a condition of QHP certification beginning with Exchange certification for PY 2024. This change would help reduce the risk of incorrect APTC calculation for the pediatric dental EHB portion of premiums, thereby reducing the risk of consumer harm. We propose that this policy would apply to Exchange-certified SADPs as a requirement of certification, whether they are sold on- or off-Exchange.

We propose at § 156.225 to require that plan and plan variation marketing names for QHPs offered through Exchanges on the Federal platform include correct information, without omission of material fact, and not include content that is misleading. If finalized as proposed, CMS would review plan and plan variation marketing names during the annual QHP certification process in close collaboration with State regulators.

We propose to revise the network adequacy and ECP standards at §§ 156.230 and 156.235 to provide that all individual market QHPs and SADPs and all Small Business Health Options Program (SHOP) QHPs across all Exchanges must use a network of providers that complies with the network adequacy and ECP standards in those sections, and to remove the exception that these sections do not apply to plans that do not use a provider network.

To expand access to care for low-income and medically underserved consumers, we propose to establish two additional stand-alone ECP categories at § 156.235(a)(2)(ii)(B) for PY 2024 and subsequent PYs, Mental Health Facilities and Substance Use Disorder Treatment Centers. HHS also proposes to require QHP issuers to contract with at least 35 percent of available FQHCs and at least 35 percent of available Family Planning Providers that qualify as an ECP in the plan's service area, in addition to meeting the current overall 35 percent ECP threshold requirement in the plan's service area.

We propose to add a timeliness standard to the requirement at § 156.270(f) for QHP issuers to send enrollees a notice of payment delinquency. Specifically, we propose to require issuers to send notices of payment delinquency promptly and without undue delay. This proposed revision will help ensure that enrollees are aware they are at risk of losing coverage and can avoid losing coverage by paying any outstanding premium amounts promptly.

We propose to revise the final deadline in § 156.1210(c) for issuers to report data inaccuracies identified in payment and collections reports for discovered underpayments of APTC to the issuer and user fee overpayments to HHS. Specifically, we propose to remove the deadline set forth at § 156.1210(c)(2). Under this proposal, we would retain only the deadline at

§ 156.1210(c)(1), which requires that issuers describe all inaccuracies identified in a payment and collections report within three years of the end of the applicable plan year to which the inaccuracy relates to be eligible to receive an adjustment to correct an underpayment of APTC to the issuer and user fee overpayments to HHS. Under this proposal, beginning with the 2020 plan year coverage, HHS would not pay additional APTC payments or reimburse user fee payments for FFE, SBE–FP, and SBE issuers for data inaccuracies reported after the 3-year deadline. Further, we propose that HHS would not accept or take action that results in an outgoing payment on data inaccuracies or payment errors (except those identifying an overpayment by HHS) for the 2015 through 2019 plan year coverage that are reported after December 31, 2023. This proposal would better align with the existing IRS limitation on filing corrected Federal tax returns and reduce administrative and operational burden on issuers, State Exchanges, and HHS when handling payment and enrollment dispute.

III. Provisions of the Proposed Regulations

A. Part 153—Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

In subparts A, 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 ACA that transfers funds from lower-than-average risk, risk adjustment covered plans to higher-than-average risk, risk adjustment covered plans in the individual, small group markets, 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 its behalf.[11] HHS did not receive any requests from States to operate risk adjustment for the 2024 benefit year. Therefore, HHS will operate risk adjustment in every State and the District of Columbia for the 2024 benefit year.

1. Sequestration

In accordance with the OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2023, the permanent risk adjustment program is subject to the fiscal year 2023 sequestration.[12] The Federal Government's 2023 fiscal year began on October 1, 2022. Therefore, the risk adjustment program will be sequestered at a rate of 5.7 percent for payments made from fiscal year 2023 resources (that is, funds collected during the 2023 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,[13] as amended, and the underlying authority for the risk adjustment program, the funds that are sequestered in fiscal year 2023 from the risk adjustment program will become available for payment to issuers in fiscal year 2024 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 in which it was sequestered.

Additionally, we note that the Infrastructure Investment and Jobs Act[14] amended section 251A(6) of the Balanced Budget and Emergency Deficit Control Act of 1985 and extended sequestration for the risk adjustment program through fiscal year 2031 at a rate of 5.7 percent per fiscal year.[15] [16]

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 HHS 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,[17] and prescription drug categories (RXCs) beginning with the 2018 benefit year.[18] 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) factor. 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 risk adjustment State payment transfer formula,[19] 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. 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 Risk Adjustment Model Recalibration for 2024 Benefit Year

We propose to use 2018, 2019 and 2020 benefit year enrollee-level EDGE data to recalibrate the 2024 benefit year risk adjustment models with an exception to exclude the 2020 benefit year data from the blending of the age-sex coefficients for the adult models.

In accordance with § 153.320, HHS develops and publishes the risk adjustment methodology applicable in States where HHS operates the program, including the draft factors to be employed in the models for the benefit year. This includes information related to the annual recalibration of the risk adjustment models using data from the most recent available prior benefit years trended forwarded to reflect the

[11] See also 42 U.S.C. 18041(c)(1).

[12] OMB. (2022, March 28). OMB Report to the Congress on the BBEDCA 251A Sequestration for Fiscal Year 2023. *https://www.whitehouse.gov/wp-content/uploads/2022/03/BBEDCA_251A_Sequestration_Report_FY2023.pdf.*

[13] Public Law 99–177 (1985).

[14] Public Law 117–58, 135 Stat. 429 (2021).

[15] 2 U.S.C. 901a.

[16] The Coronavirus Aid, Relief, and Economic Security (CARES) Act previously amended section 251A(6) of the Balanced Budget and Emergency Deficit Control Act of 1985 and extended sequestration for the risk adjustment program through fiscal year 2023 at a rate of 5.7 percent per fiscal year. Section 4408 of the CARES Act, Public Law 116–136, 134 Stat. 281 (2020).

[17] 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 one 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.

[18] 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 risk adjustment models. See, for example, 83 FR 16941.

[19] The State payment transfer formula refers to the part of the HHS risk adjustment methodology that calculates payments and charges at the State market risk pool level prior to the calculation of the high-cost risk pool payment and charge terms that apply beginning with the 2018 BY. See, for example, 81 FR 94080.

applicable benefit year of risk adjustment.

Our proposed approach for 2024 recalibration aligns with the approach finalized in the 2022 Payment Notice (86 FR 24151 through 24155) and reiterated in the 2023 Payment Notice (87 FR 27220 through 27221), that involves use of the 3 most recent consecutive years of enrollee-level EDGE data that are available at the time we incorporate the data in the draft recalibrated coefficients published in the proposed rule for the applicable benefit year, and not updating the coefficients between the proposed and final rules if an additional year of enrollee-level EDGE data becomes available for incorporation. We continue to believe this approach promotes stability, better meets the goal of the risk adjustment program, and allows issuers more time to incorporate this information when pricing their plans for the upcoming benefit year than the previous approach which allowed for updates to the data used for recalibration if more data became available between the proposed and final rules.

As such, we propose to determine coefficients for the 2024 benefit year based on a blend of separately solved coefficients from the 2018, 2019, and 2020 benefit years of enrollee-level EDGE data, with an exception to exclude the 2020 benefit year data from the blending of the age-sex coefficients for the adult models. For all adult model age-sex coefficients, we propose to use only 2018 and 2019 benefit year enrollee-level EDGE data in recalibration to account for the observed anomalous decreases in the unconstrained coefficients [20] for the 2020 benefit year enrollee-level EDGE data for older adult enrollees, especially older adult female enrollees.

To further explain, due to the potential impact of the COVID–19 PHE on costs and utilization of services in 2020, HHS considered whether the 2020 enrollee-level EDGE data was appropriate for use in the annual model recalibration for the HHS-operated risk adjustment program applicable to the individual and small group (including merged) markets. As part of this analysis, we considered comments received in response to the 2023 Payment Notice proposed rule (87 FR 598), wherein we sought comments on the future use of the 2020 enrollee-level EDGE data due to the potential impact of the COVID–19 PHE. The current policy that involves using the 3 most recent years of EDGE data available as of the proposed rule for the annual risk adjustment model recalibration promotes stability and ensures the models reflect the year-over-year changes to the markets' patterns of utilization and spending without over-relying on any factors unique to one particular year. This approach was put in place based on feedback from issuers and other interested parties and our experience operating the program since the 2014 benefit year. Furthermore, we know from our experience that every year of data can be unique and therefore some level of deviation from year to year is expected.[21] These general considerations all weigh in favor of including the 2020 benefit year data in the recalibration of the risk adjustment models.

However, we recognize that if a benefit year has significant changes that differentially impact certain conditions or populations relative to others, or is sufficiently anomalous relative to expected future patterns of care, we should carefully consider what impact that benefit year of data could have if it is used in the annual model recalibration for the HHS-operated risk adjustment program. This includes consideration of whether to exclude or adjust that benefit year of data to increase the models' predictive validity or otherwise limit the impact of anomalous trends. The situation presented by the COVID–19 PHE and its potential impact on utilization and costs in the 2020 benefit year is an example [22] of a situation that requires this additional consideration. Thus, to help further inform HHS' decision on whether it is appropriate to use 2020 enrollee-level EDGE data to calibrate the risk adjustment coefficients, HHS analyzed the 2020 benefit year enrollee-level EDGE recalibration data to assess how it compares to 2019 benefit year enrollee-level EDGE recalibration data. Our results found:

- The total sample size in the recalibration data set was similar between the 2019 and 2020 benefit years, with the individual market at the national level seeing an increase in enrollment in the 2020 benefit year and the small group market at the national level seeing a slight decrease in enrollment in the 2020 benefit year.
- In the 2020 EDGE enrollee-level recalibration data set, even though PMPM spending dropped substantially between March and April 2020, the total PMPM spending in the 2020 benefit year was similar to the 2019 benefit year, with the institutional and professional services PMPM slightly decreasing, preventive services PMPM notably decreasing, and the drug PMPM increasing. This represents a departure from historical medical costs trends, which have generally seen increases year-over-year in all cost categories.
- Across all data submitted through issuer's EDGE servers for the 2020 benefit year, we observed a large increase in telehealth paid claims amounts when compared to all data submitted through issuer's EDGE servers for the 2019 benefit year.
- The number of enrollees with one or more HCC was relatively stable between the 2019 and 2020 benefit year enrollee-level EDGE recalibration data sets in both the recalibration and full data sets.[23]
- Individual HCC frequencies and costs generally remained constant between the 2019 and 2020 benefit year enrollee-level EDGE recalibration data sets, even for the HCCs related to the severe manifestations of COVID–19. An exception was a notable increase in frequency for HCC 127 *Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes,* which was likely coded for cases in which acute respiratory distress syndrome (ARDS) was a manifestation of COVID–19, but relative allowed charges, and therefore, risk adjustment model coefficients, for HCC 127 remained similar in 2020 compared to 2019.

[20] HHS constrains the risk adjustment models in multiple distinct ways during model recalibration. These include (1) coefficient estimation groups, also referred to as G-Groups in the Risk Adjustment Do It Yourself (DIY) Software, (2) a priori stability constraints, and (3) hierarchy violation constraints. Of these, coefficient estimation groups and a priori stability constraints are applied prior to model fitting. The hierarchy violation constraints are applied after the initial estimates of coefficients are produced. We refer to the models and coefficients prior to the application of hierarchy violation constraints as the ''unconstrained models'' and ''unconstrained coefficients,'' respectively. For a description of the various constraints we apply to the risk adjustment models, see, CMS' ''Potential Updates to HHS–HCCs for the HHS-operated Risk Adjustment Program'' (the ''2019 White Paper'') (June 17, 2019). *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Potential-Updates-to-HHS-HCCs-HHS-operated-Risk-Adjustment-Program.pdf.*

[21] Every year we expect some shifting in treatment and cost patterns, for example as new drugs come to market. Our goal in using multiple years of data for model calibration is to capture some degree of year-to-year cost shifting without over-relying on any factors unique to one particular year.

[22] In the 10 years since the start of HHS model calibration for benefit year 2014, the COVID–19 PHE has been the only such situation to date. Other events and policy changes have not risen to the same level of uniqueness or impact.

[23] CMS. (2021, June 30). Summary Report on Permanent Risk Adjustment Transfers for the 2020 Benefit Year. *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2020.pdf.*

• RXC frequencies and costs were generally stable between the 2019 and 2020 benefit year enrollee-level EDGE recalibration data sets, with the exception of RXC 10 *Cystic Fibrosis Agents,* for which a new drug was introduced that increased costs in the 2020 data compared to the 2019 data.

• The unconstrained coefficients for the 2020 benefit year enrollee-level EDGE recalibration data are similar to the 2019 benefit year's unconstrainted coefficients with one exception. The exception exists within the age-sex coefficients in the adult models where we found decreases among coefficients for older enrollees, especially female enrollees, which are likely due to decreases in discretionary spending among this age group in the 2020 benefit year.

In short, on many key dimensions, HHS found that the 2019 benefit year and 2020 benefit year enrollee-level EDGE data recalibration were largely comparable.

With this analysis in mind, and based on the comments received in response to the 2023 Payment Notice proposed rule,[24] HHS considered six different options for handling the 2020 benefit year enrollee-level EDGE recalibration data for purposes of the annual recalibration of the HHS risk adjustment models for the 2024 benefit year.[25] Four options involve the use of 2020 benefit year enrollee-level EDGE recalibration data in the risk adjustment model recalibration, and two involve the exclusion of the 2020 benefit year data. These six options are as follows:

• *Option 1:* Maintain the current policy, recalibrating the 2024 benefit year risk adjustment models using 2018, 2019, and 2020 enrollee-level EDGE data with no exceptions or modifications.

• *Option 2:* Maintain the current policy, recalibrating the 2024 benefit year risk adjustment models using 2018, 2019, and 2020 benefit year enrollee-level EDGE recalibration data, but assign a lower weight to 2020 data. Assigning a lower weight to the 2020 data would dampen its impact on the models while continuing to capture in part the utilization and spending patterns underlying the data.

• *Option 3:* Utilize 4 years of enrollee-level EDGE data, instead of three, to recalibrate the 2024 benefit year risk adjustment models using 2017, 2018, 2019, and 2020 benefit year data. This would serve the purpose of dampening the effect of the 2020 data on the models by incorporating an extra year of data from a prior benefit year that was not impacted by the COVID–19 PHE.

• *Option 4:* Maintain the current policy, recalibrating the 2024 benefit year risk adjustment models using 2018, 2019, and 2020 enrollee-level EDGE recalibration data with an exception to exclude the 2020 benefit year data from the blending of the age-sex coefficients for the adult models. Under this option, we would determine coefficients for the 2024 benefit year based on a blend of separately solved coefficients from the 2018, 2019, and 2020 benefit years of enrollee-level EDGE recalibration data and would exclude the 2020 benefit year from the recalibration of the adult models' age-sex coefficients. Instead, only 2018 and 2019 benefit year enrollee-level EDGE recalibration data would be used to recalibrate the adult risk adjustment models age-sex coefficients.[26]

• *Option 5:* Exclude the 2020 benefit year enrollee-level EDGE recalibration data and instead use the 2017, 2018, and 2019 benefit year enrollee-level EDGE recalibration data, trended forward to the 2024 benefit year, in recalibration of the risk adjustment models for the 2024 benefit year, or use the final 2023 risk adjustment model coefficients for the 2024 benefit year without trending the data to account for inflation and changes in costs and utilization between the 2023 and 2024 benefit years.

• *Option 6:* Exclude the 2020 benefit year enrollee-level EDGE recalibration data and instead use only 2 years of enrollee-level EDGE data for recalibration—that is, use only 2018 and 2019 benefit year data to recalibrate the 2024 risk adjustment models.

Although it is true our analyses found that the 2019 and 2020 benefit year enrollee-level EDGE recalibration data were largely comparable, there were observed anomalous decreases in the unconstrained age-sex coefficients for the 2020 benefit year enrollee-level EDGE recalibration data for older adult enrollees, especially older female enrollees. We are therefore concerned that not making any adjustments with respect to the use of 2020 enrollee-level EDGE recalibration data could have an undue impact on the risk captured by the age-sex factors in the adult models such that these factors would less accurately reflect the expected spending patterns for the 2024 benefit year. Option 1 would not address the identified anomalous trend that is not expected to continue in future benefit years. Option 2 represents a middle ground between those commenters who expressed support for including 2020 benefit year data in model recalibration and those who expressed support for excluding the data, by capturing the utilization and spending patterns underlying the 2020 data while dampening its effects in the models. However, we are concerned this approach would require identifying an appropriate weighting methodology other than the equal weighting that we generally use to blend the factors from the 3 data years, and we do not believe there is a self-evident method of weighting 2020 data differently for this purpose. Furthermore, we are concerned that dampening the effect of the 2020 benefit year data in all of the models for all factors (as opposed to just the age-sex factors in the adult models) defeats the purpose of using the next available benefit year of data to recalibrate the models, because doing so would prevent the models from reflecting changes in utilization and cost of care that are unrelated to the impact of the COVID–19 PHE. There are similar concerns with option 3 and the inclusion of an additional prior benefit year (that is, 2017) to recalibrate the 2024 benefit year models to dampen the impact of the 2020 benefit year data. We do not believe that such a broad dampening is necessary since the anomalous coefficient changes identified from the 2020 benefit year data were largely limited to the adult model age-sex coefficients and incorporating an

[24] These comments offered a variety of perspectives with some commenters stating that 2020 enrollee-level EDGE data should be used for model recalibration as normal, a few commenters suggesting that 2020 enrollee-level EDGE data should be excluded entirely, one commenter recommending that 2020 enrollee-level EDGE data should be used with a different weight assigned, and several commenters suggesting HHS release a technical paper on the use of 2020 enrollee-level EDGE data, with several suggesting HHS do a comparison of coefficients with and without the 2020 enrollee-level EDGE data to review relative changes in coefficients, and evaluate changes for clinical reasonability and consistency with 2018 and 2019 enrollee-level EDGE data. See 87 FR 27220 through 27221.

[25] The proposals related to the use of 2020 benefit year enrollee-level EDGE data in this rule for model recalibration purposes are focused on the 2024 benefit year models. Consistent with the approach finalized in part 2 of the 2022 Payment Notice (86 FR 24151 through 24155), any changes to the use of the 3 most recent consecutive years of enrollee-level EDGE data, including proposals related to the use of 2020 benefit year data, for recalibration of the 2025 and 2026 benefit year HHS risk adjustment models would be addressed and proposed in a future rulemaking.

[26] This is a similar approach to that taken in part 2 of the 2022 Payment Notice, where we only used 2016 and 2017 enrollee-level EDGE data for the limited purpose of developing the RXC 09 coefficients, RXC 09 HCC related coefficients, and RXC 09 interaction term coefficients for the 2022 benefit year adult models, given concerns regarding unrepresentative expenditures and off-label prescribing of hydroxychloroquine during the COVID–19 PHE relative to drugs that enrollees with HCC 048, 056, or 057 may take. See 86 FR 24180.

additional prior benefit year of data would dampen the impact of the 2020 benefit year data on other factors (for example, HCCs, RXCs, and interaction factors) and would prevent the models from reflecting changes in utilization and cost of care that are unrelated to the impact of the COVID–19 PHE. Furthermore, option 3 would use older data to fit the 2024 benefit year risk adjustment models than options 1 and 2 (that is, 2017 benefit year data), which may impact the risk adjustment models such that they reflect older cost and utilization trends than would be desirable.

We are similarly concerned about options 5 and 6, which would involve the complete exclusion of 2020 benefit year data. With respect to option 5, although using the same data years for 2024 benefit year model recalibration as 2023 benefit year model recalibration or using the 2023 benefit year models for the 2024 benefit year would likely yield the same or similar coefficients [27] to those published for the 2023 benefit year, thereby providing stability that issuers may find desirable, we are concerned this approach would also involve the use of older data as with option 3, which may not be the data set that would best reflect current utilization and spending trends including changes in drug prescribing patterns. In addition, our analyses of the 2020 benefit year enrollee-level EDGE recalibration data found that it was largely comparable with the 2019 benefit year data set and we did not identify other major anomalous trends in our comparison of the unconstrained HCC coefficients in the 2019 and 2020 enrollee-level EDGE recalibration data sets, which raises the question about whether there is a sufficient justification to completely exclude 2020 benefit year enrollee-level EDGE recalibration data in the recalibration of the risk adjustment models.

Option 6 has the same drawbacks as option 5—that is, it would not use the most recently available data for the applicable benefit year model recalibration, which may be the data set that would best reflect current utilization and spending trends, and raises the same question about whether there is a sufficient justification to completely exclude the 2020 benefit year data for model recalibration purposes. This option has the additional drawback of decreasing the stabilizing effect of using multiple years of data, as our goal in using multiple years of data for model calibration is to capture some degree of year-to-year cost shifting without over-relying on any factors unique to one particular year. When using 2 years of data, each year is weighted at 50 percent, but with 3 years of data, each year is weighted at 33.3 percent. As such, a change in a coefficient occurring in 1 year of the data that is actually included in recalibration would have a greater impact on the risk adjustment model coefficients if only using 2 years of data rather than 3 years, due to the increase in the reliance of the blended coefficients on the remaining 2 years of data.[28]

After consideration of these different options, we propose option 4—that is, maintain the current policy of using the 3 most recent consecutive benefit year data sets that are available at the time of publication of this proposed rule, with a narrowly tailored exception to exclude the 2020 benefit year data from the blending of the age-sex coefficients for the adult models. Under this proposal, we would determine coefficients for the 2024 benefit year based on a blend of separately solved coefficients from the 2018, 2019, and 2020 benefit years of enrollee-level EDGE recalibration data except for the coefficients for the adult age-sex factors, which would instead be based on a blend of separately solved coefficients from only the 2018 and 2019 benefit year enrollee-level EDGE recalibration. This approach preserves the current policy and use of the 3 most recent consecutive years of data available for the majority of the risk adjustment model coefficients, allowing for the use of the next available benefit year of data to recalibrate models that appears to be largely comparable with 2019 benefit year data to reflect changes in cost and utilization patterns for payment HCCs, RXCs, enrollment duration factors and interaction factors. At the same time, it includes an exception narrowly tailored to account for the observed anomalous decreases in the unconstrainted coefficients for the 2020 benefit year enrollee-level EDGE recalibration data for older adult enrollees, especially female enrollees. Thus, we believe that this offers a balanced approach to the use of 2020 benefit year enrollee-level EDGE recalibration data for model recalibration purposes while also addressing the limited observed anomalous trends in the 2020 benefit year enrollee-level EDGE recalibration data.

Our proposal to adopt option 4 is narrowly tailored to only address the observed trend in the unconstrained age-sex coefficients for the 2020 benefit year enrollee-level EDGE recalibration data for older adult enrollees, especially older adult female enrollees, which are likely due to decreases in discretionary spending among this age group in the 2020 benefit year. We are not proposing adjustments in response to the other trends observed in the 2020 benefit year enrollee-level EDGE recalibration data, such as the decrease in PMPM spending that occurred in March and April 2020,[29] because we generally found that the 2020 benefit year data and trends were otherwise largely comparable with the 2019 benefit year data and we did not identify other anomalous trends in our comparison of the unconstrained HCC coefficients in the 2019 and 2020 benefit year enrollee-level EDGE recalibration data sets. We further note that the coefficients fit by the risk adjustment models reflect the cost of treatment rather than the number of enrollees accessing treatment or when during the year the treatment is accessed. Therefore, even though there was some observed decreased utilization in the 2020 benefit year enrollee-level EDGE recalibration data, the lack of change in diagnosis-related coefficients between the models fit with prior years of enrollee-level EDGE recalibration data and the models fit with 2020 enrollee-level EDGE recalibration data indicates that when an enrollee was able to access care and a diagnosis was recorded on EDGE for the benefit year, the cost of treatment of their diagnosed conditions was similar to that experienced in previous benefit years. As such, we believe the 2020 enrollee-level EDGE recalibration data is sufficiently similar to prior years of enrollee level EDGE recalibration data to

[27] We expect that the trending of the prior benefit year data to reflect the anticipated costs and spending trends in the applicable future benefit year of risk adjustment that occurs as part of the annual model recalibration effort would impact the 2024 risk adjustment model coefficients.

[28] We do not have the same concerns with respect to using only 2 years of data for recalibration of the adult model age-sex coefficients because age-sex coefficients tend to contribute less to enrollees' risk scores than HCC, RXC, and interaction coefficients, so changes in a single age-sex coefficient in one of the remaining years of data is less likely to have an undue impact. Additionally, the age-sex coefficients are derived from substantially larger samples of enrollees and are therefore theoretically more stable than HCC, RXC, enrollment duration and interaction coefficients. Furthermore, the anomalies seen in the age-sex coefficients fit with the 2020 EDGE data systematically impact a wide range of enrollees. As such, we believe the risks of including 2020 EDGE data in blending of the age-sex coefficients outweighs the risks of only using the 2018 and 2019 benefit years of EDGE data to blend the age-sex coefficients for the 2024 benefit year adult models.

[29] As noted above, even though PMPM spending dropped substantially between March and April 2020, our analysis found that total PMPM spending in the 2020 benefit year was generally similar to the 2019 benefit year.

use in the fitting of coefficients for HCCs, RXCs, their interactions, and enrollment duration factors. We also do not believe that any 2020 enrollee-level EDGE recalibration data exceptions are needed for the child or infant risk adjustment models because among those models we did not observe anomalous trends between age-sex groups analogous to those trends observed that differentially impacted age-sex factors in the adult models. The draft coefficients listed in Tables 2 through 7 of this proposed rule reflect the use of 2018, 2019, and 2020 benefit year enrollee-level EDGE recalibration data, with an exception to exclude the 2020 benefit year data from the blending of the age-sex coefficients for the adult models, as well as the other risk adjustment model updates proposed in this proposed rule.[30]

To aid interested parties in their consideration of the proposed option, we are providing in Table 1 the values for the adult age-sex coefficients under option 1, which blends the age-sex coefficients using all three benefit years (2018, 2019 and 2020). Interested parties may compare the coefficients in Table 1 (reflecting option 1) to those in Table 2 (reflecting proposed option 4) to understand the impact of the 2020 enrollee-level EDGE data on the blended age-sex coefficients for the 2024 benefit year.

TABLE 1: Adult Risk Adjustment Age-Sex Coefficients[31] for the 2024 Benefit Year Using 2018, 2019 and 2020 Benefit Years of Enrollee-Level EDGE Data (Option 1)

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Age 21-24, Male	0.189	0.121	0.080	0.052	0.051
Age 25-29, Male	0.192	0.120	0.078	0.049	0.047
Age 30-34, Male	0.223	0.145	0.097	0.062	0.061
Age 35-39, Male	0.244	0.159	0.105	0.065	0.064
Age 40-44, Male	0.280	0.189	0.129	0.083	0.082
Age 45-49, Male	0.309	0.211	0.147	0.097	0.095
Age 50-54, Male	0.391	0.284	0.213	0.157	0.155
Age 55-59, Male	0.441	0.325	0.246	0.185	0.183
Age 60-64, Male	0.493	0.366	0.279	0.211	0.209
Age 21-24, Female	0.286	0.186	0.121	0.075	0.073
Age 25-29, Female	0.307	0.199	0.129	0.078	0.076
Age 30-34, Female	0.373	0.257	0.180	0.122	0.120
Age 35-39, Female	0.440	0.317	0.234	0.172	0.170
Age 40-44, Female	0.497	0.368	0.279	0.210	0.207
Age 45-49, Female	0.501	0.368	0.276	0.201	0.198
Age 50-54, Female	0.544	0.407	0.309	0.230	0.227
Age 55-59, Female	0.512	0.376	0.278	0.199	0.196
Age 60-64, Female	0.511	0.372	0.271	0.190	0.188

In addition to considering alternative options to recalibration in this section, we note that the coefficients could change if we identify an error after publication of this rule or if some or all of the proposed model changes are not finalized or are modified in response to comments. 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 2024 benefit year in guidance soon after the publication of the final rule.

We seek comment on the proposal to determine 2024 benefit year coefficients based on a blend of separately solved coefficients from the 2018, 2019, and 2020 enrollee-level EDGE recalibration data, with an exception to exclude the 2020 benefit year data from the blending of the age-sex coefficients for the adult models. We also seek comment on all of the alternative approaches outlined above.

b. Pricing Adjustment for the Hepatitis C Drugs

For the 2024 benefit year, we propose to continue applying a market pricing adjustment to the plan liability associated with Hepatitis C drugs in the risk adjustment models.[32] Since the 2020 benefit year risk adjustment models, we have been making a market pricing adjustment to the plan liability associated with Hepatitis C drugs to reflect future market pricing prior to solving for coefficients for the models.[33] The purpose of this market pricing adjustment is to account for significant pricing changes associated with the introduction of new and generic Hepatitis C drugs between the data years used for recalibrating the models and the applicable recalibration benefit year.[34]

We have committed to reassessing this pricing adjustment with additional years of enrollee-level EDGE data, as data become available. As part of the 2024 benefit year model recalibration, we reassessed the cost trend for Hepatitis C drugs using available

[30] Similar to recalibration of the 2023 risk adjustment adult models and consistent with the policies adopted in the 2023 Payment Notice, the draft factors in this rule also reflect the removal of the mapping of hydroxychloroquine sulfate to RXC 09 (Immune Suppressants and Immunomodulators) and the related RXC 09 interactions (RXC 09 × HCC056 or 057 and 048 or 041; RXC 09 × HCC056; RXC 09 × HCC 057; RXC 09 × HCC048, 041) from the 2018 and 2019 benefit year enrollee-level EDGE data sets for purposes of recalibrating the 2024 benefit year adult models. See 87 FR 27232 through 27235. Additionally, the draft factors for the adult models reflect the use of the final, fourth quarter (Q4) RXC mapping document that was applicable for each benefit year of data included in the current year's model recalibration (except under extenuating circumstances that can result in targeted changes to RXC mappings). See 87 FR at 27231 through 27232.

[31] All coefficients in Table 2 except for the adult age-sex factors are blended using all three benefit years of enrollee-level EDGE data (2018, 2019, and 2020). Option 1 and proposed option 4 only differ in the values of the adult age-sex coefficients. As such, in Table 1, we only provide the adult age-sex coefficients for option 1.

[32] See for example, 84 FR 17463 through 17466.

[33] The Hepatitis C drugs market pricing adjustment to plan liability is applied for all enrollees taking Hepatitis C drugs in the data used for recalibration.

[34] Silseth, S., & Shaw, H. (2021). Analysis of prescription drugs for the treatment of hepatitis C in the United States. Milliman White Paper. *https://www.milliman.com/-/media/milliman/pdfs/2021-articles/6-11-21-analysis-prescription-drugs-treatment-hepatitis-c-us.ashx.*

enrollee-level EDGE data (including 2020 benefit year data) to consider whether the adjustment was still needed and if it is still needed, whether it should be modified. We found that the data for the Hepatitis C RXC that would be used for the 2024 benefit year recalibration [35] still do not account for the significant pricing changes due to the introduction of new Hepatitis C drugs, and therefore, do not precisely reflect the average cost of Hepatitis C treatments applicable to the benefit year in question.

Specifically, generic Hepatitis C drugs did not become available on the market until 2019, and we propose to use 2018 benefit year EDGE data in the 2024 benefit year model recalibration.[36] Due to the lag between the data years used to recalibrate the risk adjustment models and the applicable benefit year of risk adjustment, as well as the expectation that the costs for Hepatitis C drugs will not increase at the same rate as other drug costs between the data year and the applicable benefit year of risk adjustment, we do not believe that the trends used to reflect growth in the cost of prescription drugs due to inflation and related factors for recalibrating the models will appropriately reflect the average cost of Hepatitis C treatments expected in the 2024 benefit year. Therefore, we continue to believe a market pricing adjustment specific to Hepatitis C drugs in our models for the 2024 benefit year is necessary to account for the significant pricing changes associated with the introduction of new and generic Hepatitis C drugs between the data years used for recalibrating the models and the applicable recalibration benefit year. We intend to continue to assess this pricing adjustment in future benefit year recalibrations using additional years of enrollee-level EDGE data.

We seek comment on our proposal to continue applying a market pricing adjustment to the plan liability associated with Hepatitis C drugs for the 2024 benefit year.

c. Request for Information: Payment HCC for Gender Dysphoria

HHS requests information on adding a payment HCC for gender dysphoria to the HHS-operated risk adjustment models for future benefit years. As part of the ongoing assessment of improvements to the HHS-operated risk adjustment program, HHS considers whether adjustments are needed to the payment HCCs in the risk adjustment models.[37] In light of Executive Order (E.O.) 13985 ''Advancing Racial Equity and Support for Underserved Communities Through the Federal Government,'' [38] E.O. 13988 ''Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation,'' [39] and a comment received in response to the 2023 Payment Notice proposed rule, HHS is soliciting comment on whether to consider adding a new payment HCC for gender dysphoria to the risk adjustment models for future benefit years.

In considering the inclusion of a new payment HCC for gender dysphoria, we evaluated this potential payment HCC against the 10 Principles of HHS-Operated Risk Adjustment and determined that a new payment HCC for gender dysphoria would satisfy some but not all of these principles (77 FR 73128).

To further consider whether we should add a payment HCC for gender dysphoria to the HHS-operated risk adjustment models, we request feedback on the following questions:

- The implications of using the changing clinical concepts and labels from the ICD–10–CM diagnosis of ''gender identity disorder'' compared to the draft ICD–11–CM diagnosis of ''gender incongruence'' [40] for the naming and inclusion of this diagnosis or payment HCC in the HHS risk adjustment models.
- Whether a gender dysphoria HCC should be a separate and standalone payment HCC, or if gender dysphoria could be combined with any other diagnoses to form a broader payment HCC.[41]
- Any other factors HHS should consider when determining whether to add a gender dysphoria HCC to the HHS risk adjustment models as a payment HCC.

While we are not proposing to add a payment HCC for gender dysphoria to the HHS risk adjustment models at this time, we solicit comments to inform our continued consideration of potential risk adjustment model updates for future benefit years.

d. List of Factors To Be Employed in the Risk Adjustment Models (§ 153.320)

The proposed 2024 benefit year risk adjustment model factors resulting from the equally weighted (averaged) blended factors from separately solved models using the 2018, 2019, and 2020 enrollee-level EDGE data, with an exception to exclude the 2020 data from recalibration of the age-sex factors for the adult models, are shown in Tables 1 through 6. The 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.[42] Table 2 contains factors for each adult model, including the age-sex, HCCs, RXCs, RXC–HCC interactions, interacted HCC counts, and enrollment duration coefficients. Table 3 contains the factors for each child model, including the age-sex, HCCs, and interacted HCC counts coefficients. Table 4 lists the HHS–HCCs selected for the interacted HCC counts factors that apply to the adult and child models. Table 5 contains the factors for each infant model. Tables 6 and 7 contain the HCCs included in the infant models' maturity and severity categories, respectively.

BILLING CODE 4120–01–P

[35] As detailed above, we propose to use 2018, 2019 and 2020 enrollee-level EDGE data for recalibration of the 2024 benefit year HHS risk adjustment models, with an exception to exclude 2020 data from recalibration of the age-sex factors for the adult models. However, for purposes of assessing whether this pricing adjustment was still needed and, if so, if it should be modified, we also assessed 2017 enrollee-level EDGE data in the event one of the alternative proposals regarding use of 2020 enrollee-level EDGE data is adopted.

[36] See Miligan, J, (2018). A perspective from our CEO: Gilead Subsidiary to Launch Authorized Generics to Treat HCV. Gilead. *https://www.gilead.com/news-and-press/company-statements/authorized-generics-for-hcv.* See also AbbVie. (2017). AbbVie Receives U.S. FDA Approval of MAVYRET™ (glecaprevir/pibrentasvir) for the Treatment of Chronic Hepatitis C in All Major Genotypes (GT 1–6) in as Short as 8 Weeks. Abbvie. *https://news.abbvie.com/news/abbvie-receives-us-fda-approval-mavyret-glecaprevirpibrentasvir-for-treatment-chronic-hepatitis-c-in-all-major-genotypes-gt-1-6-in-as-short-as-8-weeks.htm.*

[37] See, for example, the 2019 White Paper. *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Potential-Updates-to-HHS-HCCs-HHS-operated-Risk-Adjustment-Program.pdf.*

[38] 86 FR 7009.

[39] 86 FR 7023.

[40] World Health Organization. (n.d.). Gender incongruence and transgender health in the ICD. *https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd.*

[41] Gender dysphoria codes are currently mapped to HCC 93 Other Psychiatric Disorders, a non-payment HCC that is not currently included in the HHS-operated risk adjustment models.

[42] We are not proposing changes to the high-cost risk pool parameters for the 2024 benefit year. Therefore, we would maintain the $1 million threshold and 60 percent coinsurance rate.

TABLE 2: Proposed Adult Risk Adjustment Model Factors for the 2024 Benefit Year

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Demographic Factors						
	Age 21-24, Male	0.187	0.120	0.079	0.050	0.049
	Age 25-29, Male	0.190	0.121	0.079	0.049	0.047
	Age 30-34, Male	0.222	0.146	0.097	0.062	0.060
	Age 35-39, Male	0.245	0.161	0.106	0.065	0.063
	Age 40-44, Male	0.282	0.191	0.130	0.083	0.081
	Age 45-49, Male	0.311	0.214	0.147	0.096	0.094
	Age 50-54, Male	0.398	0.292	0.218	0.161	0.159
	Age 55-59, Male	0.450	0.333	0.252	0.188	0.186
	Age 60-64, Male	0.509	0.382	0.293	0.221	0.219
	Age 21-24, Female	0.286	0.188	0.124	0.077	0.075
	Age 25-29, Female	0.308	0.203	0.133	0.082	0.080
	Age 30-34, Female	0.380	0.264	0.187	0.128	0.125
	Age 35-39, Female	0.453	0.329	0.246	0.181	0.179
	Age 40-44, Female	0.510	0.381	0.291	0.219	0.216
	Age 45-49, Female	0.515	0.382	0.287	0.209	0.206
	Age 50-54, Female	0.561	0.424	0.324	0.241	0.238
	Age 55-59, Female	0.532	0.395	0.294	0.212	0.209
	Age 60-64, Female	0.542	0.400	0.296	0.212	0.209
Diagnosis Factors						
HCC001	HIV/AIDS	0.610	0.495	0.426	0.382	0.380
HCC002	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	9.632	9.382	9.265	9.203	9.202
HCC003	Central Nervous System Infections, Except Viral Meningitis	8.965	8.831	8.747	8.678	8.675

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC004	Viral or Unspecified Meningitis	8.914	8.769	8.675	8.592	8.589
HCC006	Opportunistic Infections	8.576	8.501	8.427	8.333	8.329
HCC008	Metastatic Cancer	24.525	24.081	23.916	23.899	23.899
HCC009	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	13.190	12.873	12.733	12.672	12.670
HCC010	Non-Hodgkin Lymphomas and Other Cancers and Tumors	6.042	5.834	5.716	5.631	5.628
HCC011	Colorectal, Breast (Age < 50), Kidney, and Other Cancers	3.876	3.663	3.536	3.439	3.436
HCC012	Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	2.622	2.463	2.358	2.273	2.271
HCC013	Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.054	0.935	0.827	0.717	0.714
HCC018 43	Pancreas Transplant Status	7.002	6.831	6.765	6.687	6.672
HCC019	Diabetes with Acute Complications	0.295	0.237	0.189	0.146	0.144
HCC020	Diabetes with Chronic Complications	0.295	0.237	0.189	0.146	0.144
HCC021	Diabetes without Complication	0.295	0.237	0.189	0.146	0.144
HCC022	Type 1 Diabetes Mellitus, add-on to Diabetes HCCs 19-21	0.380	0.339	0.303	0.234	0.231
HCC023	Protein-Calorie Malnutrition	11.879	11.731	11.645	11.587	11.585
HCC026	Mucopolysaccharidosis	27.187	26.955	26.857	26.834	26.834
HCC027	Lipidoses and Glycogenosis	27.187	26.955	26.857	26.834	26.834
HCC029	Amyloidosis, Porphyria, and Other Metabolic Disorders	6.954	6.830	6.758	6.702	6.700
HCC030	Adrenal, Pituitary, and Other Significant Endocrine Disorders	1.446	1.351	1.278	1.204	1.201
HCC034	Liver Transplant Status/Complications	6.481	6.531	6.579	6.647	6.649
HCC035_1 44	Acute Liver Failure/Disease, Including Neonatal Hepatitis	7.706	7.500	7.402	7.365	7.367
HCC035_2	Chronic Liver Failure/End-Stage Liver Disorders	2.506	2.315	2.223	2.167	2.166
HCC036	Cirrhosis of Liver	0.706	0.607	0.537	0.466	0.463
HCC037_1	Chronic Viral Hepatitis C	0.528	0.451	0.389	0.324	0.322
HCC037_2	Chronic Hepatitis, Except Chronic Viral Hepatitis C	0.528	0.451	0.389	0.324	0.322
HCC041	Intestine Transplant Status/Complications	11.558	11.539	11.535	11.546	11.546
HCC042	Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	11.889	11.691	11.610	11.582	11.581
HCC045	Intestinal Obstruction	5.323	5.085	4.970	4.891	4.890
HCC046	Chronic Pancreatitis	2.842	2.639	2.547	2.497	2.497
HCC047	Acute Pancreatitis	2.842	2.624	2.517	2.427	2.425
HCC048	Inflammatory Bowel Disease	0.469	0.365	0.266	0.146	0.142
HCC054	Necrotizing Fasciitis	9.611	9.426	9.345	9.332	9.332
HCC055	Bone/Joint/Muscle Infections/Necrosis	5.113	4.911	4.827	4.805	4.804

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC056	Rheumatoid Arthritis and Specified Autoimmune Disorders	1.073	0.964	0.876	0.795	0.792
HCC057	Systemic Lupus Erythematosus and Other Autoimmune Disorders	0.467	0.376	0.280	0.173	0.168
HCC061	Osteogenesis Imperfecta and Other Osteodystrophies	2.273	2.113	2.012	1.922	1.919
HCC062	Congenital/Developmental Skeletal and Connective Tissue Disorders	2.273	2.113	2.012	1.922	1.919
HCC063	Cleft Lip/Cleft Palate	1.395	1.258	1.174	1.102	1.100
HCC066	Hemophilia	74.006	73.673	73.537	73.513	73.514
HCC067	Myelodysplastic Syndromes and Myelofibrosis	12.434	12.293	12.226	12.181	12.177
HCC068	Aplastic Anemia	12.434	12.293	12.226	12.181	12.177
HCC069	Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	12.434	12.293	12.226	12.181	12.177
HCC070	Sickle Cell Anemia (Hb-SS)	2.115	2.003	1.925	1.852	1.849
HCC071	Beta Thalassemia Major	2.115	2.003	1.925	1.852	1.849
HCC073	Combined and Other Severe Immunodeficiencies	4.051	3.941	3.879	3.832	3.831
HCC074	Disorders of the Immune Mechanism	4.051	3.941	3.879	3.832	3.831
HCC075	Coagulation Defects and Other Specified Hematological Disorders	2.211	2.111	2.041	1.976	1.974
HCC081	Drug Use with Psychotic Complications	1.844	1.675	1.544	1.399	1.394
HCC082	Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	1.844	1.675	1.544	1.399	1.394
HCC083	Alcohol Use with Psychotic Complications	1.046	0.902	0.803	0.704	0.701
HCC084	Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications	1.046	0.902	0.803	0.704	0.701
HCC087_1	Schizophrenia	2.423	2.222	2.100	1.990	1.988
HCC087_2	Delusional and Other Specified Psychotic Disorders, Unspecified Psychosis	2.407	2.208	2.086	1.969	1.966
HCC088	Major Depressive Disorder, Severe, and Bipolar Disorders	1.097	0.972	0.866	0.752	0.748
HCC090	Personality Disorders	0.777	0.675	0.568	0.452	0.448
HCC094	Anorexia/Bulimia Nervosa	2.296	2.160	2.060	1.969	1.965
HCC096	Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	8.822	8.772	8.724	8.674	8.671
HCC097	Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	1.212	1.128	1.063	1.003	1.001
HCC102	Autistic Disorder	0.871	0.770	0.669	0.571	0.567
HCC103	Pervasive Developmental Disorders, Except Autistic Disorder	0.777	0.675	0.568	0.452	0.448
HCC106	Traumatic Complete Lesion Cervical Spinal Cord	9.999	9.801	9.692	9.611	9.609
HCC107	Quadriplegia	9.999	9.801	9.692	9.611	9.609
HCC108	Traumatic Complete Lesion Dorsal Spinal Cord	7.110	6.939	6.841	6.758	6.756
HCC109	Paraplegia	7.110	6.939	6.841	6.758	6.756
HCC110	Spinal Cord Disorders/Injuries	5.642	5.424	5.314	5.240	5.238

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC111	Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	5.761	5.574	5.459	5.348	5.345
HCC112	Quadriplegic Cerebral Palsy	0.915	0.782	0.690	0.593	0.590
HCC113	Cerebral Palsy, Except Quadriplegic	0.603	0.508	0.433	0.350	0.347
HCC114	Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	1.376	1.266	1.184	1.094	1.091
HCC115	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	5.550	5.444	5.393	5.365	5.364
HCC117	Muscular Dystrophy	1.561	1.445	1.353	1.252	1.248
HCC118	Multiple Sclerosis	1.790	1.656	1.563	1.474	1.471
HCC119	Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	1.561	1.445	1.353	1.252	1.248
HCC120	Seizure Disorders and Convulsions	1.167	1.050	0.963	0.871	0.868
HCC121	Hydrocephalus	10.740	10.618	10.534	10.464	10.461
HCC122	Coma, Brain Compression/Anoxic Damage	11.024	10.847	10.738	10.657	10.654
HCC123	Narcolepsy and Cataplexy	4.582	4.419	4.310	4.218	4.215
HCC125	Respirator Dependence/Tracheostomy Status	21.711	21.476	21.356	21.292	21.293
HCC126	Respiratory Arrest	8.925	8.681	8.560	8.492	8.491
HCC127	Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	8.925	8.681	8.560	8.492	8.491
HCC128	Heart Assistive Device/Artificial Heart	19.352	19.182	19.086	19.034	19.039
HCC129	Heart Transplant Status/Complications	19.352	19.182	19.086	19.034	19.039
HCC130	Heart Failure	2.114	2.006	1.943	1.890	1.889
HCC131	Acute Myocardial Infarction	5.710	5.437	5.334	5.318	5.319
HCC132	Unstable Angina and Other Acute Ischemic Heart Disease	4.333	4.076	3.969	3.906	3.906
HCC135	Heart Infection/Inflammation, Except Rheumatic	9.550	9.428	9.336	9.245	9.241
HCC137	Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders	2.354	2.242	2.159	2.087	2.085
HCC138	Major Congenital Heart/Circulatory Disorders	2.354	2.242	2.159	2.087	2.085
HCC139	Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders	2.354	2.242	2.159	2.087	2.085
HCC142	Specified Heart Arrhythmias	2.068	1.940	1.846	1.747	1.749
HCC145	Intracranial Hemorrhage	11.501	11.303	11.199	11.134	11.132
HCC146	Ischemic or Unspecified Stroke	1.589	1.449	1.381	1.325	1.324
HCC149	Cerebral Aneurysm and Arteriovenous Malformation	2.506	2.361	2.270	2.182	2.178
HCC150	Hemiplegia/Hemiparesis	3.702	3.558	3.501	3.483	3.483
HCC151	Monoplegia, Other Paralytic Syndromes	2.759	2.625	2.548	2.482	2.481
HCC153	Atherosclerosis of the Extremities with Ulceration or Gangrene	8.513	8.338	8.287	8.310	8.312
HCC154	Vascular Disease with Complications	5.876	5.705	5.617	5.563	5.561

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC156	Pulmonary Embolism and Deep Vein Thrombosis	8.158	8.045	7.945	7.831	7.827
HCC158	Lung Transplant Status/Complications	11.241	11.061	10.970	10.928	10.928
HCC159	Cystic Fibrosis	4.651	4.456	4.346	4.270	4.268
HCC160	Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	0.708	0.610	0.518	0.424	0.420
HCC161_1	Severe Asthma	0.708	0.610	0.518	0.424	0.420
HCC161_2	Asthma, Except Severe	0.708	0.610	0.518	0.424	0.420
HCC162	Fibrosis of Lung and Other Lung Disorders	1.669	1.555	1.476	1.396	1.394
HCC163	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	6.800	6.776	6.772	6.785	6.786
HCC174	Exudative Macular Degeneration	1.410	1.250	1.133	1.006	1.002
HCC183 45	Kidney Transplant Status/Complications	7.002	6.831	6.765	6.687	6.672
HCC184	End Stage Renal Disease	22.616	22.143	22.091	22.024	21.952
HCC187	Chronic Kidney Disease, Stage 5	0.754	0.654	0.624	0.599	0.588
HCC188	Chronic Kidney Disease, Severe (Stage 4)	0.754	0.654	0.624	0.599	0.588
HCC203	Ectopic and Molar Pregnancy	2.101	1.869	1.688	1.453	1.446
HCC204	Miscarriage with Complications	0.735	0.627	0.487	0.297	0.289
HCC205	Miscarriage with No or Minor Complications	0.735	0.627	0.487	0.297	0.289
HCC207	Pregnancy with Delivery with Major Complications	4.112	3.743	3.511	3.184	3.177
HCC208	Pregnancy with Delivery with Complications	4.112	3.743	3.511	3.184	3.177
HCC209	Pregnancy with Delivery with No or Minor Complications	2.959	2.685	2.452	2.035	2.021
HCC210	(Ongoing) Pregnancy without Delivery with Major Complications	0.925	0.787	0.614	0.411	0.403
HCC211	(Ongoing) Pregnancy without Delivery with Complications	0.602	0.498	0.349	0.200	0.194
HCC212	(Ongoing) Pregnancy without Delivery with No or Minor Complications	0.045	0.011	0.000	0.000	0.000
HCC217	Chronic Ulcer of Skin, Except Pressure	1.673	1.557	1.495	1.449	1.448
HCC218	Extensive Third-Degree Burns	24.045	23.796	23.670	23.616	23.615
HCC219	Major Skin Burn or Condition	3.002	2.852	2.759	2.688	2.686
HCC223	Severe Head Injury	19.211	19.023	18.906	18.816	18.812
HCC226	Hip and Pelvic Fractures	8.717	8.433	8.321	8.299	8.299
HCC228	Vertebral Fractures without Spinal Cord Injury	4.629	4.430	4.311	4.209	4.206
HCC234	Traumatic Amputations and Amputation Complications	5.579	5.388	5.310	5.282	5.280
HCC251	Stem Cell, Including Bone Marrow, Transplant Status/Complications	19.317	19.299	19.253	19.203	19.204
HCC253	Artificial Openings for Feeding or Elimination	6.278	6.141	6.079	6.051	6.051

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC254	Amputation Status, Upper Limb or Lower Limb	1.275	1.144	1.078	1.030	1.028
Interacted HCC Counts Factors						
	Severe illness, 1 payment HCC	-6.481	-6.531	-6.579	-6.647	-6.649
	Severe illness, 2 payment HCCs	-5.980	-6.064	-6.100	-6.138	-6.138
	Severe illness, 3 payment HCCs	-4.874	-4.919	-4.880	-4.800	-4.797
	Severe illness, 4 payment HCCs	-4.038	-4.010	-3.884	-3.675	-3.667
	Severe illness, 5 payment HCCs	-3.255	-3.127	-2.917	-2.600	-2.589
	Severe illness, 6 payment HCCs	-2.821	-2.566	-2.271	-1.865	-1.850
	Severe illness, 7 payment HCCs	-2.043	-1.611	-1.209	-0.711	-0.695
	Severe illness, 8 payment HCCs	-1.976	-1.496	-1.066	-0.544	-0.526
	Severe illness, 9 payment HCCs	0.766	1.457	2.004	2.616	2.636
	Severe illness, 10 or more payment HCCs	8.825	9.947	10.723	11.493	11.519
	Transplant severe illness, 4 payment HCCs	4.029	3.981	3.935	3.854	3.847
	Transplant severe illness, 5 payment HCCs	8.160	8.097	8.057	7.989	7.980
	Transplant severe illness, 6 payment HCCs	15.312	15.232	15.196	15.140	15.128
	Transplant severe illness, 7 payment HCCs	18.743	18.632	18.584	18.522	18.511
	Transplant severe illness, 8 or more payment HCCs	36.031	36.054	36.081	36.066	36.056
Enrollment Duration Factors						
	Enrolled for 1 month, at least one payment HCC	10.880	9.150	8.099	7.149	7.117
	Enrolled for 2 months, at least one payment HCC	5.224	4.342	3.782	3.305	3.288
	Enrolled for 3 months, at least one payment HCC	3.367	2.788	2.400	2.080	2.070
	Enrolled for 4 months, at least one payment HCC	2.219	1.818	1.536	1.309	1.301
	Enrolled for 5 months, at least one payment HCC	1.636	1.339	1.121	0.944	0.938
	Enrolled for 6 months, at least one payment HCC	1.088	0.869	0.701	0.561	0.556
Prescription Drug Factors						
RXC 01	Anti-HIV Agents	5.647	5.055	4.669	4.306	4.296
RXC 02	Anti-Hepatitis C (HCV) Agents, Direct Acting Agents	8.662	8.116	7.936	7.952	7.956
RXC 0346	Antiarrhythmics	0.091	0.083	0.075	0.058	0.035
RXC 04	Phosphate Binders	1.008	1.204	1.125	1.295	1.411
RXC 05	Inflammatory Bowel Disease Agents	1.467	1.314	1.155	0.930	0.920
RXC 06	Insulin	1.429	1.215	1.022	0.841	0.834
RXC 07	Anti-Diabetic Agents, Except Insulin and Metformin Only	0.789	0.673	0.549	0.375	0.369
RXC 08	Multiple Sclerosis Agents	16.266	15.334	14.880	14.547	14.531

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
RXC 0947	Immune Suppressants and Immunomodulators	12.396	11.784	11.558	11.525	11.527
RXC 10	Cystic Fibrosis Agents	15.054	14.632	14.479	14.440	14.440
RXC 01 x HCC001	Additional effect for enrollees with RXC 01 and HCC 001	2.048	2.149	2.376	2.748	2.761
RXC 02 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)	-0.528	-0.451	-0.389	-0.324	-0.322
RXC 03 x HCC142	Additional effect for enrollees with RXC 03 and HCC 142	0.000	0.000	0.000	0.000	0.000
RXC 04 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
RXC 05 x HCC048, 041	Additional effect for enrollees with RXC 05 and (HCC 048 or 041)	-0.469	-0.365	-0.266	-0.146	-0.142
RXC 06 x HCC018, 019, 020, 021	Additional effect for enrollees with RXC 06 and (HCC 018 or 019 or 020 or 021)	0.434	0.492	0.567	0.578	0.580
RXC 07 x HCC018, 019, 020, 021	Additional effect for enrollees with RXC 07 and (HCC 018 or 019 or 020 or 021)	-0.295	-0.237	-0.189	-0.146	-0.144
RXC 08 x HCC118	Additional effect for enrollees with RXC 08 and HCC 118	0.947	1.380	1.709	2.146	2.168
RXC 09 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)	0.287	0.347	0.387	0.425	0.426
RXC 09 x HCC056	Additional effect for enrollees with RXC 09 and HCC 056	-1.073	-0.964	-0.876	-0.795	-0.792
RXC 09 x HCC057	Additional effect for enrollees with RXC 09 and HCC 057	-0.467	-0.376	-0.280	-0.173	-0.168
RXC 09 x HCC048, 041	Additional effect for enrollees with RXC 09 and (HCC 048 or 041)	2.454	2.573	2.695	2.872	2.877
RXC 10 x HCC159, 158	Additional effect for enrollees with RXC 10 and (HCC 159 or 158)	41.353	41.406	41.472	41.618	41.623

TABLE 3: Proposed Child Risk Adjustment Model Factors for the 2024 Benefit Year

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Demographic Factors					
Age 2-4, Male	0.288	0.195	0.146	0.109	0.108
Age 5-9, Male	0.213	0.132	0.093	0.069	0.068
Age 10-14, Male	0.236	0.156	0.115	0.092	0.091
Age 15-20, Male	0.271	0.186	0.135	0.101	0.100
Age 2-4, Female	0.233	0.151	0.113	0.088	0.087
Age 5-9, Female	0.160	0.087	0.056	0.037	0.036
Age 10-14, Female	0.227	0.149	0.110	0.087	0.086
Age 15-20, Female	0.314	0.210	0.145	0.099	0.097
Diagnosis Factors					
HIV/AIDS	4.490	3.999	3.762	3.617	3.615
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	14.897	14.669	14.536	14.439	14.437
Central Nervous System Infections, Except Viral Meningitis	13.638	13.470	13.360	13.293	13.291
Viral or Unspecified Meningitis	11.963	11.850	11.768	11.643	11.642
Opportunistic Infections	17.169	17.088	16.997	16.907	16.904
Metastatic Cancer	33.749	33.464	33.322	33.262	33.261
Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	9.374	9.094	8.929	8.808	8.804
Non-Hodgkin Lymphomas and Other Cancers and Tumors	7.293	7.065	6.911	6.777	6.772
Colorectal, Breast (Age < 50), Kidney, and Other Cancers	4.615	4.450	4.331	4.221	4.217
Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	4.615	4.450	4.331	4.221	4.217
Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.171	1.037	0.925	0.806	0.802
Pancreas Transplant Status	11.106	11.020	10.974	10.939	10.937
Diabetes with Acute Complications	2.624	2.312	2.075	1.754	1.745
Diabetes with Chronic Complications	2.624	2.312	2.075	1.754	1.745
Diabetes without Complication	2.624	2.312	2.075	1.754	1.745
Protein-Calorie Malnutrition	19.295	19.163	19.078	19.037	19.035
Mucopolysaccharidosis	39.965	39.679	39.551	39.501	39.500
Lipidoses and Glycogenosis	39.965	39.679	39.551	39.501	39.500
Congenital Metabolic Disorders, Not Elsewhere Classified	4.830	4.698	4.609	4.541	4.538
Amyloidosis, Porphyria, and Other Metabolic Disorders	4.830	4.698	4.609	4.541	4.538
Adrenal, Pituitary, and Other Significant Endocrine Disorders	5.553	5.285	5.146	5.079	5.078
Liver Transplant Status/Complications	11.106	11.020	10.974	10.939	10.937
Acute Liver Failure/Disease, Including Neonatal Hepatitis	9.767	9.619	9.551	9.525	9.524
Chronic Liver Failure/End-Stage Liver Disorders	9.286	9.131	9.047	8.983	8.980
Cirrhosis of Liver	4.128	3.990	3.907	3.848	3.849
Chronic Viral Hepatitis C	1.186	1.046	0.961	0.917	0.917
Chronic Hepatitis, Except Chronic Viral Hepatitis C	0.197	0.169	0.142	0.111	0.110
Intestine Transplant Status/Complications	13.858	13.756	13.667	13.582	13.579

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	17.886	17.459	17.325	17.276	17.275
Intestinal Obstruction	4.767	4.582	4.446	4.332	4.329
Chronic Pancreatitis	11.778	11.601	11.522	11.476	11.476
Acute Pancreatitis	5.360	5.102	4.953	4.826	4.823
Inflammatory Bowel Disease	9.915	9.478	9.266	9.139	9.135
Necrotizing Fasciitis	3.684	3.449	3.308	3.207	3.204
Bone/Joint/Muscle Infections/Necrosis	3.684	3.449	3.308	3.207	3.204
Rheumatoid Arthritis and Specified Autoimmune Disorders	4.733	4.456	4.296	4.195	4.192
Systemic Lupus Erythematosus and Other Autoimmune Disorders	0.746	0.619	0.500	0.376	0.372
Osteogenesis Imperfecta and Other Osteodystrophies	1.389	1.262	1.168	1.085	1.082
Congenital/Developmental Skeletal and Connective Tissue Disorders	1.389	1.262	1.168	1.085	1.082
Cleft Lip/Cleft Palate	1.174	1.006	0.881	0.756	0.752
Hemophilia	67.994	67.478	67.248	67.166	67.164
Myelodysplastic Syndromes and Myelofibrosis	13.130	12.957	12.863	12.801	12.800
Aplastic Anemia	13.130	12.957	12.863	12.801	12.800
Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	13.130	12.957	12.863	12.801	12.800
Sickle Cell Anemia (Hb-SS)	3.851	3.643	3.511	3.411	3.408
Beta Thalassemia Major	3.851	3.643	3.511	3.411	3.408
Combined and Other Severe Immunodeficiencies	4.918	4.760	4.660	4.582	4.580
Disorders of the Immune Mechanism	4.918	4.760	4.660	4.582	4.580
Coagulation Defects and Other Specified Hematological Disorders	4.218	4.082	3.982	3.897	3.894
Drug Use with Psychotic Complications	2.517	2.331	2.202	2.065	2.061
Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	2.517	2.331	2.202	2.065	2.061
Alcohol Use with Psychotic Complications	1.203	1.031	0.894	0.740	0.734
Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications	1.203	1.031	0.894	0.740	0.734
Schizophrenia	3.991	3.694	3.511	3.350	3.346
Delusional and Other Specified Psychotic Disorders, Unspecified Psychosis	3.395	3.122	2.941	2.760	2.755
Major Depressive Disorder, Severe, and Bipolar Disorders	2.638	2.413	2.243	2.082	2.077
Personality Disorders	0.378	0.270	0.155	0.042	0.038
Anorexia/Bulimia Nervosa	2.453	2.277	2.147	2.034	2.030
Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	11.637	11.535	11.450	11.378	11.376
Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	0.982	0.842	0.742	0.642	0.638
Autistic Disorder	2.638	2.413	2.243	2.082	2.077
Pervasive Developmental Disorders, Except Autistic Disorder	0.404	0.314	0.222	0.146	0.144
Traumatic Complete Lesion Cervical Spinal Cord	11.137	10.900	10.779	10.704	10.702
Quadriplegia	11.137	10.900	10.779	10.704	10.702
Traumatic Complete Lesion Dorsal Spinal Cord	11.047	10.807	10.695	10.627	10.625

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Paraplegia	11.047	10.807	10.695	10.627	10.625
Spinal Cord Disorders/Injuries	4.782	4.560	4.404	4.246	4.240
Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	50.056	49.780	49.630	49.543	49.540
Quadriplegic Cerebral Palsy	0.913	0.651	0.525	0.440	0.439
Cerebral Palsy, Except Quadriplegic	0.274	0.128	0.061	0.017	0.015
Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	1.770	1.630	1.533	1.437	1.434
Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	11.126	10.941	10.858	10.829	10.829
Muscular Dystrophy	6.190	6.018	5.902	5.793	5.790
Multiple Sclerosis	9.870	9.439	9.256	9.199	9.200
Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	6.190	6.018	5.902	5.793	5.790
Seizure Disorders and Convulsions	1.667	1.509	1.368	1.223	1.218
Hydrocephalus	11.086	11.068	11.036	11.016	11.015
Coma, Brain Compression/Anoxic Damage	10.655	10.694	10.708	10.737	10.737
Narcolepsy and Cataplexy	4.295	4.102	3.955	3.821	3.816
Respirator Dependence/Tracheostomy Status	27.170	26.905	26.769	26.706	26.705
Respiratory Arrest	16.066	15.761	15.608	15.522	15.520
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	16.066	15.761	15.608	15.522	15.520
Heart Assistive Device/Artificial Heart	13.858	13.756	13.667	13.582	13.579
Heart Transplant Status/Complications	13.858	13.756	13.667	13.582	13.579
Heart Failure	4.738	4.612	4.524	4.454	4.452
Acute Myocardial Infarction	1.087	1.045	1.017	0.993	0.993
Unstable Angina and Other Acute Ischemic Heart Disease	1.087	1.045	1.017	0.993	0.993
Heart Infection/Inflammation, Except Rheumatic	16.465	16.330	16.226	16.134	16.130
Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders	4.201	4.021	3.874	3.748	3.744
Major Congenital Heart/Circulatory Disorders	1.119	1.001	0.878	0.777	0.774
Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders	0.691	0.583	0.488	0.415	0.413
Specified Heart Arrhythmias	3.278	3.106	2.985	2.886	2.883
Intracranial Hemorrhage	12.842	12.667	12.542	12.440	12.435
Ischemic or Unspecified Stroke	1.680	1.505	1.397	1.293	1.290
Cerebral Aneurysm and Arteriovenous Malformation	1.745	1.547	1.416	1.288	1.283
Hemiplegia/Hemiparesis	5.876	5.734	5.649	5.574	5.571
Monoplegia, Other Paralytic Syndromes	3.202	3.050	2.948	2.842	2.838
Atherosclerosis of the Extremities with Ulceration or Gangrene	10.987	10.723	10.584	10.490	10.488
Vascular Disease with Complications	7.360	7.213	7.130	7.077	7.077
Pulmonary Embolism and Deep Vein Thrombosis	19.940	19.772	19.662	19.581	19.579
Lung Transplant Status/Complications	13.858	13.756	13.667	13.582	13.579
Cystic Fibrosis	46.375	45.821	45.593	45.555	45.556
Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	1.807	1.629	1.497	1.375	1.372
Severe Asthma	1.269	1.080	0.919	0.762	0.757
Asthma, Except Severe	0.347	0.258	0.172	0.104	0.102
Fibrosis of Lung and Other Lung Disorders	1.474	1.310	1.170	1.039	1.035

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	10.655	10.694	10.708	10.737	10.737
Kidney Transplant Status/Complications	11.106	11.020	10.974	10.939	10.937
End Stage Renal Disease	37.125	36.898	36.806	36.786	36.783
Chronic Kidney Disease, Stage 5	0.266	0.200	0.150	0.093	0.091
Chronic Kidney Disease, Severe (Stage 4)	0.266	0.200	0.150	0.093	0.091
Ectopic and Molar Pregnancy	1.605	1.396	1.203	1.035	1.028
Miscarriage with Complications	0.597	0.466	0.325	0.183	0.178
Miscarriage with No or Minor Complications	0.597	0.466	0.325	0.183	0.178
Pregnancy with Delivery with Major Complications	3.535	3.159	2.880	2.439	2.424
Pregnancy with Delivery with Complications	3.535	3.159	2.880	2.439	2.424
Pregnancy with Delivery with No or Minor Complications	2.619	2.338	2.064	1.572	1.553
(Ongoing) Pregnancy without Delivery with Major Complications	0.553	0.406	0.236	0.129	0.125
(Ongoing) Pregnancy without Delivery with Complications	0.553	0.406	0.236	0.129	0.125
(Ongoing) Pregnancy without Delivery with No or Minor Complications	0.365	0.249	0.135	0.060	0.057
Chronic Ulcer of Skin, Except Pressure	2.144	2.023	1.933	1.863	1.861
Extensive Third-Degree Burns	22.431	22.185	22.041	21.957	21.952
Major Skin Burn or Condition	2.195	2.007	1.877	1.757	1.753
Severe Head Injury	22.431	22.185	22.041	21.957	21.952
Hip and Pelvic Fractures	4.771	4.510	4.344	4.242	4.239
Vertebral Fractures without Spinal Cord Injury	4.693	4.459	4.289	4.124	4.119
Traumatic Amputations and Amputation Complications	3.506	3.260	3.106	2.949	2.943
Stem Cell, Including Bone Marrow, Transplant Status/Complications	13.858	13.756	13.667	13.582	13.579
Artificial Openings for Feeding or Elimination	6.435	6.241	6.156	6.110	6.110
Amputation Status, Upper Limb or Lower Limb	3.506	3.260	3.106	2.949	2.943
Interacted HCC Counts Factors					
Severe illness, 1 payment HCC	-10.655	-10.694	-10.708	-10.737	-10.737
Severe illness, 2 payment HCCs	-10.570	-10.647	-10.680	-10.723	-10.724
Severe illness, 3 payment HCCs	-8.365	-8.447	-8.418	-8.359	-8.355
Severe illness, 4 payment HCCs	-7.724	-7.718	-7.590	-7.404	-7.396
Severe illness, 5 payment HCCs	-4.948	-4.829	-4.600	-4.291	-4.279
Severe illness, 6 or 7 payment HCCs	-0.619	-0.297	0.075	0.521	0.537
Severe illness, 8 or more payment HCCs	20.186	21.065	21.786	22.505	22.529
Transplant severe illness, 4 or more payment HCCs	16.793	16.848	16.877	16.897	16.899

TABLE 4: HCCs Selected for the Proposed HCC Interacted Counts Variables for the Adult and Child Models for the 2024 Benefit Year

Payment HCC	Severity Illness Indicator	Transplant Indicator
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 Coma, 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)48	X	X

TABLE 5: Proposed Infant Risk Adjustment Model Factors for the 2024 Benefit Year

Group	Platinum	Gold	Silver	Bronze	Catastrophic
Extremely Immature * Severity Level 5 (Highest)	225.754	224.102	223.390	223.190	223.189
Extremely Immature * Severity Level 4	162.909	161.046	160.171	159.788	159.782
Extremely Immature * Severity Level 3	36.950	35.414	34.671	34.338	34.330
Extremely Immature * Severity Level 2	36.950	35.414	34.671	34.338	34.330
Extremely Immature * Severity Level 1 (Lowest)	36.950	35.414	34.671	34.338	34.330
Immature * Severity Level 5 (Highest)	127.417	125.708	124.964	124.729	124.726
Immature * Severity Level 4	75.684	73.973	73.203	72.924	72.919
Immature * Severity Level 3	36.950	35.414	34.671	34.338	34.330
Immature * Severity Level 2	36.950	35.414	34.671	34.338	34.330
Immature * Severity Level 1 (Lowest)	28.369	26.894	26.146	25.745	25.734
Premature/Multiples * Severity Level 5 (Highest)	115.509	114.050	113.404	113.199	113.198
Premature/Multiples * Severity Level 4	32.082	30.557	29.821	29.460	29.453
Premature/Multiples * Severity Level 3	15.009	13.884	13.202	12.641	12.623
Premature/Multiples * Severity Level 2	8.402	7.557	6.909	6.201	6.175
Premature/Multiples * Severity Level 1 (Lowest)	6.306	5.569	4.951	4.366	4.346
Term * Severity Level 5 (Highest)	86.920	85.564	84.906	84.586	84.580
Term * Severity Level 4	17.039	15.909	15.237	14.692	14.677
Term * Severity Level 3	6.250	5.550	4.948	4.333	4.311
Term * Severity Level 2	3.964	3.368	2.784	2.177	2.155
Term * Severity Level 1 (Lowest)	2.042	1.592	1.108	0.790	0.781
Age1 * Severity Level 5 (Highest)	70.542	69.775	69.404	69.235	69.232
Age1 * Severity Level 4	13.870	13.286	12.950	12.711	12.704
Age1 * Severity Level 3	3.079	2.756	2.528	2.344	2.337
Age1 * Severity Level 2	2.039	1.758	1.531	1.324	1.317
Age1 * Severity Level 1 (Lowest)	0.611	0.499	0.443	0.406	0.405
Age 0 Male	0.634	0.590	0.557	0.494	0.491
Age 1 Male	0.103	0.086	0.069	0.049	0.048

TABLE 6: HHS HCCs Included in Infant Model Maturity Categories

Maturity Category	HCC/Description
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 7: HHS HCCs Included in Infant Model Severity Categories

Severity Category	HCC/Description
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	Coma, 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 Category	HCC/Description
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	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 Anemia (Hb-SS)
Severity Level 2	Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital

Severity Category	HCC/Description
	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	Beta Thalassemia Major
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

e. CSR Adjustments[43 44 45 46 47 48]

We propose to continue including an adjustment for the receipt of CSRs in the risk adjustment models in all 50 States and the District of Columbia. While we continue to study and explore a range of options to update the CSR adjustments to improve prediction for CSR enrollees and whether changes are needed to the risk adjustment transfer formula to account for CSR plans,[49] to maintain stability and certainty for issuers for the 2024 benefit year, we are proposing to maintain the CSR adjustment factors finalized in the 2019, 2020, 2021, 2022, and 2023 Payment Notices.[50] See Table 8. We also propose to continue to use a CSR adjustment factor of 1.12 for all Massachusetts wrap-around plans in the risk adjustment plan liability risk score calculation, as all of Massachusetts' cost-sharing plan variations have AVs above 94 percent (81 FR 12228).

We seek comment on these proposals.

[43] Starting with the 2024 risk adjustment adult models, HHS will group HCC 18 Pancreas Transplant Status and HCC 183 Kidney Transplant Status/Complications to reflect that these transplants frequently co-occur for clinical reasons and to reduce volatility of coefficients across benefit years due to the small sample size of HCC 18. This change will also be reflected in the DIY Software for the 2024 benefit year.

[44] HCC numbers that appear with an underscore in this document will appear without the underscore in the DIY software. For example, HCC 35_1 in this table will appear as HCC 351 in the DIY software.

[45] Starting with the 2024 risk adjustment adult models, HHS will group HCC 18 Pancreas Transplant Status and HCC 183 Kidney Transplant Status/Complications to reflect that these transplants frequently co-occur for clinical reasons and to reduce volatility of coefficients across benefit years due to the small sample size of HCC 18. This change will also be reflected in the DIY Software for the 2024 benefit year.

[46] As a note, 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 0. See CMS. (2016, March 24). March 2016 Risk Adjustment Methodology Discussion Paper. *https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/downloads/ra-march-31-white-paper-032416.pdf* (where we previously discussed the use of constraints in the risk adjustment models).

[47] Similar to recalibration of the 2023 risk adjustment adult models and consistent with the final policies adopted in the 2023 Payment Notice, the draft factors in this rule reflect the removal of the mapping of hydroxychloroquine sulfate to RXC 09 (Immune Suppressants and Immunomodulators) and the related RXC 09 interactions (RXC 09 x HCC056 or 057 and 048 or 041; RXC 09 x HCC056; RXC 09 x HCC 057; RXC 09x HCC048, 041) from the 2018 and 2019 benefit year enrollee-level EDGE data sets for purposes of recalibrating the 2024 benefit year adult models. See 87 FR 27232 through 27235. Additionally, the draft factors for the adult models reflect the use of the final, fourth quarter (Q4) RXC mapping document that was applicable for each benefit year of data included in the current year's model recalibration (except under extenuating circumstances that can result in targeted changes to RXC mappings), while continuing to engage in annual and quarterly review processes. See 87 FR 27231 through 27232.

[48] Starting with the 2024 risk adjustment adult models, HHS will group HCC 18 Pancreas Transplant Status and HCC 183 Kidney Transplant Status/Complications to reflect that these transplants frequently co-occur for clinical reasons and to reduce volatility of coefficients across benefit years due to the small sample size of HCC 18. This change will also be reflected in the DIY Software for the 2024 benefit year and will be applied to the adult models only. In the child models, HCC 18 and HCC 183 are subject to an *a priori* constraint (S1) with HCC 34, also for sample size reasons. See Section 4.2.2 of the 2019 White Paper. (June 17, 2019.) *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Potential-Updates-to-HHS-HCCs-HHS-operated-Risk-Adjustment-Program.pdf.* Nevertheless, in both the adult and child models, the presence of one of these HCCs either alone or in a group will trigger a severity illness indicator and/or a transplant indicator for the interacted counts model specification depending on the total number of HCCs the enrollee has.

[49] See CMS. (2021, October 26). HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes. Appendix A. *https://www.cms.gov/files/document/2021-ra-technical-paper.pdf.* We are also considering a letter recently published by the American Academy of Actuaries regarding accounting for the receipt of CSRs in risk adjustment and plan rating and are continuing to monitor changes related to these issues. Bohl, J., Novak, D., & Karcher, J. (2022, September 8). *Comment Letter on Cost-Sharing Reduction Premium Load Factors.* American Academy of Actuaries. *https://www.actuary.org/sites/default/files/202209/Academy_CSR_Load_Letter_09.08.22.pdf.*

[50] See 83 FR 16930 at 16953; 84 FR 17478 through 17479; 85 FR 29190; 86 FR 24181; and 87 FR 27235 through 27236.

TABLE 8: Cost-Sharing Reduction Adjustment Factors

Household Income	Plan AV	Adjustment Factor
Silver Plan Variant Recipients		
100-150% of Federal Poverty Line (FPL)	Plan Variation 94%	1.12
150-200% of FPL	Plan Variation 87%	1.12
200-250% of FPL	Plan Variation 73%	1.00
>250% of FPL	Standard Plan 70%	1.00
Zero Cost Sharing Recipients		
<300% of FPL	Platinum (90%)	1.00
<300% of FPL	Gold (80%)	1.07
<300% of FPL	Silver (70%)	1.12
<300% of FPL	Bronze (60%)	1.15
Limited Cost Sharing Recipients		
>300% of FPL	Platinum (90%)	1.00
>300% of FPL	Gold (80%)	1.07
>300% of FPL	Silver (70%)	1.12
>300% of FPL	Bronze (60%)	1.15

f. Model Performance Statistics

Each benefit year, to evaluate 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 model 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 risk adjustment models.[51] Because we propose to blend the coefficients from separately solved models based on the 2018, 2019, and 2020 benefit years' enrollee-level EDGE data, with an exception to exclude 2020 benefit year data from the recalibration of the age-sex factors for the adult models, we are publishing the R-squared statistic for each model separately to verify their statistical validity. The R-squared statistics for the proposed 2024 benefit models are shown in Table 9.

TABLE 9: R-Squared Statistic for the Proposed HHS Risk Adjustment Models

Models	2018 Enrollee-Level EDGE Data	2019 Enrollee-Level EDGE Data	2020 Enrollee-Level EDGE Data
Platinum Adult	0.4411	0.4441	0.4347
Gold Adult	0.4348	0.4379	0.4278
Silver Adult	0.4310	0.4341	0.4237
Bronze Adult	0.4277	0.4309	0.4204
Catastrophic Adult	0.4276	0.4307	0.4203
Platinum Child	0.3614	0.3569	0.3420
Gold Child	0.3583	0.3536	0.3381
Silver Child	0.3558	0.3510	0.3352
Bronze Child	0.3531	0.3483	0.3325
Catastrophic Child	0.3530	0.3482	0.3323
Platinum Infant	0.3130	0.3166	0.2898
Gold Infant	0.3093	0.3130	0.2858
Silver Infant	0.3072	0.3109	0.2835
Bronze Infant	0.3055	0.3094	0.2817
Catastrophic Infant	0.3055	0.3094	0.2816

[51] 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.*

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 explained that under this approach, we will no longer republish these formulas in future annual HHS notice of benefit and payment parameter rules unless changes are being proposed. We are not proposing any changes to the formula in this rule, and therefore, are not republishing the formulas in this rule. We would continue to apply the formula as finalized in the 2021 Payment Notice (86 FR 24183 through 24186) [52] in the States where HHS operates the risk adjustment program in the 2024 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 any changes to the high-cost risk pool parameters for the 2024 benefit year; therefore, we would maintain the $1 million threshold and 60 percent coinsurance rate.

4. Repeal of Risk Adjustment State Flexibility To Request a Reduction in Risk Adjustment State Transfers (§ 153.320(d))

We propose to repeal the flexibility under § 153.320(d) for States to request reductions of risk adjustment State transfers under the State payment transfer formula in all State market risk pools, including those prior participant States that previously requested a reduction,[53] for the 2025 benefit year and beyond. We also solicit comment on Alabama's requests to reduce risk adjustment State transfers in the individual (including the catastrophic and non-catastrophic risk pools) and small group markets for the 2024 benefit year.

a. Repeal of State Flexibility To Request Transfer Reductions

We propose to amend § 153.320(d) to repeal the ability for any State to request a reduction in risk adjustment State transfers beginning with the 2025 benefit year. As part of this repeal, we propose conforming amendments to the introductory text of § 153.320(d), which currently provides that prior participant States may request to reduce risk adjustment transfers in all State market risk pools by up to 50 percent beginning with the 2024 benefit year, to remove this flexibility for the 2025 benefit year and beyond and limit the timeframe available for prior participants to request reductions to the 2024 benefit year only. Similarly, we propose conforming amendments to paragraphs (d)(1)(iv) and (d)(4)(i)(B), which describe the conditions for a prior participant State to request a reduction beginning with the 2024 benefit year, to also limit these requests to the 2024 benefit year only and to eliminate the ability for prior participant States to request a reduction for the 2025 benefit year and beyond.

In the 2019 Payment Notice (83 FR 16955 through 16960), we amended § 153.320 to add paragraph (d) to provide States the flexibility to request a reduction to the applicable risk adjustment State transfers calculated by HHS using the State payment transfer formula for the State's individual (catastrophic or non-catastrophic risk pools), small group, or merged market risk pool by up to 50 percent in States where HHS operates the risk adjustment program to more precisely account for differences in actuarial risk in the applicable State's markets beginning with the 2020 benefit year. We finalized that any requests we received would be published in the applicable benefit year's proposed HHS notice of benefit and payment parameters, and the supporting evidence provided by the State in support of its request would be made available for public comment.[54]

In the 2023 Payment Notice (87 FR 27236), HHS limited this flexibility by finalizing amendments to § 153.320(d) that repealed the State flexibility framework for States to request reductions in risk adjustment State transfer payments for the 2024 benefit year and beyond, with an exception for prior participants.[55] We also limited the options for prior participants to request reductions by finalizing that beginning with the 2024 benefit year, States submitting reduction requests must demonstrate that the requested reduction satisfies the de minimis standard—that is, the premium increase necessary to cover the affected issuer's or issuers' reduced risk adjustment payments does not exceed 1 percent in the relevant State market risk pool.[56] In the 2023 Payment Notice (87 FR 27239 through 27241), we also finalized the conforming amendments to the HHS approval framework in § 153.320(d)(4) to reflect the changes to the applicable criteria (that is, only retaining the de minimis criterion) beginning with the 2024 benefit year, and we finalized the proposed definition of ''prior participant'' in § 153.320(d)(5). In addition, HHS indicated our intention to propose in future rulemaking to repeal the exception for prior participants beginning with the 2025 benefit year.[57]

Since finalizing the ability for States to request a reduction of risk adjustment transfers in the 2019 Payment Notice (83 FR 16955 through 16960), we received public comments on subsequent proposed rulemakings requesting that HHS repeal this policy, with several commenters noting that reducing risk adjustment transfers to plans with higher-risk enrollees could create incentives for issuers to avoid enrolling high-risk enrollees in the future by distorting plan offerings and designs, including by avoiding broad network plans, not offering platinum plans at all, and only offering limited gold plans. Commenters further stated that issuers could also distort plan designs by excluding coverage or imposing high cost-sharing for certain drugs or services. For example, one commenter stated that the risk adjustment State payment transfer formula already adjusts for differences in types of individuals enrolled in different States and aggregate differences in prices and utilization by using the Statewide average premium as a scaling factor, so State flexibility to account for State-specific factors is unnecessary.[58] In addition, since establishing this framework, we have observed a lack of

[52] Discussion provided an illustration and further details on the State payment transfer formula.

[53] Alabama is the only State that has previously requested a reduction in risk adjustment transfers through this flexibility and therefore is the only State considered a ''prior participant State''.

[54] If the State requests that HHS not make publicly available certain supporting evidence and analysis because it contains trade secrets or confidential commercial or financial information within the meaning of HHS' Freedom of Information Act regulations at 45 CFR 5.31(d), HHS will only make available on the CMS website the supporting evidence submitted by the State that is not a trade secret or confidential commercial or financial information by posting a redacted version of the State's supporting evidence. See § 153.320(d)(3).

[55] Section 153.320(d)(5) defines prior participants as States that submitted a State reduction request in the State's individual catastrophic, individual non-catastrophic, small group, or merged market risk pool in the 2020, 2021, 2022, or 2023 benefit year.

[56] 87 FR 27239 through 27241. See also 83 FR 16957.

[57] 87 FR 27239 through 27241. See also 83 FR 16957.

[58] See Fielder, M, & Layton, T. (2020, December 30). *Comment Letter on 2022 Payment Notice Proposed Rule.* Brookings. *https://www.brookings.edu/wp-content/uploads/2020/12/FiedlerLaytonCommentLetterNBPP2022.pdf.*

interest from States in using this policy. Only one State (Alabama) has exercised this flexibility and requested reductions to transfers in its individual and/or small group markets.[59]

HHS believes this proposal to completely repeal the option for States to request reductions in risk adjustment State transfers would align HHS policy with Section 1 of E.O. 14009 (86 FR 7793), which prioritizes protecting and strengthening the ACA and making high-quality health care accessible and affordable for all individuals. Section 3 of E.O. 14009 directs HHS, and the heads of all other executive departments and agencies with authorities and responsibilities related to Medicaid and the ACA, to review all existing regulations, orders, guidance documents, policies, and any other similar agency actions to determine whether they are inconsistent with policy priorities described in Section 1 of E.O. 14009. Consistent with this directive, HHS reviewed the risk adjustment State flexibility under § 153.320(d) and determined it is inconsistent with policies described in sections 1 and 3 of E.O. 14009. We believe that a complete repeal of § 153.320(d) would prevent the potential negative outcomes of risk adjustment State flexibility identified through public comment, including the possibility of risk selection, market destabilization, increased premiums, smaller networks, and less-comprehensive plan options, the prevention of which would protect and strengthen the ACA and make health care more accessible and affordable. For all of these reasons, we propose to amend § 153.320(d) to fully repeal the flexibility for States, including prior participants, to request reductions of risk adjustment State transfers calculated by HHS under the State payment transfer formula in all State market risk pools beginning with the 2025 benefit year. If these amendments are finalized, no State would be able to request a reduction in risk adjustment transfers calculated by HHS under the State payment transfer formula starting with the 2025 benefit year.

We seek comment on this proposal.

b. Requests To Reduce Risk Adjustment Transfers for the 2024 Benefit Year

In accordance with § 153.320(d)(2), beginning with the 2020 benefit year, States requesting a reduction in the transfers calculated by HHS under the State payment transfer formula must submit their requests with the supporting evidence and analysis outlined under § 153.320(d)(1) by August 1 of the calendar year that is 2 calendar years prior to the beginning of the applicable benefit year. As finalized in the 2023 Payment Notice (87 FR 27239 through 27241), under § 153.320(d)(1)(iv), State requests for a reduction to transfers must include a justification for the reduction requested demonstrating the requested reduction would have de minimis impact on the necessary premium increase to cover the transfers for issuers that would receive reduced transfer payments beginning with the 2024 benefit year. In accordance with § 153.320(d)(4)(i)(B), HHS will approve State reduction requests if HHS determines, based on the review of the information submitted as part of the State's request, along with other relevant factors, including the premium impact of the transfer reduction for the State market risk pool, and relevant public comments, that the requested reduction would have *de minimis* impact on the necessary premium increase to cover the transfers for issuers that would receive reduced transfer payments beginning with the 2024 benefit year. In addition, pursuant to § 153.320(d)(4)(ii), HHS may approve a reduction amount that is lower than the amount requested by the State if the supporting evidence and analysis do not fully support the requested reduction amount. If approved by HHS, State reduction requests are applied to the plan PMPM payment or charge State payment transfer amount (Ti in the State payment transfer formula).

For the 2024 benefit year, HHS received requests from Alabama to reduce risk adjustment State transfers for its individual[60] and small group markets by 50 percent. As Alabama has stated in previous years, Alabama asserts that the HHS-operated risk adjustment program does not work precisely in the Alabama market, clarifying that they do not assert that the risk adjustment formula is flawed, only that it produces imprecise results in Alabama which has an ''extremely unbalanced market share.'' The State reports that its review of the issuers' 2021 financial data suggested that any premium increase resulting from a reduction of 50 percent to the 2024 benefit year risk adjustment payments for the individual market would not exceed one percent, the *de minimis* premium increase threshold set forth in § 153.320(d)(1)(iv) and (d)(4)(i)(B). Additionally, the State reports that its review of the issuers' 2021 financial data also suggested that any premium increase resulting from a 50 percent reduction to risk adjustment payments in the small group market for the 2024 benefit year would not exceed the *de minimis* threshold of one percent.

At this time, to make HHS's approval determination under § 153.320(d)(4), we seek comment on Alabama's requests to reduce risk adjustment State transfers in their individual and small group markets by 50 percent for the 2024 benefit year. The request and additional documentation submitted by Alabama are posted under the ''State Flexibility Requests'' heading at *https://www.cms.gov/cciio/programs-and-initiatives/premium-stabilization-programs.*

5. Risk Adjustment Issuer Data Requirements (§§ 153.610, 153.700, and 153.710)

We propose, beginning with the 2023 benefit year, to collect and extract from issuers' EDGE servers through issuers' EDGE Server Enrollment Submission (ESES) files and risk adjustment recalibration enrollment files a new data element, a QSEHRA indicator. We also propose to extract plan ID and rating area data elements issuers have submitted to their EDGE servers from certain benefit years prior to 2021.

45 CFR 153.610(a) requires that health insurance issuers of risk adjustment covered plans submit or make accessible all required risk adjustment data in accordance with the data collection approach established by HHS[61] in States where HHS operates the program on behalf of a State.[62] In the 2014 Payment Notice (78 FR 15497 through 15500; § 153.720), HHS established an approach for obtaining the necessary data for risk adjustment calculations in States where HHS operates the program

[59] For the 2020 and 2021 benefit years, Alabama submitted a 50 percent risk adjustment transfer reduction request for its small group market, which HHS approved in the 2020 Payment Notice (84 FR 17454) and in the 2021 Payment Notice (85 FR 29164). For the 2022 and 2023 benefit years, Alabama submitted 50 percent risk adjustment transfer reduction requests for its individual and small group markets. HHS approved the State's requests for the 2022 benefit year in part 2 of the 2022 Payment Notice final rule (86 FR 24140) and approved a 25 percent reduction for Alabama's individual market State transfers (including the catastrophic and non-catastrophic risk pools) and a 10 percent reduction for the State's small group market transfers for the 2023 benefit year in the 2023 Payment Notice (87 FR 27208).

[60] Alabama's individual market request is for a 50 percent reduction to risk adjustment transfers for its individual market non-catastrophic and catastrophic risk pools.

[61] Also see 45 CFR 153.700–153.740.

[62] The full list of required data elements can be found in Appendix A of OMB Control Number 0938–1155/CMS–10401. (2022, May 26). Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment. *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10401.*

through a distributed data collection model that prevented the transfer of individuals' personally identifiable information (PII). Then, in several subsequent rulemakings,[63] we finalized policies for the extraction and use of enrollee-level EDGE data. The purpose of collecting and extracting enrollee-level data is to provide HHS with more granular data to use for recalibrating the HHS risk adjustment models, informing updates to the AV Calculator, conducting policy analysis, and calibrating HHS programs in the individual and small group (including merged) markets and the PHS Act requirements enforced by HHS that are applicable market-wide,[64] as well as informing policy and improving the integrity of other HHS Federal health-related programs.[65] The use of enrollee-level data extracted from issuers' EDGE servers and summary level reports produced from remote command and ad hoc queries enhances HHS' ability to develop and set policy and limits the need to pursue alternative burdensome data collections from issuers. We also previously finalized policies related to creating on an annual basis an enrollee-level EDGE Limited Data Set (LDS) using masked enrollee-level data submitted to EDGE servers by issuers of risk adjustment covered plans in the individual and small group (including merged) markets and making this LDS available to requestors who seek the data for research purposes.[66] [67]

a. Collection and Extraction of the QSEHRA Indicator

In the 2023 Payment Notice (87 FR 27241 through 27252), we finalized that we will collect and extract an individual coverage Health Reimbursement Arrangement (ICHRA) indicator and that we will make this indicator available in the enrollee-level EDGE LDS beginning with the 2023 benefit year. The primary purpose of collecting and extracting ICHRA indicator data is to allow HHS to conduct analyses to examine whether there are any unique actuarial characteristics of the ICHRA population (such as the health status of enrollees with ICHRAs), and to investigate what impact (if any) ICHRA enrollment is having on State individual and small group (or merged) market risk pools. The additional information collected through the ICHRA indicator will be used to further analyze if any refinements to the HHS risk adjustment methodology should be examined or proposed through notice and comment rulemaking, and similarly may also be used to inform policy analysis and potential updates to the AV Calculator, other HHS individual or small group (including merged) market programs, or other HHS Federal health-related programs.

Since finalizing the collection of the ICHRA indicator as part of the enrollee-level EDGE data extracted from issuers' EDGE servers, we determined that also collecting and extracting a QSEHRA indicator would provide a more thorough picture of the actuarial characteristics of the Health Reimbursement Arrangement (HRA) population and how or whether HRA enrollment is impacting State individual and small group (including merged) market risk pools. HHS needs QSEHRA data in order to conduct a comprehensive assessment of the HRA markets. A QSEHRA indicator would also allow HHS to investigate whether the risk profile of enrollees in QSEHRAs, which differ from ICHRAs with respect to standards related to employer eligibility, employee eligibility, restrictions on allowance amounts, and eligibility for PTCs, differ from enrollees in ICHRAs.[68] While we acknowledge that FFEs, SBE–FPs, and SBEs collect information about the provision of QSEHRAs, we note that adding a QSEHRA indicator to the required risk adjustment EDGE data submissions would provide more uniform and comprehensive information than what is submitted by Exchange enrollees, as it would capture information on both Exchange and non-Exchange enrollment. It also would provide HHS the ability to extract and aggregate the QSEHRA indicator alongside other claims and enrollment data accessible through issuers' EDGE servers, which would not be possible with the data collection from consumers through other processes since the EDGE data is masked[69] and therefore cannot be linked with other enrollment data sources.[70]

We therefore propose that, beginning with the 2023 benefit year, issuers would be required to collect and submit a QSEHRA indicator as part of the required risk adjustment data that issuers make accessible to HHS from their respective EDGE servers in States where HHS operates the risk adjustment program. This new data element would be included as part of the enrollee-level EDGE data extracted from issuers' EDGE servers and summary level reports produced from remote command and ad hoc queries beginning with the 2023 benefit year.[71] We also propose to include this indicator in the enrollee-level EDGE LDS made available to qualified researchers upon request once available (that is, beginning with 2023 benefit year data).

In the 2023 Payment Notice (87 FR at 27248), we acknowledged that ICHRA information is collected by HHS from FFE or SBE–FP enrollees through the eligibility application process and from SBE enrollees through the State Exchange enrollment and payment files, as well as collected directly by issuers and their affiliated agents and brokers. We also noted the ICHRA indicator was intended to capture whether a particular enrollee's health care coverage involves (or does not involve) an ICHRA and that we would structure this data element for EDGE data submissions similar to current collections, where possible. Additionally, we explained that the collection and extraction of an ICHRA indicator as part of the required risk adjustment data submissions issuers make accessible to HHS through their respective EDGE servers provides more uniform and comprehensive information than what is submitted by FFE and SBE–FP enrollees on a QHP application and by SBE enrollees through enrollment and payment files, as it would capture both on and off Exchange enrollees.

The same is also true for QSEHRA information and we therefore propose to apply the same approach for the QSEHRA indicator. Currently, the FFEs and SBE–FPs collect information about

[63] See the 2018 Payment Notice, 81 FR 94101; the 2020 Payment Notice, 84 FR 17488; and the 2023 Payment Notice, 87 FR 27241.

[64] See, for example, 42 U.S.C. 300gg–300gg–28.

[65] As detailed in the 2023 Payment Notice, the finalized policies related to the permitted uses of EDGE data and reports make clear that HHS can use this information to inform policy analyses and improve the integrity of other HHS Federal health-related programs outside the commercial individual and small group (including merged) markets, such as the programs in certain States to provide wrap-around QHP coverage through Exchanges to Medicaid expansion populations and coverage offered by non-Federal Governmental plans. See 87 FR 27243; 87 FR 630 through 631.

[66] See the 2020 Payment Notice, 84 FR 17486 through 17490 and the 2023 Payment Notice, 87 FR 27243. Also see CMS. (2022, August 15). Enrollee-Level External Data Gathering Environment (EDGE) Limited Data Set (LDS). *https://www.cms.gov/research-statistics-data-systems/limited-data-set-lds-files/enrollee-level-external-data-gathering-environment-edge-limited-data-set-lds.*

[67] As explained in the 2020 Payment Notice, we do not currently make the EDGE LDS available to requestors for public health or health care operation activities. See 84 FR 17488.

[68] Rosso, R. (2022, May 7). Health Reimbursement Arrangements (HRAs): Overview and Related History. Congressional Research Service. *https://crsreports.congress.gov/product/pdf/R/R47041.*

[69] 45 CFR 153.720.

[70] For information on the challenges associated with linking the extracted enrollee-level EDGE data to other sources, see 87 FR 631 through 632.

[71] The deadline for submission of 2023 benefit year risk adjustment data is April 30, 2024. See 45 CFR 153.730.

QSEHRA provision from all applicants to determine whether they are eligible for a special enrollment period (SEP), as individuals and their dependents who become newly eligible for a QSEHRA may be eligible for a SEP. SBEs also collect similar information from their applicants to determine SEP eligibility. This data may also be provided directly to issuers by consumers who seek to enroll in coverage directly with the issuer. In addition, an issuer may currently have or collect information that could be used to populate the QSEHRA indicator in situations where the issuer is being paid directly by the employer through the QSEHRA for the individual market coverage. We therefore propose to generally permit issuers to populate the required QSEHRA indicator with information from the FFE or SBE–FP enrollees or enrollees through SBEs, or from other sources for collecting this information. The QSEHRA indicator would be used to capture whether a particular enrollee's health care coverage involves (or does not involve) a QSEHRA, and we propose to structure this data element for EDGE data submissions similar to current collections, where possible. Beginning with the 2023 benefit year, HHS would provide additional operational and technical guidance on how issuers should submit this new data element to HHS through issuer EDGE servers via the applicable benefit year's EDGE Server Business Rules and the EDGE Server Interface Control Document, as may be necessary.

We are also proposing, similar to the transitional approach for the ICHRA indicator finalized in the 2023 Payment Notice (87 FR 27241 through 27252), a transitional approach for the collection and extraction of the QSEHRA indicator. For the 2023 and 2024 benefit years, issuers would be required to populate the QSEHRA indicator using only data they already collect or have accessible regarding their enrollees. For example, when an FFE enrollee is using an SEP, information about QSEHRA provision is collected by the FFE, and the FFE may make these data available to issuers. In addition, as noted above, there may be situations where an issuer has or collects information that could be used to populate the QSEHRA indicator. Then, beginning with the 2025 benefit year, we propose that the transitional approach would end, and issuers would be required to populate the QSEHRA field using available sources (for example, information from Exchanges, and requesting information directly from enrollees) and, in the absence of an existing source for particular enrollees, to make a good faith effort to ensure collection and submission of the QSEHRA indictor for these enrollees. HHS would provide additional details on what constitutes a good faith effort to ensure collection and submission of the QSEHRA indicator in the future. HHS intends to seek input from issuers and other interested parties to inform development of the good faith standard and determine the most feasible methods for issuers to collect the information used to populate this data field.[72]

We believe this transitional approach is necessary as the burden associated with the collection of this data would be similar to that of the collection of the ICHRA indicator, as finalized in the 2023 Payment Notice (87 FR 27241 through 27252). Much like the ICHRA indicator data, we believe that some issuers already collect the relevant QSEHRA data. However, we do not believe the information to populate the QSEHRA indicator is routinely collected by all issuers at this time; therefore, we anticipate that there may be administrative burden for some issuers in developing processes for collection, validation, and submission of this new data element. In recognition of the burden that collection of this new data element potentially would pose for some issuers, we propose to adopt a transitional approach for the 2023 and 2024 benefit years. This transitional approach for the QSEHRA indicator would be the same as the approach finalized for the ICHRA indicator in the 2023 Payment Notice and is also similar to how we have handled other new data collection requirements.[73] Further details regarding the estimated burden may be found below in the *ICRs Regarding Risk Adjustment Issuer Data Submission Requirements (§§ 153.610, 153.700, and 153.710).*

Consistent with the policy adopted in the 2020 Payment Notice (84 FR 17488 through 17490) regarding HHS' use of data and reports extracted from issuers EDGE servers (including data reports and ad hoc query reports), and the policy adopted in the 2023 Payment Notice (87 FR 27243) to expand the permissible uses of such data and reports, beyond the risk adjustment program, we would also use the QSEHRA indicator once it is available to conduct policy analysis; operationalize and calibrate other HHS programs in the individual and small group (including merged) markets; and to inform policy analysis and improve the integrity of other HHS Federal health-related programs to the extent such use is otherwise authorized by, required under, or not inconsistent with applicable Federal law. We would not use the QSEHRA indicator or any analysis that relied upon the indictor to pursue changes to our policies until we conduct data quality checks and ensure the response rate is adequate to support any analytical conclusions. These data quality and reliability checks would generally be consistent with other data standard checks that HHS performs related to data collected through issuers' EDGE servers.

In conjunction with the proposal to collect and extract this new data element, we also propose to include the QSEHRA indicator in the LDS containing enrollee-level EDGE data that HHS makes available to qualified researchers upon request once the QSEHRA indicator is available, beginning with the 2023 benefit year. We propose to include the new indicator as part of the LDS because it would enhance the usefulness of the data set for qualified researchers by making available additional data to increase understanding of these markets, particularly the impact QSEHRA provision may have on the individual and small group (including merged) markets, and contribute to greater transparency. We further note that similar to the ICHRA indicator, the proposed QSEHRA indicator would not be a direct identifier that must be excluded from an LDS under the HIPAA Privacy Rule and thus would not add to the risk of enrollees being identified. As noted in the 2023 Payment Notice (87 FR at 27245), only an LDS of certain masked enrollee-level EDGE data elements is made available and this LDS is available only to qualified researchers if they meet the requirements for access to such file(s), including entering into a data use agreement that establishes the permitted uses or disclosures of the information and prohibits the recipient from identifying the information.[74] [75] In

[72] If the burden estimate for collection of QSEHRA indicator changes beginning with the 2025 benefit year (after the transitional approach ends), the information collection under OMB control number 0938–1155 would be revised accordingly and interested parties would be provided the opportunity to comment through that process.

[73] For example, HHS did not penalize issuers for temporarily submitting a default value for the in/out-of-network indictor for the 2018 benefit year in order to give issuers time to make the necessary changes to their operations and systems to comply with the new data collection requirement, but required issuers to provide full and accurate information for the in/out-of-network indicator beginning with the 2019 benefit year.

[74] See CMS. (2020, June). Data Use Agreement. (Form CMS–R–0235L).*https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/*

addition, consistent with how we created the LDS in prior years, HHS will continue to exclude data from the LDS that could lead to identification of certain enrollees.[76]

b. Extracting Plan ID and Rating Area

Finally, in addition to collecting and extracting a QSEHRA indicator, we propose to extract the plan ID[77] and rating area data elements from the 2017, 2018, 2019 and 2020 benefit year data submissions that issuers already made accessible to HHS. In the 2023 Payment Notice (87 FR 27249), we finalized the proposal to extract these data elements beginning with the 2021 benefit year. However, HHS has determined that to aid in annual model recalibration, as well as HHS' analyses of risk adjustment data, it would be beneficial to also include these two data elements as part of the enrollee-level EDGE data and reports extracted from issuers' EDGE servers for the 2017, 2018, 2019 and 2020 benefit years. Inclusion of plan ID and rating area in extractions of these additional benefit year data sets would also support analysis of other HHS individual and small group (including merged) market programs, as well as other HHS Federal health-related programs.

Moreover, since finalizing the 2023 Payment Notice, we have found that the analysis of risk adjustment data would be more valuable if we could compare historical trends, and access to these data elements for past years would further our ability to analyze and improve the risk adjustment program. For example, in assessing the 2020 enrollee-level EDGE data set for inclusion in the 2024 benefit year model recalibration, having access to plan ID and rating area would have allowed us to consider the different patterns of utilization and costs at a more granular level (for example, the State market risk pool level). Since issuers already collected and made available these data elements to HHS for the 2017, 2018, 2019 and 2020 benefit years,[78] we do not believe that this proposal would increase burden on issuers. We are also not proposing any changes to the accompanying policies finalized in the 2023 Payment Notice with respect to these data elements and the enrollee-level EDGE LDS. Although we recognize that including plan ID and rating area would enhance the usefulness of the LDS, we continue to believe it is appropriate to exclude these data elements from the LDS to mitigate the risk that entities that receive the LDS file could identify issuers based on these identifiers, particularly in areas with a small number of issuers. As such, HHS would not include these data elements (plan ID and rating area) in the LDS files made available to qualified researchers upon request.

We seek comment on these proposals.

6. Risk Adjustment User Fee for 2024 Benefit Year (§ 153.610(f))

We propose a risk adjustment user fee for the 2024 benefit year of $0.21 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. As noted previously in this proposed rule, for the 2024 benefit year, HHS will operate the risk adjustment program 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 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.[79] 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 associated with potential adverse risk selection.[80] The 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 2023 Payment Notice (87 FR 27252), we calculated the Federal administrative expenses of operating the risk adjustment program for the 2023 benefit year to result in a risk adjustment user fee rate of $0.22 PMPM based on our estimated costs for risk adjustment operations and estimated BMM for individuals enrolled in risk adjustment covered plans. For the 2024 benefit year, HHS proposes to use the same methodology to estimate our administrative expenses to operate the risk adjustment program. These costs cover development of the models and methodology, collections, payments, account management, data collection, data validation, program integrity and audit functions, operational and fraud analytics, interested parties training, operational support, and administrative and personnel costs dedicated to risk adjustment program activities. To calculate the risk adjustment user fee, we divided HHS' projected total costs for administering the risk adjustment 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 2024 benefit year.

We estimate that the total cost for HHS to operate the risk adjustment program on behalf of States for the 2024 benefit year will be approximately $60 million, which remains stable with the approximately $60 million estimated for the 2023 benefit year. We also project higher enrollment than our prior estimates in the individual and small group (including merged) markets in the 2023 and 2024 benefit years based on the increased enrollment between the 2020 and 2021 benefit years, likely due to the increased PTC subsidies provided for in the American Rescue Plan Act of 2021 (ARP).[81] [82] In light of the passage

CMS-R-0235L.pdf. See also 84 FR 17486 through 17490.

[75] CMS. (2020, June). Data Use Agreement. (Form CMS–R–0235L). *https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS-R-0235L.pdf.*

[76] See, for example, CMS. (2021, August 25). Creation of the 2019 Benefit Year Enrollee-Level EDGE Limited Data Sets: Methods, Decisions and Notes on Data Use. *https://www.cms.gov/files/document/2019-data-use-guide.pdf.*

[77] For details on the plan ID and its components, see p. 42 of the following: CMS. (2013, March 22). *CMS Standard Companion Guide Transaction Information: Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the FFE. https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/companion-guide-for-ffe-enrollment-transaction-v15.pdf.*

[78] As detailed in the 2023 Payment Notice, issuers have been required to submit these two data elements as part of the required risk adjustment data submissions to their respective EDGE servers to support HHS' calculation of risk adjustment transfers since the 2014 benefit year. See 87 FR 27243.

[79] OMB. (1993). *OMB Circular No. A–25 Revised, Transmittal Memorandum No. https://www.whitehouse.gov/wp-content/uploads/2017/11/Circular-025.pdf.*

[80] Ibid.

[81] ARP. Public Law 117–2 (2021).

Continued

of the Inflation Reduction Act of 2022 (IRA), in which Section 12001 extended the enhanced PTC subsidies in section 9661 of the ARP through the 2025 benefit year, we project increased 2021 enrollment levels to remain steady through the 2025 benefit year.[83] Because this provision of the IRA is expected to continue higher enrollment, we propose a slightly lower risk adjustment user fee of $0.21 PMPM.

We seek comment on the proposed risk adjustment user fee for the 2024 benefit year.

7. Risk Adjustment Data Validation Requirements When HHS Operates Risk Adjustment (HHS–RADV) (§§ 153.350 and 153.630)

HHS will conduct risk adjustment data validation under §§ 153.350 and 153.630 in any State where HHS is operating risk adjustment on a State's behalf.[84] The purpose of risk adjustment data validation 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 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 initial validation audit entity. The issuer provides demographic, enrollment, and medical record documentation for a sample of enrollees selected by HHS to its initial validation auditor 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 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. Materiality Threshold for Risk Adjustment Data Validation

Beginning with 2022 benefit year HHS–RADV, we propose to change the HHS–RADV materiality threshold definition, first implemented in the 2018 Payment Notice (81 FR 94104 through 94105), from $15 million in total annual premiums Statewide to 30,000 total BMM Statewide, calculated by combining an issuer's enrollment in a State's individual non-catastrophic, catastrophic, small group, and merged markets, as applicable, in the benefit year being audited.[85] Consistent with the application of the current materiality threshold definition and accompanying exemption under § 153.630(g)(2), issuers that fall below the new proposed materiality threshold would not be subject to the annual IVA (and SVA) audit requirements, but may be selected to participate in a given benefit year of HHS–RADV based on random sampling or targeted sampling due to the identification of any risk-based triggers that warrant more frequent audits.

In the 2020 Payment Notice (84 FR 17508 through 17511), HHS established § 153.630(g) to codify exemptions to HHS–RADV requirements, including an exemption for issuers that fell below a materiality threshold, as defined by HHS, to ease the burden of annual audit requirements for smaller issuers of risk adjustment covered plans that do not materially impact risk adjustment transfers.[86] This materiality threshold was first implemented and defined in the 2018 Payment Notice (81 FR 94104 through 94105), where HHS finalized a policy that issuers with total annual premiums at or below $15 million (calculated based on the Statewide premiums of the benefit year being validated) would not be subject to annual IVA requirements, but would still be subject to random and targeted sampling.[87] Under this approach, issuers below the materiality threshold are subject to an IVA approximately every 3 years, barring any risk-based triggers that would warrant more frequent audits.

We implemented the materiality threshold based on an evaluation of the burden associated with HHS–RADV, particularly the fixed costs associated with hiring an initial validation auditor and submitting IVA results to HHS on an annual basis, which may be a large portion of some issuers' administrative costs.[88] To ease the burden of annual audit requirements for smaller issuers of risk adjustment covered plans that do not materially impact risk adjustment transfers, we finalized a threshold of $15 million in total annual premiums Statewide—a threshold at which 1 percent of an issuer's premiums would cover the estimated $150,000 cost of the IVA.[89] When defining this threshold, we also considered the impact of the exemption on risk adjustment transfers and data validation activities, and estimated issuers above this threshold represented approximately 98.5 percent of enrollment in risk adjustment covered plans nationally. As such, we determined the annual audit of issuers at or below the threshold of total annual premiums Statewide of $15 million was not material.[90] We committed to continue to monitor this threshold and further noted we may propose adjustments in the future to maintain this balance.[91]

Since we established the materiality threshold definition, the estimated costs to complete the IVA have increased, especially with the addition of prescription drug categories to the adult models starting with the 2018 benefit year, and our current estimate of the cost of the IVA is approximately $170,000 per an issuer. To maintain the same general framework and effectively limit the proportion of an issuer's premiums that would be used to cover IVA costs to 1 percent, we would need to adjust the current materiality threshold definition and increase it to

[82] CMS. (2022, July 19). *Summary Report on Permanent Risk Adjustment Transfers for the 2021 Benefit Year.* (p. 9). *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2021.pdf.*

[83] Inflation Reduction Act. Public Law 1217–169 (2022).

[84] HHS has operated the risk adjustment program in all 50 States the District of Columbia since the 2017 benefit year.

[85] Activities related to the 2022 benefit year of HHS–RADV will generally begin in March 2023, when issuers can start selecting their IVA entity, and IVA entities can start electing to participate in HHS–RADV for the 2022 benefit year. See, for example, the 2021 Benefit Year HHS–RADV Activities Timeline (May 3, 2022), available at: *https://regtap.cms.gov/uploads/library/HRADV_2021Timeline_5CR_050322.pdf.*

[86] Additionally, in the 2019 Payment Notice (83 FR 16966), we finalized an exemption from HHS–RADV for issuers with 500 or fewer BMM Statewide in the benefit year being audited. This very small issuer exemption is codified at 45 CFR 153.630(g)(1). Issuers with 500 or fewer BMM Statewide are not subject to random or targeted sampling.

[87] While the 2018 Payment Notice (81 FR 94104 through 94105) provided an applicability date for the materiality threshold that began with the 2017 benefit year of HHS–RADV, we postponed the application of the materiality threshold to the 2018 benefit year in the 2019 Payment Notice (83 FR 16966 through 16967).

[88] See 81 FR 94104 through 94105. Also see 81 FR 61490.

[89] See 81 FR 94104 through 94105.

[90] See 81 FR 94104 through 94105. Also see 81 FR 61490.

[91] See 81 FR 94105.

$17 million in total annual premiums Statewide. We estimate that 30,000 BMM Statewide translates to approximately $17 million in total annual premiums Statewide on average across markets, and this proposed threshold would maintain that issuers of risk adjustment covered plans below this threshold would represent no more than 1.5 percent of enrollment in risk adjustment covered plans nationally. We therefore propose to change the HHS definition of the materiality threshold under § 153.630(g)(2) to 30,000 BMM Statewide in the benefit year being audited beginning with the 2022 benefit year of HHS–RADV.

We propose shifting the exemption from a dollar threshold to BMM threshold because a BMM threshold would continue to exempt small issuers that face a disproportionally higher burden even in situations where PMPM premiums grow overtime. Shifting the materiality threshold under § 153.630(g)(2) to a BMM basis would also align with the threshold established in § 153.630(g)(1), which exempts issuers with 500 or fewer BMM Statewide in the benefit year being audited from HHS–RADV requirements, including random and targeted sampling. We do not anticipate that this proposal would change the current estimated burdens of the annual HHS–RADV requirements on issuers as the pool of issuers falling below a 30,000 BMM Statewide threshold does not significantly differ from the pool of issuers falling below a $15 million total annual premiums Statewide threshold. On average, between the 2017 and 2021 benefit years, there were 197 issuers of risk adjustment covered plans with total annual premiums Statewide below $15 million and 201 issuers of risk adjustment covered plans with total BMM Statewide below 30,000. The proposed changes should also have a minimal impact on data validation activities as issuers of risk adjustment covered plans below this proposed threshold are estimated to represent no more than 1.5 percent of enrollment in risk adjustment covered plans nationally. We continue to believe that setting this 1.5 percent of enrollment threshold promotes the goals of the HHS–RADV process, while also considering the burden of the process on smaller plans, and therefore represents the appropriate balance.

We are not proposing any changes to the regulatory text at § 153.630(g)(2) or to the other accompanying policies. As such, beginning with the 2022 benefit year of HHS–RADV, issuers below the proposed 30,000 BMM Statewide threshold would be exempt from participating in the annual HHS–RADV IVA and SVA requirements if not otherwise selected by HHS to participate under random and targeted sampling conducted approximately every 3 years (barring any risk-based triggers based on experience that would warrant more frequent audits). To determine whether an issuer falls under the materiality threshold, its BMM would be calculated Statewide, that is, by combining an issuer's enrollment in a State's individual non-catastrophic, catastrophic, small group, and merged markets, as applicable, in the benefit year being audited. Issuers that qualify for the exemption under § 153.630(g)(2) from HHS–RADV requirements for a particular benefit year must continue to maintain their risk adjustment documents and records consistent with § 153.620(b) and may be required to make those documents and records available for review or to comply with an audit by the Federal Government.[92] We further note that if an issuer of a risk adjustment covered plan that falls within the materiality threshold is not exempt from HHS–RADV for a given benefit year (that is, the issuer is selected as part of random or targeted sampling), and fails to engage an IVA or submit IVA results to HHS, the issuer would be subject to the default data validation charge in accordance with § 153.630(b)(10) and may be subject to other enforcement action. Lastly, we affirm that an issuer that qualifies for an exemption under § 153.630(g)(2) from HHS–RADV requirements for a particular benefit year would not have its risk scores and State transfers adjusted due to its own risk score error rate(s), but its risk scores and State transfers could be adjusted if other issuers in the applicable State market risk pools were outliers in that benefit year of HHS–RADV.

We solicit comments on this proposal as well as comments on whether we should increase the materiality threshold to $17 million in total annual premiums Statewide instead of switching to 30,000 BMM Statewide and on the applicability date for when a new HHS–RADV materiality threshold should begin to apply.

b. HHS–RADV Adjustments for Issuers That Have Exited the Market

Beginning with 2021 benefit year HHS–RADV, we propose to remove the policy to only apply an exiting issuer's HHS–RADV results if that issuer is a positive error rate outlier.[93] We are proposing to change this policy because it is no longer necessary to treat exiting issuers differently from non-exiting issuers when they are negative error rate outliers in the applicable benefit year's HHS–RADV given the transition to the concurrent application of HHS–RADV results for all issuers.

Consistent with 45 CFR 153.350(b) and (c), adjustments are made to risk scores and risk adjustment State transfers based on the errors discovered in HHS–RADV. In the 2015 Payment Notice (79 FR 13768 through 13769), HHS established a prospective approach to adjust risk scores and risk adjustment State transfers based on the results of HHS–RADV. Under the prospective approach, an issuer's HHS–RADV error rate for a given benefit year is applied to the following benefit year's risk scores and risk adjustment State transfers. However, an issuer that exits all market risk pools in the State during or at the end of the benefit year being audited would not have risk scores and State transfers to adjust in the next applicable benefit year. As such, the 2019 Payment Notice (83 FR 16965 through 16966) created an exception to the prospective approach for exiting issuers that provides for the concurrent application of HHS–RADV results for exiting issuers identified as outliers. Under this exception, the HHS–RADV error rate of an outlier exiting issuer is used to adjust the exiting issuer's prior year risk scores and State transfers for the applicable State market risk pool(s). Due to the budget neutral nature of the HHS-operated risk adjustment program, including HHS–RADV, the application of an outlier exiting issuer's HHS–RADV error rate would also impact other issuers in the applicable State market risk pool(s). Recognizing the impact on non-exiting issuers, we further refined the exiting issuer HHS–RADV policies in the 2020 Payment Notice (84 FR 17503 through 17504) to limit the re-opening of risk pools to make HHS–RADV adjustments to non-exiting issuers' risk adjustment State transfers in certain situations. More specifically, HHS finalized a policy to only make risk score and risk adjustment State transfer adjustments to reflect an exiting issuer's HHS–RADV results if that issuer is a

[92] See 45 CFR 153.620(b) and (c).

[93] To qualify as an exiting issuer, an issuer must exit all of the market risk pools in the State (that is, not selling or offering any new plans in the State). If an issuer only exits some markets or risk pools in the State, but continues to sell or offer new plans in others, it is not considered an exiting issuer. A small group market issuer with off-calendar year coverage who exits the market but has only carry-over coverage that ends in the next benefit year (that is, carry-over of run out claims for individuals or groups enrolled in the previous benefit year, with no new coverage being offered or sold) is considered an exiting issuer. See the 2020 Payment Notice, 84 FR 17503 through 17504.

positive error rate outlier in the benefit year being audited, beginning with the 2018 benefit year.[94] This policy makes adjustments for positive error rate outliers because those HHS–RADV results indicate there was an undercharge or overpayment in the initial calculation of the exiting issuer's State transfer amount(s).[95] Adjustments were not made if an exiting issuer was found to be a negative error rate outlier.[96] This policy was designed to ensure that other issuers in a State market risk pool are made whole when an issuer with a positive error rate exits the State and to remove the additional burden of having transfers adjusted (including the potential for additional charges to be assessed to other issuers) for a prior benefit year when a negative error rate outlier exits the State.

Subsequently, in the 2020 HHS–RADV Amendments Rule (85 FR 76979), HHS finalized a transition to the concurrent application of HHS–RADV results for all issuers, including non-exiting issuers, beginning with the 2020 benefit year HHS–RADV, and has continued the policy to only make risk scores and risk adjustment State transfers adjustments for exiting issuers if they are positive error rate outliers. However, in light of this shift to the concurrent application of HHS–RADV adjustments for all issuers, there is no longer a reason to treat exiting issuers differently than non-exiting issuers. We therefore propose, beginning with 2021 HHS–RADV, to modify this policy and apply HHS–RADV results to adjust the plan liability risk scores of the benefit year being audited for all positive and negative error rate outlier issuers.[97]

We are not proposing any other changes to the policies regarding HHS–RADV adjustments for issuers that exit the market and therefore would maintain the existing framework for determining whether an issuer is an exiting issuer. As such, the issuer would have to exit all of the market risk pools in the State (that is, not selling or offering any new plan in the State) to be considered an exiting issuer. If an issuer only exits some of the markets or risk pools in the State, but continues to sell or offer new plans in others, it would not be considered an exiting issuer. We also affirm that small group market issuers with off-calendar year coverage who exit the market and only have carry-over coverage that ends in the next benefit year (that is, carry-over of run out claims for individuals enrolled in the previous benefit year, with no new coverage being offered or sold) would be considered an exiting issuer and would be exempt from HHS–RADV under § 153.630(g)(4). Individual market issuers offering or selling any new individual market coverage in the subsequent benefit year would be required to participate in HHS–RADV, unless another exemption applies.

We solicit comments on this proposal.

c. Discontinue Lifelong Permanent Conditions List and Use of Non-EDGE Claims in HHS–RADV

We seek comment on discontinuing the use of the Lifelong Permanent Conditions (LLPC) list[98] and the use of non-EDGE claims starting with the 2022 benefit year of HHS–RADV.

The LLPC list was developed for HHS–RADV medical record abstraction purposes beginning with the 2016 benefit year, when issuers were first learning the HHS–RADV protocols and still gaining experience with EDGE data submissions.[99] The intention of the LLPC list was to balance the burdens and costs of HHS–RADV with the program integrity goals of validating the actuarial risk of enrollees in risk adjustment covered plans to ensure that the HHS-operated risk adjustment program accurately assesses charges to issuers with plans with lower-than-average actuarial risk while making payments to issuers with plans with higher-than-average actuarial risk. The LLPC list was designed to ease the burden of medical record retrieval for lifelong conditions by simplifying and standardizing coding abstraction for IVA and SVA entities that may have different interpretations of standard coding guidelines. Conditions on the LLPC list can be abstracted by IVA and SVA entities and validated in HHS–RADV if present anywhere on an enrollee's valid and authenticated medical record, even if the associated diagnosis is not present on a claim that meets EDGE server data submission requirements for the applicable benefit year.[100] The associated diagnoses for the health conditions selected by HHS are considered to be lifelong, permanent conditions which last for multiple years, require ongoing medical attention, and are typically unresolved once diagnosed.[101]

While the LLPC list was developed for HHS–RADV medical record abstraction purposes, the EDGE Server Business Rules for risk adjustment EDGE data submissions direct that EDGE server data submissions are claim-based and follow standard coding principles and guidelines. EDGE Server Business Rules require that diagnoses codes submitted to the EDGE server be related to medical services performed during the patient's visit, be performed by a State licensed medical provider, be associated with a paid claim submitted to the issuer's EDGE server, and be associated with an active enrollment period with the issuer for the applicable risk adjustment benefit year.[102] Some issuers have raised concerns that the LLPC list may incentivize issuers to submit EDGE supplemental diagnosis files containing LLPC diagnoses even though those diagnoses may not have been addressed in the claim submitted to the EDGE server for that encounter. While we allowed the use of the LLPC list for the last several years of HHS–RADV, we continued to consider these issues and

[94] In adjusting exiting issuers with positive error rates, HHS collects funds (either increasing the charge amount or reducing the payment amount) from the exiting issuer and redistributes these funds to the other issuers who participated in that State market risk pool in the prior benefit year. See 84 FR 17503 through 17504.

[95] A positive error rate generally has the effect of decreasing an issuer's risk score and thereby decreasing its risk adjustment State transfer payment amount or increasing its risk adjustment State transfer charge amount.

[96] A negative error rate generally has the effect of increasing an issuer's risk score and thereby increasing its risk adjustment State transfer payment amount or decreasing its risk adjustment State transfer charge amount.

[97] Due to the budget neutral nature of the HHS-operated risk adjustment program, including HHS–RADV, the application of an outlier issuer's HHS–RADV error rate would also impact other issuers in the applicable State market risk pool(s). As such, non-outlier and exempt issuers may also see their State transfers adjusted as a result of the application of HHS–RADV results if there are one or more outliers in the State market risk pool(s).

[98] See, for example, Appendix C: Lifelong Permanent Conditions in the 2021 Benefit Year PPACA HHS Risk Adjustment Data Validation (HHS–RADV) Protocols (November 9, 2022) available at *https://regtap.cms.gov/uploads/library/HRADV_2021_Benefit_Year_Protocols_5CR_110922.pdf.* Also see, for example, Appendix E: Lifelong Permanent Conditions in the 2018 Benefit Year PPACA HHS Risk Adjustment Data Validation (HHS–RADV) Protocols (June 24, 2019) available at *https://regtap.cms.gov/uploads/library/HRADV_2018Protocols_070319_RETIRED_5CR_070519.pdf.*

[99] CMS first published the ''Chronic Condition HCCs'' list in the 2016 Benefit Year PPACA HHS Risk Adjustment Data Validation (HHS–RADV) Protocols (October 20, 2017) available at *https://regtap.cms.gov/uploads/library/HRADV_2016Protocols_v1_5CR_052218.pdf.* Beginning with 2018 benefit year, CMS has provided the ''Lifelong Permanent Conditions'' list, a simplified list of health conditions which share similar characteristics as those on the ''Chronic Condition HCCs'' list. See supra note 93.

[100] Ibid.

[101] See, for example, Appendix C: Lifelong Permanent Conditions in the 2021 Benefit Year PPACA HHS Risk Adjustment Data Validation (HHS–RADV) Protocols (August 17, 2022) available at *https://regtap.cms.gov/uploads/library/HRADV_2021_Benefit_Year_Protocols_v1_5CR_081722.pdf.*

[102] See, for example, Section 8.1 Guidance on Diagnosis Code(s) Derived from Health Assessments of the EDGE Server Business Rules (ESBR) (November 1, 2022) available at *https://regtap.cms.gov/uploads/library/DDC-ESBR-110122-5CR-110122.pdf.*

are now soliciting comments on the discontinuance of the use of the LLPC list beginning with the 2022 benefit year of HHS–RADV.

We believe that discontinuing the use of the LLPC list in HHS–RADV, beginning with the 2022 benefit year, would better align HHS–RADV guidance with the EDGE Server Business Rules and would eliminate some situations where an issuer may receive risk score credit for conditions that did not require treatment during an active enrollment period with the issuer for the applicable risk adjustment benefit year. In addition, we also believe that issuers have now gained sufficient experience with the EDGE data submission process and HHS–RADV protocols that it may not be necessary to continue use of the LLPC list. For example, while nearly half the States subject to the HHS-operated risk adjustment program for the 2015 benefit year [103] were not eligible to receive an interim risk adjustment summary report,[104] this trend has not continued. In fact, all States have received an interim risk adjustment summary report since the 2017 benefit year of the HHS-operated risk adjustment program [105] and only one State where HHS was responsible for operating the risk adjustment program failed to receive an interim risk adjustment summary report for the 2016 benefit year.[106] Further, after several pilot years of HHS–RADV, issuers also have now gained several years of experience with HHS–RADV and HHS–RADV protocols.[107] Therefore, we solicit comment on all aspects of this potential change, including the applicability date for the discontinuance of the LLPC list. We also request comment on the extent that issuers and their IVA entities have relied on the LLPC list to document diagnoses when official coding guidance was unclear or the medical record lacked documentation to support diagnosis of a lifelong, permanent condition.

Similarly, we seek comments on discontinuing the current policy that permits the use of non-EDGE claims in HHS–RADV beginning with the 2022 HHS–RADV benefit year. Under § 153.630(b)(6), issuers are required to provide their IVA entity with all relevant claims data and medical record documentation for the enrollees selected for audit. HHS currently allows issuers to submit medical records to their IVA entity for which no claim was accepted into the EDGE server in certain situations.[108] Under the non-EDGE claims protocol, if issuers identify medical records with no associated EDGE server claim in HHS–RADV, they must demonstrate that a non-EDGE claim meets risk adjustment eligibility criteria. Issuers must also allow the IVA entity to view the associated non-EDGE claim, and IVA entities must record their validation results in their IVA Entity Audit Results Submission.[109] This protocol was also adopted during the early years of HHS–RADV when issuers were gaining experience with HHS–RADV protocols and some may have experienced challenges submitting claims to the EDGE server. However, as explained above, issuers have consistently met data integrity criteria for their EDGE data submissions for multiple consecutive benefit years such that we are now examining the non-EDGE claims protocol and considering whether it should be discontinued. Thus, as part of our ongoing effort to examine ways to better align HHS–RADV guidance and the EDGE Server Business Rules, and in recognition of the experience issuers have gained with HHS–RADV and EDGE data submissions, we solicit comments on discontinuing this protocol. If this change is adopted, beginning with the 2022 benefit year of HHS–RADV, issuers would no longer be able to submit non-EDGE claims to their IVA entities to supplement EDGE claims reviewed during HHS–RADV. We solicit comment on all aspects of this potential protocol change, including the applicability date. We also request comment on the extent that issuers and their IVA entities have relied on the current non-EDGE claims protocol and on how this potential change would impact issuers.

d. HHS–RADV Discrepancy and Administrative Appeals Process

We propose to shorten the window to confirm the findings of the SVA (if applicable),[110] or file a discrepancy report, to within 15 calendar days of the notification by HHS, beginning with the 2022 benefit year of HHS–RADV. Under § 153.630(d)(2), issuers currently have 30 calendar days to confirm the findings

[103] See the Interim Summary Report on Risk Adjustment for the 2015 Benefit Year (March 18, 2016), available at: *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/InterimRAReport_BY2015_5CR_032816.pdf.*

[104] Since the 2015 benefit year of the HHS-operated risk adjustment program, in order for a State to receive the interim risk adjustment summary report, all issuers with 0.5 percent of market share must successfully submit at least 90 percent of full year enrollment and 90 percent of three quarters of medical claims to their EDGE servers by the applicable deadline, as well as pass EDGE quality checks. Details of EDGE quantity and quality assessment can be found in the ''Evaluation of EDGE Data Submissions'' guidance published every year. See, for example, the Evaluation of EDGE Data Submissions for 2015 Benefit Year EDGE Server Data Bulletin (March 18, 2016), available at: *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Part-2-EDGE-Q_Q-Guidance_03182016.pdf.* Also see, for example, the Evaluation of EDGE Data Submissions for 2022 Benefit Year EDGE Server Data Bulletin (October 25, 2022), available at: *https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/edge_2022_qq_guidance.pdf.*

[105] See the Interim Summary Report on Risk Adjustment for the 2017 Benefit Year (April 27, 2018), available at: *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Interim-RA-Report-BY2017.pdf.* Also see, for example, the Interim Summary Report on Risk Adjustment for the 2018 Benefit Year (March 22, 2019), available at: *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Interim-RA-Report-BY2018.pdf.* Also see, for example, the Interim Summary Report on Risk Adjustment for the 2019 Benefit Year (March 25, 2020), available at: *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Interim-RA-Report-BY2019.pdf.* Also see, for example, the Interim Summary Report on Risk Adjustment for the 2020 Benefit Year (March 31, 2021), available at: *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Interim-RA-Report-BY2020.pdf.* Also see, for example, the Interim Summary Report on Risk Adjustment for the 2021 Benefit Year (March 22, 2022), available at: *https://www.cms.gov/files/document/interim-ra-report-by2021.pdf.*

[106] See the Interim Summary Report on Risk Adjustment for the 2016 Benefit Year (April 11, 2017), available at: *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/InterimRAReport_BY2016_5CR_033117.pdf.*

[107] CMS conducted two (2) pilot years for HHS–RADV for the 2015 and 2016 benefit years. The results of 2015 and 2016 benefit year HHS–RADV were not applied to adjust plan liability risk scores or risk adjustment transfers. In addition, 2017 benefit year HHS–RADV was a pilot year for Massachusetts issuers; therefore, these issuers' 2017 benefit year HHS–RADV results were not applied to risk scores or transfers. Except for Massachusetts issuers, the 2017 benefit year was the first non-pilot year where HHS–RADV results were used to adjust risk scores and risk adjustment transfers. See 84 FR at 17508 (April 25, 2019). Also see the Summary Report of 2017 Benefit Year HHS–RADV Adjustments to Risk Adjustment Transfers (August 1, 2019), available at: *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/BY2017-HHSRADV-Adjustments-to-RA-Transfers-Summary-Report.pdf.*

[108] See, for example, Section 9.2.6.5: Documentation of Claims Not Accepted in EDGE of the 2021 Benefit Year PPACA HHS Risk Adjustment Data Validation (HHS–RADV) Protocols (August 17, 2022) available at *https://regtap.cms.gov/uploads/library/HRADV_2021_Benefit_Year_Protocols_v1_5CR_081722.pdf.*

[109] The non-EDGE claim must be risk adjustment eligible paid/positively adjudicated within the benefit year for the specified sampled enrollee. Although the non-EDGE claim would have been accepted to EDGE had it met the EDGE submission deadline, diagnoses associated with non-EDGE claim s are not included in the risk adjustment risk score calculations in the June 30th Summary Report on Permanent Risk Adjustment Transfers. Diagnoses associated with non-EDGE claims are only used as an option for HCC validation purposes in HHS–RADV when the applicable criteria are met.

[110] Only those issuers who have insufficient pairwise agreement between the IVA and SVA receive SVA findings. See 84 FR 17495. Also see 86 FR 24201.

of the SVA, or file a discrepancy report, in the manner set forth by HHS, to dispute those SVA findings. We propose the shorter attestation and discrepancy reporting window for SVA findings to improve HHS' ability to finalize SVA findings results prior to release of the applicable benefit year HHS Risk Adjustment Data Validation (RADV) Results Memo and the Summary Report of Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers for the applicable benefit year, which are time-sensitive publications because information on HHS–RADV adjustments is used by issuers for medical loss ratio (MLR) reporting.[111]

We do not propose to shorten the 30-calendar-day window set forth in § 153.630(d)(2) to confirm the risk score error rate, or file a discrepancy, as the same timing considerations do not extend to the risk score error rate attestation and discrepancy reporting window. In addition, all issuers who participate in HHS–RADV for the applicable benefit year must complete the risk score error rate attestation and discrepancy reporting process, whereas the SVA findings attestation and discrepancy reporting process is limited to the small number of issuers that have insufficient pairwise agreement between the IVA and SVA.

In prior rulemakings, we proposed shortening the attestation and discrepancy reporting window for the SVA findings, but did not finalize these proposals in response to comments suggesting that we revisit this proposal once issuers had more experience with HHS–RADV after the first non-pilot year.[112] Since issuers now have more than 4 years of experience with HHS–RADV, including several non-pilot years, HHS believes it is appropriate to revisit the proposal to shorten the reporting window to confirm the findings of the SVA, or file a discrepancy report, and that any disadvantages of this shortened reporting window would be outweighed by the benefits of timely resolution of any discrepancies before the release of the applicable benefit year HHS Risk Adjustment Data Validation (RADV) Results Memo and the Summary Report of Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers for the applicable benefit year. Specifically, based on our experience, we found that few issuers have insufficient pairwise agreement between the IVA and SVA that results in receiving SVA findings, and therefore, few issuers would even have the option to file an SVA discrepancy.[113] Of these issuers, even fewer of them will actually file a discrepancy, and therefore, based on this experience, HHS believes only a very small number of issuers will receive SVA findings and file discrepancies in future years of HHS–RADV.

More importantly, without this timing change, we are concerned about HHS' continued ability to release the applicable benefit year HHS Risk Adjustment Data Validation (RADV) Results Memo and Summary Report of Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers on a timely basis. Specifically, this proposal would improve our ability to follow the HHS–RADV timeline as described in part 2 of the 2022 Payment Notice,[114] which provides for release of the Summary Report of Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers in early summer of 2 calendar years after the applicable benefit year. This schedule was developed to support timely reporting of HHS–RADV adjustment amounts in the MLR reports [115] due by July 31st of the same calendar year in which the results are released.[116] The SVA findings need to be finalized to begin the HHS–RADV error estimation process, publish the HHS–RADV Results Memo (which is released alongside issuer's HHS–RADV results reports), and prepare the Summary Report of Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers for publication. Shortening the current 30-calendar-day attestation and discrepancy reporting window for SVA findings (if applicable) to 15 calendar days would better allow HHS to finalize SVA findings results and timely release the Summary Report of Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers in summer, which would support timely reporting of the HHS–RADV adjustments to risk adjustment State transfers in issuers' MLR reports.

We further note that a 15-calendar-day attestation and discrepancy reporting window is consistent with the IVA sample and EDGE attestation and discrepancy reporting windows at §§ 153.630(d)(1) and 153.710(d), respectively. At the conclusion of the SVA for a given benefit year, we distribute SVA findings to issuers that have insufficient agreement between their IVA and SVA results during the pairwise means analysis, and use the SVA findings for the risk score error rate calculation.[117] Under this proposal, a 15-calendar-day window to confirm the findings or file a discrepancy, in the manner set forth by HHS, would begin when the SVA finding reports are issued.

To effectuate this proposed amendment, we propose the following four revisions to § 153.630(d). First, we propose to revise § 153.630(d)(2) to remove the reference to the calculation of the risk score error rate as a result of HHS–RADV. Second, we propose to revise § 153.630(d)(2) to establish that the attestation and discrepancy reporting window for the SVA findings (if applicable) would be within 15 calendar days of the notification by HHS of the SVA findings (if applicable), rather than the current 30-calendar-day reporting window. Third, we propose to redesignate current paragraph (d)(3) as paragraph (d)(4), to maintain the existing provision which explains that an issuer may appeal findings of an SVA (if applicable) or the calculation of a risk score error rate as a result HHS–RADV, under the process set forth in § 156.1220. Fourth, we propose to add a new § 153.630(d)(3) to maintain the current attestation and discrepancy reporting window for the calculation of the risk score error rate. This new regulatory subsection would provide that within 30 calendar days of the notification by HHS of the calculation of the risk score error rate, in the manner set forth by HHS, an issuer must either confirm or file a discrepancy report to dispute the calculation of the risk score error rate as a result of HHS–RADV.

In addition, we propose to make corresponding amendments to the cross-references to § 153.630(d)(2) that appear in §§ 153.710(h)(1) and 156.1220(a)(4)(ii). Section 153.630(d)(2) currently sets forth the attestation and discrepancy reporting window for both SVA findings (if applicable) and the calculation of the risk score error rate as a result of HHS–RADV. Under this proposal, the attestation and discrepancy reporting window for SVA

[111] Section 2718 of the PHS Act, as added by the ACA generally requires health insurance issuers to submit an annual MLR report to HHS and provide rebates to enrollees if the issuers do not achieve specified MLR thresholds. See 42 U.S.C. 300gg–18 and 45 CFR part 158. Also see 45 CFR 153.710(h).

[112] See 84 FR 17495 and 86 FR 24201.

[113] Only those issuers who have insufficient pairwise agreement between the IVA and SVA receive SVA findings. See, for example, 84 FR 17495 and 86 FR 24201.

[114] 86 FR 24198 through 24201.

[115] Issuer MLRs are calculated using a 3-year average. See 45 CFR 158.220(b).

[116] See 45 CFR 158.110(b). Also see 45 CFR 153.710(h)(1)(v).

[117] If sufficient pairwise means agreement is achieved, the IVA findings will be used for purposes of the risk score error rate calculation. Issuers with sufficient pairwise means agreement are only permitted to file a discrepancy or appeal the risk score error rate calculation. See 78 FR 72334 through 72337 and 79 FR 13761 through 13768.

findings (if applicable) and the calculation of the risk score error rate as a result of HHS–RADV would be set forth in separate paragraphs, § 153.630(d)(2) and (d)(3), respectively. As such, we propose to amend the existing cross-reference to § 153.630(d)(2) in §§ 153.710(h)(1) and 156.1220(a)(4)(ii) to add a reference to paragraph (d)(3).

We seek comment on this proposal and the accompanying conforming amendments.

8. EDGE Discrepancy Materiality Threshold (§ 153.710)

We propose to amend the EDGE discrepancy materiality threshold set forth at § 153.710(e) to align it with the final policy adopted in preamble in part 2 of the 2022 Payment Notice.[118] We also propose a conforming amendment to § 153.710(h)(1) to add a reference to new proposed § 153.630(d)(3).

An issuer of a risk adjustment covered plan must provide to HHS, through their EDGE server,[119] access to enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data as specified by HHS for a benefit year.[120] Consistent with § 153.730, to be considered for risk adjustment payments and charges, issuers of risk adjustment covered plans must submit their respective EDGE data by April 30th of the year following the applicable benefit year or, if such date is not a business day, the next applicable business day. At the end of the EDGE data submission process, HHS issues final EDGE server reports [121] which reflect an issuer's data that was successfully submitted by the data submission deadline. Within 15 calendar days of the date of these final EDGE server reports, the issuer must confirm to HHS that the information in the final EDGE server reports accurately reflect the data to which the issuer has provided access to HHS through its EDGE server for the applicable benefit year by submitting an attestation; or the issuer must describe to HHS any discrepancies it identifies in the final EDGE server reports.[122]

In part 2 of the 2022 Payment Notice (86 FR 24194 through 24195), we codified at § 153.710(e) a materiality threshold for EDGE discrepancies reported under § 153.710(d)(2) that the amount in dispute must equal or exceed $100,000 or one percent of the applicable payment or charge payable to or due from the issuer for the benefit year, whichever is less. However, in preamble, we explained the final policy was intended to establish that the amount in dispute must equal or exceed $100,000 or one percent of the total estimated transfer amount in the applicable State market risk pool, whichever is less.[123] That is, the preamble uses one percent of the total estimated transfer amount in the applicable State market risk pool while the regulation uses one percent of the applicable payment or charge payable to or due from the issuer. As explained in the preamble in part 2 of the 2022 Payment Notice, the intended threshold is $100,000 or one percent of the total estimated transfer amount in the applicable State market risk pool because HHS generally only takes action on reported material EDGE discrepancies that harm other issuers in the same State market risk pool and, based on HHS' experience with prior benefit years, EDGE discrepancies that are less than a fraction of total State market risk pool transfers are unlikely to materially impact other issuers. We therefore propose to amend § 153.710(e) to revise the materiality threshold for EDGE discrepancies to reflect that the amount in dispute must equal or exceed $100,000 or one percent of the total estimated transfer amount in the applicable State market risk pool, whichever is less.

Finally, as discussed in section III.A.7.d of this preamble (HHS–RADV Discrepancy and Administrative Appeals Process), we also propose amendments to § 153.710(h)(1) to add a reference to new proposed § 153.630(d)(3). As discussed in the HHS–RADV Discrepancy and Administrative Appeals Process section of this proposed rule, under new proposed § 153.630(d)(3), we would retain the 30-calendar-day window to confirm, or file a discrepancy, regarding the calculation of the risk score error rate as a result of HHS–RADV. Under this proposal, the cross-reference to § 153.630(d)(2) in § 153.710(h)(1) would be maintained and would capture the new proposed 15-calendar-day window to confirm, or file a discrepancy, for SVA findings (if applicable).

We seek comment on the proposed amendment to § 153.710 and the accompanying policies.

B. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Exchange Blueprint Approval Timelines (§ 155.106)

We propose a change to address the Exchange Blueprint approval timelines for States transitioning from either a Federally-facilitated Exchange (FFE) to a State-based Exchange on the Federal Platform (SBE–FP) or to a State-based Exchange (SBE), or from an SBE–FP to an SBE. At § 155.106(a)(3) (for FFE or SBE–FP to SBE transitions) and § 155.106(c)(3) (for FFE to SBE–FP transitions), we propose to revise the current timelines by which a State must have an approved or conditionally approved Exchange Blueprint to require that States gain approval prior to the date on which the Exchange proposes to begin open enrollment either as an SBE or SBE–FP. The current regulatory timeline by which a State must have an approved or conditionally approved Exchange Blueprint was finalized in the 2017 Payment Notice (81 FR 12203, 12241 through 12242). Based on our experience with Exchange transitions since then, we believe the current timeline by which a State must gain Exchange Blueprint approval does not sufficiently support States' need to work with HHS to finalize and submit an approvable Exchange Blueprint.

Section 155.106 requires States to have an approved or conditionally approved Exchange Blueprint 14 months prior to an SBE–FP to SBE transition in accordance with paragraph (a)(3) and three months prior to a FFE to SBE–FP transition in accordance with paragraph (c)(3). The submission and approval of Exchange Blueprints is an iterative process that generally takes place over the course of 15 months prior to a State's first open enrollment with an SBE, or three to six months prior to a State's first open enrollment with an SBE–FP. The Exchange Blueprint serves as a vehicle for a State to document its progress toward implementing its intended Exchange operational model. HHS' review and approval of the Exchange Blueprint involves providing

[118] See 86 FR 24194 through 24195.

[119] This is also known as the dedicated distributed data collection environment.

[120] 45 CFR 153.710(a) through (c).

[121] These reports are: Enrollee (Without) Claims Summary (ECS), Enrollee (Without) Claims Detail (ECD), Frequency Report by Data Element for Medical Accepted Files (FDEMAF), Frequency Report by Data Element for Pharmacy Accepted Files (FDEPAF), Frequency Report by Data Element for Supplemental Accepted Files (FDESAF), Frequency Report by Data Element for Enrollment Accepted Files (FDEEAF), Claim and Enrollee Frequency Report (CEFR), High Cost Risk Pool Summary (HCRPS), High Cost Risk Pool Detail Enrollee (HCRPDE), Risk Adjustment Claims Selection Summary (RACSS), Risk Adjustment Claims Selection Detail (RACSD), Risk Adjustment Transfer Elements Extract (RATEE), Risk Adjustment Risk Score Summary (RARSS), Risk Adjustment Risk Score Detail (RARSD), Risk Adjustment Data Validation Population Summary Statistics (RADVPS), Risk Adjustment Payment Hierarchical Condition Category Enrollee (RAPHCCER), Risk Adjustment User Fee (RAUF).

[122] 45 CFR 153.710(d).

[123] See 86 FR 24194 through 24195. Also see 85 FR 78604 through 78605.

substantial technical assistance to States as they design, finalize, and implement their Exchange operations. The transition from a FFE or SBE–FP to SBE, or SBE–FP to SBE, involves significant collaboration between HHS and States to develop plans and document readiness for the State to transition from one Exchange operational model and information technology infrastructure to another. These activities include the State completing key milestones, meeting established deadlines, and implementing contingency measures.

Our proposal to require Exchange Blueprint approval or conditional approval prior to an Exchange's first open enrollment period would allow States the additional time and flexibility if needed, that, in HHS' experience, is necessary to support the development and finalization of an approvable Exchange Blueprint, as well as for completion of the myriad activities necessary to transition QHP enrollees in the State to a new Exchange model and operator. HHS is of the view that the more generous proposed timeline is appropriate and necessary to support a State's submission of an approvable Exchange Blueprint. The proposed timeline is more protective of the significant investments of personnel time and State tax dollars a State must make to stand up a new Exchange, by providing the State a more generous timeline to develop an approvable Exchange Blueprint that shows the Exchange will be ready to support the State's current and future QHP enrollees and applicants for QHP enrollment.

We seek comment on this proposal, including comments related to how transitioning SBEs could provide greater transparency to consumers regarding the Exchange Blueprint approval process.

2. Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210, 155.215, and 155.225)

a. Repeal of Prohibitions on Door-to-Door and Other Direct Contacts

HHS proposes to repeal the provisions that currently prohibit Navigators, certified application counselors, non-Navigator assistance personnel in FFEs, and non-Navigator assistance personnel in certain State Exchanges funded with section 1311(a) Exchange Establishment grants (collectively, Assisters) from going door-to-door or using other unsolicited means of direct contact to provide enrollment assistance to consumers. This proposal would eliminate barriers to coverage access by maximizing pathways to enrollment.

Sections 1311(d)(4)(K) and 1311(i) of the ACA direct all Exchanges to establish a Navigator program. Navigator duties and requirements for all Exchanges are set forth in section 1311(i) of the ACA and § 155.210. Section 1321(a)(1) of the ACA directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the ACA, with respect to, among other things, the establishment and operation of Exchanges. Pursuant to section 1321(a)(1) of the ACA, the Secretary issued § 155.205(d) and (e), which authorizes Exchanges to perform certain consumer service functions in addition to the Navigator program, such as the establishment of a non-Navigator assistance personnel program. Section 155.215 establishes standards for non-Navigator assistance personnel in FFEs and in State Exchanges if they are funded with section 1311(a) Exchange Establishment grant funds.[124] Section 155.225 establishes the certified application counselor program as a consumer assistance function of the Exchange, separate from and in addition to the functions described in §§ 155.205(d) and (e), 155.210, and 155.215.

Assisters are certified and trusted community partners who provide free and impartial enrollment assistance to consumers. They conduct outreach and education to raise awareness about the Exchanges and other coverage options. Their mission focuses on assisting the uninsured and other underserved communities to prepare applications, establish eligibility and enroll in coverage through the Exchanges, among many other things. The regulations governing these Assisters prohibit Assisters from soliciting any consumer for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling a consumer to provide application or enrollment assistance without the consumer initiating the contact, unless the individual has a pre-existing relationship with the individual Assister or designated organization and other applicable State and Federal laws are otherwise complied with. HHS has interpreted this prohibition in the 2015 Market Standards final rule (79 FR 30240, 30284 through 30285) as still permitting door-to-door and other unsolicited contacts to conduct for general consumer education or outreach, including to let the community know that the Assister's organization is available to provide application and enrollment assistance services to the public.

The existing regulations prohibiting Navigators (at § 155.210(d)(8)), non-Navigator assistance personnel (through the cross-reference to § 155.210(d) in § 155.215(a)(2)(i)), and certified application counselors (at § 155.225(g)(5)) were initially finalized in the 2015 Market Standards final rule (79 FR 30240). At the time that HHS proposed and finalized the 2015 Market Standards rule in 2014, the Exchanges were still in their infancy. At the time, we believed that prohibiting door-to-door solicitation and other unsolicited means of direct consumer contact by an Assister for application or enrollment assistance would ensure that Assisters' practices were sufficiently protective of the privacy and security interests of the consumers they served. We also believed that prohibiting unsolicited means of direct contacts initiated by Assisters was necessary to provide important guidance and peace of mind to consumers, especially when they were faced with questions or concerns about what to expect in their interactions with individuals offering Exchange assistance.[125]

However, under existing regulations, Navigators and other non-Navigator assistance personnel in FFE States are permitted to conduct outreach to consumers using consumer information provided to them by an FFE. The Health Insurance Exchanges (HIX) System of Records Notice,[126] Routine Use No. 1 provides that the FFEs may share consumer information with CMS grantees, including Navigators and other non-Navigator assistance personnel in FFE States, who have been engaged by CMS to assist in an FFE authorized function, which includes conducting outreach to persons who have been redetermined ineligible for Medicaid/CHIP. In this limited circumstance, an FFE may share with Navigators and other non-Navigator assistance personnel in FFE States consumer information that the FFE receives from Medicaid/CHIP agencies once a consumer has been redetermined ineligible for Medicaid/CHIP in order for the Navigators and other non-Navigator assistance personnel to conduct outreach to such consumers regarding opportunities for coverage through the FFEs.

Since finalizing the 2015 Market Standards final rule, HHS has enacted a number of measures designed to ensure that Assisters are properly safeguarding

[124] At this time, no State Exchanges are funded with section 1311(a) Exchange Establishment grant funds.

[125] 79 FR 30240.

[126] 78 FR 63211, 63215.

the personally identifiable information of all consumers they assist. As part of their annual certification training, HHS requires Assisters to complete a course on privacy, security, and fraud prevention standards. Further, we require Assisters to obtain a consumer's consent before discussing or accessing their personal information (except in the limited circumstance described above) and to only create, collect, disclose, access, maintain, store and/or use consumer personally identifiable information to perform the functions that they are authorized to perform as Assisters in accordance with §§ 155.210(b)(2)(iv) and (c)(1)(v), 155.225(d)(3), and 155.215(b)(2), as applicable. In addition, now that the Exchanges and their Assister programs have been in operation for almost 10 years, Assisters have more name recognition and consumer trust within the communities the Assisters serve. Accordingly, HHS believes that its previous concerns related to consumers' privacy and security interests and consumers not knowing what to expect when interacting with Assisters have been sufficiently mitigated with the measures HHS has enacted such that a blanket prohibition on unsolicited direct contact of consumers by Assisters for application or enrollment assistance is no longer necessary.

The prohibition on door-to-door enrollment places additional burden on consumers and Assisters to make subsequent appointments to facilitate enrollment, which creates access barriers for consumers to receive timely and relevant enrollment assistance. Additionally, this prohibition could impede the Exchanges' potential to reach a broader consumer base in a timely manner, reduce uninsured rates, and increase access to health care. We believe it is important to be able to increase access to coverage for those whose ability to travel is impeded due to mobility, sensory or other disabilities, who are immunocompromised, and who are limited by a lack of transportation.

Consistent with the proposal to remove the general prohibition on door-to-door and other direct outreach by Navigators, we propose to delete § 155.210(d)(8). If finalized, the repeal of § 155.210(d)(8) would remove the general prohibition on door-to-door and other direct outreach by non-Navigator assistance personnel in FFEs and in State Exchanges if funded with section 1311(a) Exchange Establishment grants, as § 155.215(a)(2)(i) requires such entities to comply with the prohibitions on Navigator conduct set forth at § 155.210(d). Likewise, we propose to repeal § 155.225(g)(5), which currently imposes the general prohibition against door-to-door and other direct contacts on certified application counselors.

As we explained earlier in this preamble, HHS is now of the view that repealing restrictions on an Exchange's ability to allow Navigators, non-Navigator assistance personnel, and certified application counselors to offer application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact is a positive step that would enable Assisters to reach a broader consumer base in a timely manner—helping to reduce uninsured rates and health disparities by removing underlying barriers to accessing health coverage.

We seek comment on this proposal.

3. 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)

Section 1312(e) of the ACA 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. In addition, section 1313(a)(5)(A) of the ACA directs the Secretary to provide for the efficient and non-discriminatory administration of Exchange activities and to implement any measure or procedure the Secretary determines is appropriate to reduce fraud and abuse. Under § 155.220, we established 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) for HHS to suspend or terminate an agent's, broker's, or web-broker's Exchange agreement(s) in circumstances that involve fraud of abusive conduct or where there are sufficiently severe findings of non-compliance. We also established FFE standards of conduct under § 155.220(j) for agents and brokers that assist consumers in enrolling in coverage through the FFEs to protect consumers and ensure the proper administration of the FFEs. Consistent with § 155.220(l), agents, brokers and web-brokers that assist with or facilitate enrollment in States with SBE–FPs must comply with all applicable FFE standards, including the requirements in § 155.220. In this rule, we propose to build on this foundation with new proposed procedures and additional consumer protection standards for agents, brokers, and web-brokers that assist consumers with enrollments through FFEs and SBE–FPs.

a. Extension of Time To Review Suspension Rebuttal Evidence and Termination Reconsideration Requests (§ 155.220(g) and (h))

We propose to allow HHS up to an additional 15 or 30 calendar days to review evidence submitted by agents, brokers, or web-brokers to rebut allegations that led to suspension of their Exchange agreement(s) or to request reconsideration of termination of their Exchange agreement(s), respectively. This proposal would provide HHS a total of up to 45 or 60 calendar days to review such rebuttal evidence or reconsideration request and notify the submitting agents, brokers, or web-brokers of HHS' determination regarding the suspension of their Exchange agreement(s) or reconsideration decision related to the termination of their Exchange agreement(s), respectively. In the 2017 Payment Notice, we added paragraph (5) to § 155.220(g) to address the temporary suspension or immediate termination of an agent's or broker's agreements with the FFEs in cases involving fraud or abusive conduct.[127] Consistent with section 1313(a)(5)(A) of the ACA, we added these procedures to give HHS authority to act quickly in these situations to prevent further harm to consumers and to support the efficient and effective administration of Exchanges on the Federal platform. Under § 155.220(g)(5)(i)(A), if HHS reasonably suspects that an agent, broker, or web-broker may have engaged in fraud or abusive conduct using personally identifiable information of Exchange applicants or enrollees or in connection with an Exchange enrollment or application, HHS may temporarily suspend the agent's, broker's or web-broker's Exchange agreement(s) for up to 90 calendar days, with the suspension effective as of the date of the notice to the agent, broker, or web-broker. This temporary suspension is effective immediately and prohibits the agent, broker, or web-broker from assisting with or facilitating enrollment in coverage in a manner that constitutes enrollment through the Exchange, including participating in the Classic DE and EDE Pathways, during this 90-day period.[128] [129] As previously

[127] See 81 FR at 12258–12264. Also see 80 FR at 75525–75526.

[128] 45 CFR 155.220(g)(5)(iii).

[129] The agent, broker, or web-broker must continue to protect any personally identifiable

Continued

explained, immediate suspension is critical in these circumstances to stop additional potentially fraudulent enrollments through the FFEs and SBE–FPs.[130] Consistent with § 155.220(g)(5)(i)(B), the agent, broker, or web-broker can submit evidence to HHS to rebut the allegations that they have engaged in fraud or abusive conduct that led to a temporary suspension by HHS of their Exchange agreement(s) at any time during 90-day period. If such rebuttal evidence is submitted, HHS will review it and make a determination as to whether a suspension should be lifted within 30 days of receipt of such evidence.[131] If HHS determines that the agent, broker, or web-broker satisfactorily addresses the concerns at issue, HHS will lift the temporary suspension and notify the agent, broker, or web-broker. If the rebuttal evidence does not persuade HHS to lift the suspension, HHS may terminate the agent's, broker's, or web-broker's Exchange agreement(s) for cause.[132] [133]

HHS also previously established a framework for termination of an agent's, broker's, or web-broker's Exchange agreement(s) for cause in situations where, in HHS' determination, a specific finding of noncompliance or pattern of noncompliance is sufficiently severe.[134] This framework provides HHS the ability to 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 these situations, HHS provides the agent, broker, or web-broker, an advance 30-day notice and an opportunity to cure and address the non-compliance finding(s).[135] [136] More specifically, upon identification of a sufficiently severe violation, HHS notifies the agent, broker, or web-broker of the specific finding(s) of noncompliance or pattern of noncompliance. The agent, broker, or web-broker then has a period of 30 days from the date of the notice to correct the noncompliance to HHS' satisfaction. If after 30 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)(3), 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.[137] [138] Consistent with § 155.220(h)(1), an agent, broker, or web-broker whose Exchange agreement(s) are terminated can request reconsideration of such action. 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 30 calendar days of receipt of the request for reconsideration.

Our experience reviewing evidence and other information submitted by agents, brokers, or web-brokers to rebut allegations that led to the suspension of their Exchange agreement(s) or to request reconsideration of the termination of their Exchange agreement(s), found that the process, especially in more complex situations, often requires significant resources and time. The review process can involve parsing complex technical information and data, as well as revisiting consumer complaints or conducting outreach to consumers. The amount of time it takes for the review process is largely dependent on the particular situation at hand (for example, the number of alleged violations and impacted consumers, how much and what type of information an agent, broker, or web-broker submits, the amount of time it takes for consumers to locate and provide documentation related to their complaints, and the number of concurrent submissions in need of review). Given the large number of factors involved, we believe that allowing HHS additional time to complete the review would be beneficial.

We are cognizant that this additional time could delay the ability of agents, brokers, and web-brokers to conduct business, which may be particularly burdensome to those who have compelling evidence to rebut allegations of noncompliance. Given the critical role that agents, brokers, and web-brokers serve in enrolling consumers in plans on the Exchanges, it is our intention to minimize the burden imposed on agents, brokers, and web-brokers to the greatest extent possible while also ensuring that HHS has additional time (if necessary) to review any submitted rebuttal evidence. As stated above, this additional time is warranted to accommodate particularly complex situations that require significant resources and time. We expect that not all reviews are so complex that they would require the use of this additional time; in cases where agents, brokers, and web-brokers present compelling evidence to rebut allegations of noncompliance, we expect to be able to resolve the vast majority of those reviews without the use of this additional time.

We believe that the proposal to allow HHS a total of up to 45 calendar days to review rebuttal evidence is warranted given that agents, brokers, and web-brokers have up to 90 days to submit rebuttal evidence to HHS during their suspension period, while HHS currently only has 30 days to review, consider, and make determinations based on that evidence. It does not seem unreasonable to increase this combined maximum 120-day time period[139] to 135 days.[140]

We believe that this is not an unreasonable maximum timeframe,

information accessed during the term of their Exchange agreements. See, *e.g.,* 45 CFR 155.220(g)(5)(iii) and 155.260.

[130] See, *e.g.,* 81 FR at 12258–12264.

[131] See 45 CFR 155.220(g)(5)(i)(B).

[132] See 45 CFR 155.220(g)(5)(i)(B).

[133] If the agent, broker, or web-broker fails to submit rebuttal information during this 90-day period, HHS may terminate their Exchange agreement(s) for cause. 45 CFR 155.220(g)(5)(i)(B).

[134] See 45 CFR 155.220(g)(1)–(4). Also see, *e.g.,* 78 FR at 37047 through 37048 and 78 FR at 54076 through 54081.

[135] See 45 CFR 155.220(g)(3)(i).

[136] 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.

[137] 45 CFR 155.220(g)(4).

[138] The agent, broker, or web-broker must continue to protect any PII accessed during the term of their Exchange agreements. See, *e.g.,* 45 CFR 155.220(g)(4) and 155.260.

[139] As noted above, an agent, broker, or web-broker whose Exchange agreement(s) are temporarily suspended can submit rebuttal evidence at any time during the 90-day suspension period, thus triggering the start of the HHS review period and limiting the length of the suspension period. For example, under this proposal, if an agent were to submit rebuttal evidence within seven days of receiving the suspension notice and HHS were to respond on the last day of the proposed new review period (day 45) and lift the suspension, that would mean the agent's Exchange agreement(s) would have been suspended for only 52 days.

[140] For example, under this proposal, if an agent whose Exchange agreement(s) were temporarily suspended were to submit rebuttal evidence to rebut allegations that led to the suspension of their Exchange agreement(s) on the final day of the suspension period (day 90), pursuant to § 155.220(g)(5)(i)(B), and HHS were to respond on the final day of the proposed new review period (day 45) and lift the suspension, that agent's Exchange agreement(s) would be suspended for a maximum of 135 days.

particularly where HHS has a reasonable suspicion the agent, broker, or web-broker engaged in fraud or abusive conduct that may cause imminent or ongoing consumer harm using personally identifiable information of an Exchange enrollee or applicant or in connection with an Exchange enrollment or application. As noted in the 2017 Payment Notice, there is a similar requirement for Medicare providers, as 42 CFR 405.371 provides HHS with the authority to suspend payment for at least 180 days if there is reliable information that an overpayment exists, or there is a credible allegation of fraud (81 FR 12262 through 12263). Under § 155.220(g)(5)(i)(A), HHS temporarily suspends an agent, broker or web-broker's Exchange agreement(s) only in situations in which there is sufficient evidence or other information such that HHS reasonably suspects the agent, broker or web-broker engaged in fraud, or in abusive conduct that may cause imminent or ongoing consumer harm using personally identifiable information of an Exchange enrollee or applicant or in connection with an Exchange enrollment or application. As such, HHS exercises this authority and sends suspension notices only in the limited situations where there may have been fraud or abusive conduct to stop further Exchange enrollment activity when the misconduct may cause imminent or ongoing harm to consumers or the effective and efficient administration of Exchanges. We also further emphasize that the proposed extension to allow for up to 45 days for HHS to review rebuttal evidence in these situations represents the maximum timeframe.[141] To the extent the situation at hand does not, for example, involve a large number of alleged violations or impacted consumers, HHS may not need the maximum timeframe to complete the review and notify the agent, broker, or web-broker whether the suspension is lifted.

Terminations of Exchange agreement(s) by HHS are also limited, but in a different way. As outlined above, § 155.220(g)(1) allows HHS to terminate an agent, broker, or web-brokers Exchange agreement for cause only when, in HHS' determination, a specific finding of noncompliance or pattern of noncompliance is sufficiently severe. Examples of specific findings of noncompliance that HHS might determine to be sufficiently severe to warrant termination of an agent's, broker's, or web-broker's Exchange agreement for cause under section § 155.220(g)(1) include, but are not limited to, violations of the Exchange privacy and security standards.[142] Patterns of noncompliance that HHS might determine to be sufficiently severe to warrant termination for cause include, for example, repeated violations of any of the applicable standards in § 155.220 or § 155.260(b) for which the agent or broker was previously found to be noncompliant.[143] As proposed, if HHS takes the total up to 60 calendar days to review rebuttal evidence submitted by the agent, broker, or web-broker whose Exchange agreement was terminated for cause, the maximum timeframe for the reconsideration process under § 155.220(h) would be 90 days. We believe this approach strikes the appropriate balance with respect to reviewing information submitted with a request to reconsider termination of their Exchange agreement(s) because it provides the agent, broker, or web-broker due process while also protecting consumers from potential harm. We are proposing a longer time period of 60 days for HHS review of information and evidence submitted by an agent, broker, or web-broker as part of their reconsideration request (versus 45 days for HHS review of rebuttal evidence and information submitted in response to a suspension determination) because the HHS reviews under § 155.220(h)(2) are part of the appeal process. As such, the agent, broker, or web-broker had an opportunity at an earlier stage of the suspension or termination process to rebut the allegations and/or findings, or otherwise take remedial steps to address the concerns identified by HHS, that led to suspension or termination of their Exchange agreement(s).[144] [145]

For these reasons, we propose to amend § 155.220(g)(5)(i)(B) to provide HHS with up to 45 calendar days to review evidence and other information submitted by agents, brokers, or web-brokers to rebut allegations that led to suspension of their Exchange agreement(s) and make a determination of whether to lift the suspension. We also propose to amend § 155.220(h)(3) to provide HHS with up to 60 days to review evidence and other information submitted by agents, brokers, or web-brokers to rebut allegations that led to termination of their Exchange agreement(s) and provide written notice of HHS' reconsideration decision.

We seek comment on this proposal.

b. Providing Correct Information to the FFEs (§ 155.220(j))

We propose to amend § 155.220(j)(2)(ii) to require agents, brokers, or web-brokers assisting with and facilitating enrollment through FFEs and SBE–FPs or assisting an individual with applying for APTC and CSRs for QHPs to document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or their authorized representative designated in compliance with § 155.227, prior to application submission. We propose that such documentation would be created by the assisting agent, broker, or web-broker and would require the consumer or their authorized representative to take an action, such as providing a signature or a recorded verbal confirmation, that produces a record that can be maintained by the agent, broker, or web-broker and produced to confirm the submitted eligibility application information was reviewed and confirmed to be accurate by the consumer or their authorized representative. In addition, we propose that the documentation must include the date the information was reviewed, the name of the consumer or their authorized representative, an explanation of the attestations at the end of the eligibility application, and the name of the agent, broker, or web-broker providing assistance. Lastly, we propose that the documentation must be maintained by the agent, broker, or web-broker for a minimum of 10 years and produced upon request in response to monitoring, audit, and enforcement activities conducted consistent with § 155.220(c)(5), (g), (h) and (k). These proposed changes would require amending § 155.220(j)(2)(ii), creating new paragraph § 155.220(j)(2)(ii)(A), and redesignating current § 155.220(j)(2)(ii)(A), § 155.220(j)(2)(ii)(B),

[141] Further, as detailed above, the agent, broker, or web-broker whose Exchange agreement(s) are suspended has an opportunity to limit the overall length of the suspension period with the timely submission of rebuttal evidence.

[142] As outlined in § 155.220(g)(2), an agent, broker, or web-broker may be determined noncompliant if HHS finds that the agent, broker, or web-broker violated any standard specified in § 155.220; any term or condition of their Exchange agreement(s); any State law applicable to agents, brokers, or web-brokers; or any Federal law applicable to agents, brokers, or web-brokers.

[143] Ibid.

[144] See 45 CFR 155.220(g)(5)(i)(B) (providing an opportunity to rebut allegations of fraud or abusive conduct) and 45 CFR 155.220(g)(3)(i) (providing advance notice and an opportunity to correct the noncompliance).

[145] The one exception is for immediate terminations for cause due to the lack of appropriate State licensure under 45 CFR 155.220(g)(3)(ii). In these situations, however, the maximum timeframe between the agent, broker, or web-broker receiving the termination notice and the issuance of the HHS reconsideration decision would be 90 days.

§ 155.220(j)(2)(ii)(C) and
§ 155.220(j)(2)(ii)(D) without change as
§ 155.220(j)(2)(ii)(B),
§ 155.220(j)(2)(ii)(C),
§ 155.220(j)(2)(ii)(D), and
§ 155.220(j)(2)(ii)(E), respectively.

Agents, brokers and web-brokers are among those who play a critical role in educating consumers about Exchanges and insurance affordability programs, and in helping consumers complete and submit applications for eligibility determinations, compare plans, and enroll in coverage. Consistent with section 1312(e) of the ACA, § 155.220 establishes the minimum standards for the process by which an agent, broker, or web-broker may help enroll an individual in a QHP in a manner that constitutes enrollment through the Exchange and to assist individuals in applying for PTC and CSRs. This process and minimum standards require the applicant's completion of an eligibility verification and enrollment application and the agent's, broker's, or web-broker's submission of the eligibility application information through the Exchange website or an Exchange-approved web service.[146] While agents, brokers, and web-brokers can assist a consumer with completing the Exchange application, the consumer is the individual with the knowledge to confirm the accuracy of the information provided on the application.[147]

Section 155.220(j)(2) sets forth the standards of conduct for agents, brokers, or 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. 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. Under § 155.220(j)(2)(ii), agents, brokers, or web-brokers must provide the FFEs and SBE–FPs with ''correct information under section 1411(b) of the Affordable Care Act.''

Section 1411(h) of the ACA provides for the imposition of civil penalties if any person fails to provide correct information under section 1411(b) to the Exchange. Consistent with § 155.220(l), agents, brokers and web-brokers that assist with or facilitate enrollment of qualified individuals, qualified employers, or qualified employees in States with SBE–FPs must comply with all applicable FFE standards. This includes, but is not limited to, compliance with the FFE standards of conduct in § 155.220(j).

Currently, § 155.220(j)(2)(ii) requires that agents, brokers, and web-brokers provide the FFEs and SBE–FPs with correct information under section 1411(b) of the ACA, but it does not explicitly require agents, brokers, or web-brokers assisting consumers with completing eligibility applications through the FFEs and SBE–FPs to confirm with those consumers the accuracy of the information entered on their applications prior to application submission or document the consumer has reviewed and confirmed the information to be accurate. HHS has continued to observe applications submitted to the FFEs and SBE–FPs that contain incorrect consumer information. We have also received consumer complaints stating the information provided on their eligibility applications submitted by agents, brokers, or web-brokers on their behalf was incorrect. These complaints can be difficult to investigate and adjudicate, because the only evidence available is often the word of one person against another and the FFEs and SBE–FPs generally do not have access to other contextual information to help resolve the matter. By requiring the creation and maintenance of documentation that the assisting agent, broker, or web-broker confirmed with the consumer or their authorized representative that the entered information was reviewed and accurate, the adjudication of such complaints could be expedited and more easily resolved. In addition, the inclusion of incorrect consumer information on eligibility applications may result in consumers receiving inaccurate eligibility determinations, and may affect consumers' tax liability, or produce other potentially negative results. If a consumer receives an incorrect APTC determination or is unaware they are enrolled in a QHP, that consumer may owe money to the IRS when they file their Federal income tax return. Ensuring a consumer's income determination has been reviewed and is accurate would help avoid these situations. Incorrect consumer information on eligibility applications may also affect Exchange operations or HHS's analysis of Exchange trends. For example, a high volume of applications all containing the 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 focus its time and efforts on addressing these erroneous applications. This proposal is consistent with the fact that the consumer or their authorized representative is the individual with the knowledge to confirm the accuracy of the information provided on the application and would serve as an additional safeguard and procedural step to ensure the accuracy of the application information submitted to Exchanges. Thus, we propose to revise § 155.220(j)(2)(ii) to require agents, brokers, and web-brokers to document that the eligibility application information was reviewed and confirmed to be accurate by the consumer or their authorized representative before application submission.

We also propose to establish in new proposed § 155.220(j)(2)(ii)(A) standards for what constitutes adequate documentation that eligibility application information has been reviewed and confirmed to be accurate by the consumer or their authorized representative. First, we propose to revise § 155.220(j)(2)(ii)(A) to establish that documenting that eligibility application information has been reviewed and confirmed to be accurate by the consumer or their authorized representative would require the consumer or their authorized representative to take an action that produces a record that can be maintained and produced by the agent, broker, or web-broker and produced to confirm the consumer or their authorized representative has reviewed and confirmed the accuracy of the eligibility application information.

We do not propose any specific method for documenting that eligibility application information has been reviewed and confirmed to be accurate by the consumer or their authorized representative. To provide guidance to agents, brokers, and web-brokers, we propose to include in § 155.220(j)(2)(ii)(A) a non-exhaustive list of acceptable methods to document that eligibility application information has been reviewed and confirmed to be accurate, including obtaining the signature of the consumer or their authorized representative (electronically or otherwise), verbal confirmation by the consumer or their authorized representative that is captured in an audio recording, or a written response (electronic or otherwise) from the consumer or their authorized

[146] 45 CFR 155.220(c)(1). Also see, *e.g.,* 77 FR at 18334–18336.

[147] This is evidenced by the language in § 155.220(j)(1) that refers to agents, brokers, or web-brokers that *assist* or *facilitate* enrollment (emphasis added).

representative to a communication sent by the agent, broker, or web-broker. We also invite comment on whether there may be other acceptable methods of documentation that HHS should consider specifying to be permissible for purposes of documenting that eligibility application information has been reviewed and confirmed to be accurate by the consumer or their authorized representative. For example, we are specifically interested in any current best practices or approaches that agents, brokers or web-brokers may use to create records or otherwise document that eligibility application information was reviewed by the consumer or their authorized representative prior to submission to the Exchange.

We also propose that the consumer would be able to review and confirm the accuracy of application information on behalf of other applicants (for example, dependents or other household members), and authorized representatives would be able to provide review and confirm the accuracy of application information on behalf of the people they are designated to represent, as it may be difficult or impossible to obtain confirmation from each consumer whose information is included on an application. This would allow agents, brokers, and web-brokers to continue assisting consumers as they currently do (for example, often by working with an individual representing a household when submitting an application for a family).

Next, we propose to require at new proposed § 155.220(j)(2)(ii)(A)(*1*) that the eligibility application information documentation, which would be created by the assisting agent, broker, or web-broker, must include an explanation of the attestations at the end of the eligibility application that the eligibility application information has been reviewed by and confirmed to be accurate by the consumer or their authorized representative. At the end of the Exchange eligibility application, one of the attestations the consumer must currently agree to before submitting the application is as follows: ''I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know I may be subject to penalties under Federal law if I intentionally provide false information.'' The documentation the agent, broker, or web-broker creates to satisfy this proposed requirement would be required to include this language for awareness and to remind the consumer that they are responsible for the accuracy of the application information, even if the information was entered into the application on their behalf by an agent or broker assisting them. We believe that this proposal would help ensure that the consumer or their authorized representative understands the importance of confirming the accuracy of the information contained in the eligibility application and further safeguard against the provision and submission of incorrect eligibility application information. We also believe that that proposal would help safeguard consumers from the negative consequences of failing to understand the attestations and potentially attesting to conflicting information. For example, one common error we see on applications completed by agents, brokers, or web-brokers is an attestation that a consumer does not have an SSN while also including an attestation that the consumer is a U.S. citizen. These conflicting attestations can generate DMIs, which, if not resolved during the allotted resolution window, could result in the consumer's coverage being terminated. For these reasons, we propose to add a requirement at new § 155.220(j)(2)(ii)(A)(*1*) that the documentation include the date the information was reviewed, the name of the consumer or their authorized representative, an explanation of the attestations at the end of the eligibility application, and the name of the assisting agent, broker, or web-broker.

Lastly, at new proposed § 155.220(j)(2)(ii)(A)(*2*) we propose to require agents, brokers, and web-brokers to maintain the documentation demonstrating that the eligibility application information was reviewed and confirmed as accurate by the consumer or their authorized representative for a minimum of 10 years. Section 155.220(c)(5) states HHS or our designee may periodically monitor and audit an agent, broker, or web-broker to assess their compliance with applicable requirements. However, there is not currently a maintenance of records requirement directly applicable to all agents, brokers, and web-brokers assisting consumers through the FFEs and SBE–FPs.[148] Capturing a broad-based requirement mandating that all agents, brokers, and web-brokers assisting consumers in the FFEs and SBE–FPs maintain the records and documentation demonstrating that information captured in their application has been reviewed and confirmed to be accurate by the consumer or their authorized representative they are assisting would provide a clear, uniform standard. It also would ensure this documentation is maintained for sufficient time to allow for monitoring, audit, and enforcement activities to take place.[149] Therefore, consistent with other Exchange maintenance of records requirements,[150] we propose to capture in new proposed § 155.220(j)(2)(iii)(A)(*2*) that agents, brokers, and web-brokers must maintain the documentation described in proposed § 155.220(j)(2)(ii)(A) for a minimum of 10 years, and produce the documentation upon request in response to monitoring, audit, and enforcement activities conducted consistent with § 155.220(c)(5), (g), (h), and (k).

We seek comment on these proposals.

c. Documenting Receipt of Consumer Consent (§ 155.220(j))

We propose to amend § 155.220(j)(2)(iii) to require agents, brokers, or web-brokers assisting with and facilitating enrollment through FFEs and SBE–FPs or assisting an individual with applying for APTC and CSRs for QHPs to document the receipt of consent from the consumer, or the consumer's authorized representative designated in compliance with § 155.227, qualified employers, or qualified employees they are assisting. We propose that documentation of receipt of consent would be created by the assisting agent, broker, or web-broker and would require the consumer seeking to receive assistance, or the consumer's authorized representative, to take an action, such as providing a signature or a recorded verbal authorization, that produces a record that can be maintained by the agent, broker, or web-broker and produced to confirm the consumer's or their authorized representative's consent was provided. With regard to the content of

[148] Section 155.220(c)(3)(i)(E) requires web-brokers to maintain audit trails and records in an electronic format for a minimum of 10 years and cooperate with any audit under this section. Section 156.340(a)(2) places responsibility on QHP issuers participating in Exchanges using the Federal platform to ensure their downstream and delegated entities (including agents and brokers) are complying with certain requirements, including the maintenance of records requirements in § 156.705. In addition, under § 156.340(b), agents and brokers that are downstream entities of QHP issuers in the FFEs must be bound by their agreements with the QHP issuer to comply with certain requirements, including the records maintenance standards in § 156.705. Section 156.705(c) and (d) requires QHP issuers in the FFEs to maintain certain records for 10 years and to make all such records available to HHS, the OIG, the Comptroller General, or their designees, upon request.

[149] While investigations consumer complaints are an example of a more immediate, real-time monitoring and oversight activity, market conduct examinations, audits, and other types of investigations (*e.g.,* compliance reviews) may occur several years after the applicable coverage year.

[150] See, for example, 45 CFR 155.220(c)(3)(i)(E) and 156.705(c).

the documentation of consent, in addition to the date consent was given, name of the consumer or their authorized representative, and the name of the agent, broker, web-broker, or agency being granted consent, we propose the documentation would be required to include a description of the scope, purpose, and duration of the consent provided by the consumer, or their authorized representative, as well as the process by which the consumer or their authorized representative may rescind such consent. Lastly, we propose that documentation of the consumer's or their authorized representative's, consent be maintained by the agent, broker, or web-broker for a minimum of 10 years and produced upon request in response to monitoring, audit, and enforcement activities conducted consistent with § 155.220(c)(5), (g), (h) and (k).

Currently, § 155.220(j)(2)(iii) requires agents, brokers, or web-brokers assisting with or facilitating enrollment through the FFEs or SBE–FPs or assisting an individual in applying for APTC and CSRs for QHPs to obtain the consent of the individual, employer, or employee prior to providing such assistance. However, § 155.220(j)(2)(iii) does not currently require agents, brokers, or web-brokers to document the receipt of consent. We have observed several cases in which there have been disputes between agents, brokers, or web-brokers and the individuals they are assisting, or between two or more agents, brokers, or web-brokers, about who has been authorized to act on behalf of a consumer or whether anyone has been authorized to do so. We have also received complaints alleging enrollments by agents, brokers, and web-brokers that occurred without the consumer's consent, and have encountered agents, brokers, and web-brokers who attest they have obtained consent and have acted in good faith, but who do not have reliable records of such consent to defend themselves from allegations of misconduct. Thus, we are proposing this standard because we believe that it would be beneficial to have reliable records of consent to help with the resolution of such disputes or complaints and to minimize the risk of fraudulent activities such as unauthorized enrollments. For these reasons, we propose to revise § 155.220(j)(2)(iii) to require agents, brokers, and web-brokers to document the receipt of consent from the consumer seeking to receive assistance or the consumer's authorized representative, employer, or employee prior to assisting with or facilitating enrollment through the FFEs and SBE–FPs, making updates to an existing application or enrollment, or assisting the consumer in applying for APTC and CSRs for QHPs.

We also propose to establish in proposed new § 155.220(j)(2)(iii)(A)–(C) standards for what constitutes obtaining and documenting consent to provide agents, brokers, and web-brokers with further clarity regarding this proposed requirement. First, we propose to add new proposed § 155.220(j)(2)(iii)(A) to establish that obtaining and documenting the receipt of consent would require the consumer seeking to receive assistance, or the consumer's authorized representative designated in compliance with § 155.227, to take an action that produces a record that can be maintained by the agent, broker, or web-broker and produced to confirm the consumer's or their authorized representative's consent has been provided.

We do not intend to prescribe the method to document receipt of individual consent, so long as whatever method is chosen requires the consumer or their authorized representative to take an action and results in a record that can be maintained and produced by the agent, broker, or web-broker. Therefore, we propose to include in new proposed § 155.220(j)(2)(iii)(A) a non-exhaustive list of acceptable means to document receipt of consent, including obtaining the signature of the consumer or their authorized representative (electronically or otherwise), verbal confirmation by the consumer or their authorized representative that is captured in an audio recording, a response from the consumer or their authorized representative to an electronic or other communication sent by the agent, broker, or web-broker, or other similar means or methods that HHS specifies in guidance. Other methods of documenting individual consent may be acceptable, such as requiring individuals to create user accounts on an agent's or agency's website where they designate or indicate the agents, brokers, or web-brokers to whom they have provided consent. Under this proposal, agents, brokers, and web-brokers would also be permitted to continue to utilize State Department of Insurance forms, such as agent or broker of record forms, provided these forms cover the minimum requirements set forth in this proposed rule. If agents, brokers, and web-brokers have already adopted consent documentation processes consistent with this proposed framework, no changes would be required if this proposed standard is finalized. We intend to allow for documentation methods well-suited to the full range of ways agents, brokers, and web-brokers interact with consumers they are assisting (for example: in-person, via phone, electronic communications, use of an agent's or agency's website, etc.). We also intend for the primary applicant to be able to provide consent on behalf of other applicants (for example, dependents or other household members), and authorized representatives to be able to provide consent on behalf of the people they are designated represent (for example, incapacitated persons), as it may be difficult or impossible to obtain consent from each individual whose information is included on an application. This would allow agents, brokers, and web-brokers to continue assisting individuals as they currently do (for example, often by working with an individual representing a household when submitting an application for a family).

Second, we propose to require at new proposed § 155.220(j)(2)(iii)(B) that the consent documentation must include the date consent was given, name of the consumer or their authorized representative, name of the agent, broker, web-broker, or agency being granted consent, a description of the scope, purpose, and duration of the consent obtained by the individual, as well as a process through which the consumer or their authorized representative may rescind consent. Agents, brokers, and web-brokers may work with individuals in numerous capacities. For example, they may assist individuals with applying for financial assistance and enrolling in QHPs through the FFEs and SBE–FPs, as well as shopping for other non-Exchange products. Similarly, agents, brokers, and web-brokers may have different business models such that individuals may interact with specific individuals consistently or numerous individuals representing a business entity that may vary upon each contact (for example, call center representatives), and the methods of interaction may vary as well (for example: in-person, phone calls, use of an agent's or agency's website etc.). In addition, individuals may wish to change the agents, brokers, or web-brokers they work with and provide consent to over time. For these reasons, the scope, purpose, and duration of the consent agents, brokers, and web-brokers seek to obtain from individuals can vary widely. Therefore, this proposal is intended to ensure individuals are making an informed decision when providing their consent

to the agents, brokers, or web-brokers assisting them, that individuals can make changes to their provision of consent over time, and that the documentation of consent at a minimum captures who is providing and receiving consent, for what purpose(s) the consent is being provided, when consent was provided, the intended duration of the consent, and how specifically consent may be rescinded. We expect that the information in the consent documentation would align with the information in the corresponding individuals' applications (for example: names, phone numbers, or email addresses should align as applicable depending on whether the consent is obtained via email, text message, call recording, or otherwise), except for in instances in which consent is being provided by an authorized representative.

Lastly, at new proposed § 155.220(j)(2)(iii)(C), we propose to require agents, brokers, and web-brokers to maintain the documentation described in proposed § 155.220(j)(2)(iii)(A) for a minimum of 10 years. Section 155.220(c)(5) states HHS or our designee may periodically monitor and audit an agent, broker, or web-broker to assess their compliance with applicable requirements. However, there is not currently a maintenance of records requirement directly applicable to all agents, brokers, and web-brokers assisting consumers through the FFEs and SBE–FPs.[151] Capturing a broad-based requirement mandating that all agents, brokers, and web-brokers assisting consumers in the FFEs and SBE–FPs to maintain the records and documentation demonstrating receipt of consent from consumers or their authorized representative would provide a clear, uniform standard. It would also ensure these records and documentation are maintained for sufficient time to allow for monitoring, audit, and enforcement activities to take place.[152] Therefore, consistent with other Exchange maintenance of records requirements,[153] we propose to capture in new proposed § 155.220(j)(2)(iii)(C) that agents, brokers, and web-brokers must maintain the documentation described in proposed § 155.220(j)(2)(iii)(A) for a minimum of 10 years, and produce the documentation upon request in response to monitoring, audit and enforcement activities conducted consistent with § 155.220(c)(5), (g), (h) and (k).

We seek comment on these proposals, including whether there are other means or methods of documentation that HHS should consider specifying are permissible for purposes of documenting the receipt of consent from consumer or their, qualified employers, or qualified employees.

4. Eligibility Standards (§ 155.305)

a. Failure to File and Reconcile Process (§ 155.305(f)(4))

We are proposing to amend § 155.305(f)(4) which currently prohibits an Exchange from determining a taxpayer eligible for APTC if HHS notifies the Exchange that a taxpayer (or a taxpayer's spouse, if married) has failed to file a Federal income tax return and reconcile their past APTC for a year for which tax data would be utilized for verification of household income and family size in accordance with § 155.320(c)(1)(i).

As background, Exchange enrollees whose taxpayer fails to comply with current paragraph § 155.305(f)(4) are referred to as having failed to ''file and reconcile''. Since 2015, HHS has taken regulatory and operational steps to help increase taxpayer compliance with filing and reconciliation requirements under the Code as described at 26 CFR 1.36B–4(a)(1)(i) and (a)(1)(ii)(A) by tying eligibility for future APTC to the taxpayer's reconciliation of past APTC paid. However, since the finalization of the requirement at § 155.305(f)(4), HHS has determined that the costs of the current policy outweigh the benefits for a number of reasons. For one, Exchanges have faced a longstanding operational challenge, specifically that Exchanges sometimes have to determine an enrollee ineligible for APTC without having up-to-date information on the tax filing status of households while Federal income tax returns are still being processed by the IRS. Currently, Exchanges determine an enrollee ineligible for APTC if the IRS, through data passed from the IRS to HHS, via the Federal Data Services Hub (the Hub), tells an Exchange that the taxpayer did not comply with the requirement to file a Federal income tax return and reconcile APTC for one specific tax year. To address the challenge of receiving up-to-date information, and to promote continuity of coverage in an Exchange QHP, we are proposing a new process for Exchanges to conduct FTR while also ensuring that Exchanges preserve program integrity by paying APTC only to consumers who are eligible to receive it. HHS believes that any FTR process should encourage compliance with the filing and reconciling requirement under the Code, minimize the potential for APTC recipients to incur large tax liabilities over time, and support eligible enrollees' continuous enrollment in Exchange coverage with APTC by avoiding situations where enrollees become uninsured when their APTC is terminated.

For Exchanges using the Federal eligibility and enrollment platform, which includes the FFEs and SBE–FPs, taxpayers who have not met the requirement of § 155.305(f)(4) are put into the FTR process with the Exchange. As part of the normal process used by Exchanges using the Federal eligibility and enrollment platform during Open Enrollment, enrollees for whom IRS data indicates an FTR status for their taxpayer receive notices from the Exchange alerting them that IRS data shows that their taxpayer has not filed a Federal income tax return for the applicable tax year and reconciled APTC for that year using IRS Form 8962. FTR Open Enrollment notices sent directly to the taxpayer clearly state that IRS data indicates the taxpayer failed to file and reconcile, whereas FTR Open Enrollment notices sent to the applicant's household contact, who may or may not be the taxpayer, list a few different reasons consumers may be at risk of losing APTC, including the possibility that IRS data indicates the taxpayer failed to file and reconcile. Notices to the applicant's household contact can be confusing because of the multiple reasons listed. Both of these Open Enrollment notices encourage taxpayers identified as having an FTR status to file their Federal income tax return and reconcile their APTC for that year using IRS Form 8962, or risk losing APTC eligibility for the next coverage year.

In late 2015, to allow consumers with an FTR status to be determined eligible for APTC temporarily (if otherwise eligible), HHS added a question to the single, streamlined application used by the Exchanges using the Federal eligibility and enrollment platform that allows enrollees to attest on their

[151] Section 155.220(c)(3)(i)(E) requires web-brokers to maintain audit trails and records in an electronic format for a minimum of 10 years and cooperate with any audit under this section. Section 156.340(a)(2) places responsibility on QHP issuers participating in Exchanges using the Federal platform to ensure their downstream and delegated entities (including agents and brokers) are complying with certain requirements, including the maintenance of records requirements in § 156.705. Section 156.705(c) requires QHP issuers in the FFEs to maintain certain records for 10 years.

[152] While investigations consumer complaints are an example of a more immediate, real-time monitoring and oversight activity, market conduct examinations, audits, and other types of investigations (*e.g.,* compliance reviews) may occur several years after the applicable coverage year.

[153] See, for example, 45 CFR 155.220(c)(3)(i)(E) and 156.705(c).

application, under the penalty of perjury, that they have filed and reconciled their APTC by checking a box that says, ''Yes, I reconciled premium tax credits for past years.'' [154] Enrollees who check this attestation and enroll in coverage during Open Enrollment retain their APTC, even if IRS data has not been updated to reflect their most current Federal income tax filing status or if the individual has not actually reconciled their APTC. Allowing enrollees to attest to filing and reconciling even though IRS data indicates that they did not, is a critical step to safeguard enrollees from losing APTC erroneously as the IRS typically takes several weeks to process Federal income tax returns, with additional time required for returns or amendments that are filed using a paper process.

After Open Enrollment, Exchanges using the Federal platform then conduct a second look at FTR data to follow up and verify an enrollee(s)' reconciliation attestation by conducting a verification of their taxpayer's FTR status early in the next coverage year, which includes additional notices to enrollees and taxpayers. This verification process early in the next coverage year is referred to as FTR Recheck. State Exchanges that operate their own eligibility and enrollment platform have each implemented similar processes to check the FTR status of their enrollees annually based on data provided by the IRS, to identify and notify enrollees who are at risk of losing APTC eligibility, and to allow enrollees to attest under the penalty of perjury that they have filed and reconciled their APTC.

There are many reasons we are proposing the changes to § 155.305(f)(4) described herein. First, HHS' and State Exchanges' experiences with running FTR operations have shown that Exchange enrollees often do not understand the requirement that their taxpayer must file a Federal income tax return and reconcile their APTC or that they must also submit IRS Form 8962 to properly reconcile their APTC, even though the single, streamlined application used by Exchanges on the Federal platform and QHP enrollment process require a consumer to attest to understanding the requirement to file and reconcile in two places. For example, HHS is aware anecdotally that many third-party tax preparers, such as accountants, are not aware of the requirement to file and reconcile, nor prompt consumers to also include IRS Form 8962 along with their Federal income tax return. Although enrollees who rely on third party tax preparers such as accountants or third-party tax preparation software to prepare their Federal income tax returns are still required to file and reconcile even if their tax preparer was unaware of the requirement, consumers should have the opportunity to receive additional guidance from Exchanges on the requirement to file and reconcile to promote compliance and prevent termination of APTC.

While annual FTR notices help with this issue as the notices alert consumers that they did not provide adequate documentation to fulfill the requirement to file and reconcile, the current process that requires Exchanges to determine an enrollee ineligible for APTC after 1 year of having an FTR status is overly punitive. Some consumers may have their APTC ended due to delayed data, in which case their only remedy is to appeal to get their APTC reinstated. Consumers also may be confused or may have received inadequate education on the requirement to file and reconcile, in which case they must actually file, reconcile, and appeal to get their APTC reinstated. By requiring Exchanges to determine an enrollee ineligible for APTC only after having an FTR status for two consecutive tax years (specifically, years for which tax data would be utilized for verification of household income and family size), Exchanges would have more opportunity to conduct outreach to consumers whom data indicate have failed to file and reconcile to prevent erroneous terminations of APTC and to provide access to APTC for an additional year even when APTC would have been correctly terminated under the original FTR process. Under the proposed change, Exchanges on the Federal platform would continue to send notices to consumers for the year in which they have failed to reconcile APTC as an initial warning to inform and educate consumers that they 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. This change would also alleviate burden on HHS hearing officers by reducing the number of appeals related to denial of APTC due to FTR, and prevent consumers who did reconcile, but for whom IRS data was not updated quickly enough, from having to go through an appeal process to have their APTC rightfully reinstated.

HHS believes in ensuring consumers have access to affordable coverage and places high value on consumers maintaining continuity of coverage in the Exchange as HHS has found that FFE and SBE–FP enrollees who lose APTC tend to end their Exchange coverage and will experience coverage gaps, as they cannot afford unsubsidized coverage. In light of this, HHS believes it is imperative that any change to the current FTR operations be done carefully and that HHS thoughtfully balance how it enforces the requirement to file and reconcile, since a consequence of losing APTC effectively means many consumers may lose access to needed medical care.

Therefore, given these challenges that both Exchanges and consumers have faced with the requirement to file and reconcile, we are proposing to revise § 155.305(f)(4) under which Exchanges would not be required, or permitted, to determine consumers ineligible for APTC due to having an FTR status for only 1 year. Given that HHS's experience running FTR shows continued issues with compliance with the requirement to file and reconcile, we propose that beginning on January 1, 2024, Exchanges must find an applicant ineligible for APTC only if the applicant has an FTR delinquent status for two consecutive years (specifically, two consecutive years for which tax data would be utilized for verification of household income and family size).

Previously, CMS announced that Exchanges on the Federal platform would not act on data from the IRS for enrollees who have failed to file Federal income tax returns and reconcile a previous year's APTC with the PTC allowed for the year. The guidance also announced flexibility for State Exchanges that operate their own eligibility and enrollment platforms to take similar action.[155] Due to the ongoing COVID–19 PHE in 2020, for plan year 2021, CMS temporarily paused ending APTC for enrollees with an FTR status due to IRS processing delays of 2019 Federal income tax returns.[156] CMS then extended this pause for the 2023 plan year in July 2022.[157] As a result of these changes, 55 percent of enrollees who were automatically re-enrolled during 2021 open enrollment with an FTR status

[154] We note that this question was removed from the single streamlined application once the FTR process was paused in 2020 for the 2021 PY.

[155] See CMS. (2022, July 18). *Failure to File and Reconcile (FTR) Operations Flexibilities for Plan Year 2023. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/FTR-flexibilities-2023.pdf.*

[156] See CMS. (2021, July 23). *Failure to File and Reconcile (FTR) Operations Flexibilities for Plan Years 2021 and 2022—Frequently Asked Questions (FAQ). https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/FTR-flexibilities-2021-and-2022.pdf.*

[157] See CMS. (2022, July 18). *Failure to File and Reconcile (FTR) Operations Flexibilities for Plan Year 2023. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/FTR-flexibilities-2023.pdf.*

remained enrolled in Exchange coverage as of March 2021. In contrast, only 12 percent of those enrollees with an FTR status who were automatically re-enrolled without APTC during the 2020 open enrollment were still enrolled in coverage as of March 2020. These results show the significant impact that loss of APTC due to FTR status has on whether enrollees continue to remain in coverage offered through the Exchange as these impacted enrollees must pay the full cost of their Exchange plan, which is often unaffordable without APTC.

CMS proposes to continue to pause FTR until the point in time that HHS and the IRS will be able to implement the new FTR policy, if finalized. That is to say, until the IRS can update its systems to implement the new FTR policy, and HHS can notify the Exchange of an enrollee's consecutive 2-year FTR status, the Exchange will not determine enrollees ineligible for APTC based on either the one-year or 2-year FTR status. We believe that removing APTC after 2 consecutive years of an FTR status instead of one will help consumers avoid gaps in coverage by increasing retention in the Exchange even if they have failed to reconcile for 1 year, and will reduce the punitive nature of the current process which may erroneously terminate APTC for consumers who have filed and reconciled. We also believe that these proposed changes would help protect consumers from accruing large tax liabilities over multiple years by notifying and ending APTC for consumers with an FTR status for two consecutive years. Finally, we believe these proposed changes would allow Exchanges to maintain program integrity by denying APTC to consumers who have, over the course of two years, been given ample notification of their obligation to file and reconcile and have nevertheless failed to do so.

We seek comment on this proposal, especially from States or other interested parties regarding tax burdens on consumers which would inform our decision on this proposal.

5. Verification Process Related to Eligibility for Insurance Affordability Programs (§§ 155.315 and 155.320)

a. Income Inconsistencies

We propose to amend § 155.320 to require Exchanges to accept an applicant's or enrollee's attestation of projected annual household income when the Exchange requests tax return data from the IRS to verify attested projected annual household income, but the IRS confirms there is no such tax return data available. We further propose to amend § 155.315(f) to add that income inconsistencies must receive an automatic 60-day extension in addition to the 90 days provided by § 155.315(f)(2)(ii).

Section 155.320 sets forth the verification process for household income. The Exchange requires that an applicant or enrollee applying for financial assistance must attest to their projected annual household income. *See* § 155.320(a)(1) and (c)(3)(ii)(b). The regulation also requires that for any individual in the applicant's or enrollee's tax household (and for whom the Exchange has a SSN), the Exchange must request tax return data regarding income and family size from the IRS.[158] *See* § 155.320(c)(i)(A). When the Exchange requests tax return data from the IRS and the data indicates that attested projected annual household income represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the Exchange must determine eligibility for APTC and CSR based on the IRS tax data. *See* § 155.320(c)(3)(ii)(C).

When the Exchange requests tax return data from the IRS and the IRS returns data that reflects that the attested projected annual household income *is not* an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the applicant or enrollee is considered to have experienced a change in circumstances, which allows HHS to establish procedures for determining eligibility for APTC on information other than IRS tax return data, as described in § 155.320(c)(3)(iii)–(vi). *See* ACA § 1412(b)(2).

The Exchange also considers an applicant or enrollee to have experienced a change in circumstances when the Exchange requests tax return data from the IRS to verify attested projected household income, but the IRS confirms such data is unavailable. This is because tax data is usually unavailable when an applicant or enrollee has experienced a change in family size, other household circumstances (such as a birth or death), filing status changes (such as a marriage or divorce), or the applicant or enrollee was not required to file a tax return for the year involved. *See* § ACA 1412(b)(2). When an applicant or enrollee has experienced a change in circumstances as described in ACA § 1412(b)(2), the Exchange determines eligibility for APTC and CSR using alternate procedures designed to minimize burden and protect program integrity, described in § 155.320(c)(3)(iii)–(vi).

If an applicant or enrollee qualifies for an alternate verification process as described above, and the attested projected annual household income is greater than the income amount returned by the IRS, the Exchange accepts the applicant's attestation without further verification under § 155.320(c)(iii)(A). If an applicant qualifies for an alternate verification process, and the attested projected annual household income is more than a reasonable threshold less than the income amount returned by the IRS, or there is no IRS data available, the Exchange generates an income inconsistency (also referred to as a data matching issue or DMI) and proceeds with the process described in § 155.315(f)(1) through (4), unless a different electronic data source returns an amount within a reasonable threshold of the projected annual household income. *See* § 155.320(c)(3)(iv) and (c)(3)(vi)(D). This process usually requires the applicant or enrollee to present satisfactory documentary evidence of projected annual household income. If the applicant fails to provide documentation verifying their projected annual household income attestation, the Exchange determines the consumer's eligibility for APTC and CSRs based on available IRS data, as required in § 155.320(c)(3)(vi)(F). However, if there is no IRS data available, the Exchange must determine the applicant ineligible for APTC and CSRs as required in § 155.320(c)(3)(vi)(G). We propose to make clarifying revisions to the current regulations to ensure consistency between the regulations and the current operations of the Exchanges on the Federal platform, as described here.

We propose to add § 155.320(c)(5) which would require Exchanges to accept an applicant's or enrollee's attestation of projected annual household income when the Exchange requests IRS tax return data but IRS confirms such data is not available. The current process is overly punitive to consumers and burdensome to Exchanges; reasons for IRS not returning consumer data can extend beyond the consumer not filing tax returns, and can be attributed to tax household composition changes (such as birth, marriage, and divorce), name changes, or other demographic updates or mismatches—all of which are legitimate changes that currently prevent a consumer from avoiding an income

[158] The Exchange must also request data regarding Social Security Benefits from the Social Security Administration.

DMI. Additionally, the consequence of receiving an income DMI and being unable to provide sufficient documentation to verify projected household income outweighs the intended programmatic benefits: under § 155.320(c)(3)(vi)(G) consumers are determined completely ineligible for APTC and CSRs. With respect to burden on Exchanges, DMI verification by the Exchange requires an outlay of administrative hours to monitor and facilitate the resolution of income inconsistencies. Within the Federal Platform, this administrative task accounts for approximately 300,000 hours of labor annually, which we believe is proportionally mirrored by State Exchanges.

Accordingly, we propose to accept an applicant's or enrollee's attestation of projected annual household income when IRS tax return data is requested but is not available, and to determine the applicant or enrollee eligible for APTC or CSRs in accordance with the applicant's or enrollee's attested projected household income, to more fairly determine eligibility for consumers and to reduce unnecessary burden on Exchanges. This proposal is consistent with § 1412(b)(2) of the ACA, which allows the Exchange to utilize alternate verification procedures when a consumer has experienced substantial changes in income, family size or other household circumstances, or filing status, or when an applicant or enrollee was not required to file a tax return for the applicable year.[159] It is also consistent with the flexibility under ACA § 1411(c)(4)(B) to modify methods for verification of the information where we determine such modifications would reduce the administrative costs and burdens on the applicant.

We clarify that the Exchange would continue to generate income DMIs when IRS tax data is available and the attested projected household income amount is more than a reasonable threshold below the income amount returned by the IRS, and other sources cannot provide income data within the reasonable threshold. Additionally, the Exchange would continue to generate income DMIs when IRS tax data cannot be requested, because an applicant or enrollee did not provide sufficient information (namely, a social security number), and other sources cannot provide income data within the reasonable threshold of the attested projected household income. Under § 1411(c)(3) of the ACA, only data from the IRS is required to be used to determine if income is inconsistent. Currently, there are no reliable and accurate income data sources legally available to the Exchange that would provide quality data for the purpose of generating income DMIs. Income data from other electronic data sources may continue to be used by Exchanges to verify income when the attested projected household income amount is more than a reasonable threshold below the income amount returned by the IRS or IRS data cannot be requested.

Lastly, we propose to revise § 155.315(f) to add new paragraph (f)(7) to require that applicants must receive an automatic 60-day extension in addition to the 90 days currently provided by § 155.315(f)(2)(ii) to allow applicants sufficient time to provide documentation to verify household income. The extension would be automatically granted when consumers exceed the allotted 90 days without resolving any active household income DMIs. This proposal aligns with current § 155.315(f)(3), which provides extensions to applicants beyond the existing 90 days if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period. It is also consistent with the flexibility under ACA § 1411(c)(4)(B) to modify methods for verification of the information where we determine such modifications would reduce the administrative costs and burdens on the applicant.

We have found that 90 days is often an insufficient amount of time for many applicants to provide this income documentation, since it can require multiple documents from various household members along with an explanation of seasonal employment or self-employment, including multiple jobs. As applicants are asked to provide a projection for their next year's income, they often submit documents that do not fully explain their attestation due to the complexities noted above, which requires contact from the Exchange and additional document submission, which often pushes the verification timeline past 90 days. An additional 60 days would allow consumers more time to gather multiple documents from multiple sources, and also allows time for back and forth review with the Exchange. The majority of households with income DMIs are low income and consumers often have multiple sources of employment that can change frequently. Therefore, collecting and submitting documentation to verify projected household income is extremely complicated and difficult. The proposed extension would provide consumers with necessary time to gather and submit sufficient documentation to verify projected household income. The current authority allowing for the granting of extensions is applied on a case by case basis and requires the consumers to demonstrate difficulty before the 90- day deadline, which does not address the need for additional time more broadly for households with income DMIs.

A review of income DMI data indicates that when consumers receive additional time, they are more likely to successfully provide documentation to verify their projected household income. Between 2018 and 2021, over one third of consumers who resolved their income DMIs on the Exchange did so in more than 90 days. These consumers were provided additional time under § 155.315(f)(3), but the extension under this existing provision places the burden on the consumer to obtain more time to submit documentation. The proposed extension would treat consumers more equitably and would take into consideration the complicated process of obtaining and submitting income documents for these households. We believe the proposed extension would provide more opportunity to work with consumers to submit the correct documentation to verify their projected annual household income. Extensions enabled HHS to determine eligibility for more consumers truly eligible for coverage. HHS continues to study consumer behavior in resolving consistencies to continue to support accurate eligibility determination.

HHS has found that income DMIs have a negative impact on access, health equity, and the risk pool. Per a review of PY 2022 data, the majority of income DMIs disproportionately impacted households with lower attested household income. Among households with an income DMI in PY 2022, more than 60 percent attested to a household income of less than $25,000; compared to households without an income DMI, where only about 40 percent attested to household income less than $25,000. Additionally, households with an attested household income below $25,000 successfully submitted documentation to verify their income 25 percent less often than households with higher household incomes.

Income DMIs also may pose a strain on populations of color. A review of available data indicates that income DMI expirations are higher than expected among Black or African American consumers. Further, the proposed changes would ensure that all consumers are able to continue to have access to more affordable coverage by continuing to receive their APTC, which

[159] 42 U.S.C. 18081

also supports HHS' goal of consumers maintaining continuous coverage.

Income DMIs also negatively impact the risk pool. When households are unable to submit documentation to verify their household income and lose eligibility for APTC, they are much more likely to drop coverage since they must pay the entire monthly premium, which in many cases may be significantly more than the premium minus the APTC. We found that consumers who were unable to submit sufficient documentation to verify their income and lost their eligibility for APTC were half as likely as other consumers to remain covered through the end of the plan year. Consumers aged 25–35 were the age group most likely to lose their APTC eligibility due to an income DMI, resulting in a loss of a population that, on average, has a lower health risk, thereby negatively impacting the risk pool. This finding underscores the importance of consumers being provided ample time to resolve their Income DMIs in order to support HHS' commitment to advancing health equity for consumers participating in the Exchange.

Given the information we have on the negative and disproportionate impacts of income DMIs, we are proposing to adjust the household income verification requirements in order to treat consumers more equitably, help ensure continuous coverage, and strengthen the risk pool. If the proposed changes are finalized, Exchanges would utilize only data from the IRS to determine if income is inconsistent and would accept attestation when tax return data is requested from IRS but not returned. In cases where the IRS returns tax data that reflects that the attested projected annual household income is not an accurate projection of the tax filer's household income, Exchanges would continue existing operations. Additionally, Exchanges would utilize the additional time provided to work with consumers to submit documentation to verify their projected annual household income. While the increased protection for consumers from loss of eligibility for APTC could present a program integrity risk, households are required to provide true answers to application questions under penalty of perjury. Additionally, HHS does not believe that individuals with a mismatch due to situations such as family size change have a greater incentive to misreport income than their counterparts, given that changes in family size and other changes in circumstances are unlikely to be correlated with income misreporting incentives. HHS will continue to engage with partners to evaluate the impact of this proposal on APTC accuracy.

We seek comment on these proposals.

6. Annual Eligibility Redetermination (§ 155.335)

We propose amending § 155.335(j)(1) and (2) to allow Exchanges, beginning for PY 2024, to modify their re-enrollment hierarchies such that enrollees who are eligible for CSRs in accordance with § 155.305(g) and who would otherwise be automatically re-enrolled in a bronze-level QHP without CSRs, to instead be automatically re-enrolled in a silver-level QHP (with income-based CSRs) in the same product with a lower or equivalent premium (after APTC), provided that certain conditions are met.[160] Furthermore, we propose to amend the Exchange re-enrollment hierarchy to allow all Exchanges (Exchanges on the Federal platform and SBEs) to ensure enrollees whose QHPs are no longer available to them and enrollees who would be re-enrolled into a silver-level QHP in order to receive income-based CSRs are re-enrolled into plans with the most similar network to the plan they had in the previous year, provided that certain conditions are met. To honor other criteria the enrollee may have used to make the original selection, we propose to limit re-enrollment of such enrollees into plans offered by the same issuer and of the same product if the enrollee's plan and product remains available through the Exchange for renewal consistent with § 147.106. We propose that Exchanges (including Exchanges on the Federal platform and SBEs) would implement this option beginning with the open enrollment period for plan year 2024 coverage, if operationally feasible, and if not then beginning with the open enrollment period for plan year 2025 coverage.

The re-enrollment hierarchy previously prioritized placing an enrollee in a similar metal level; however, HHS now believes other factors, such as access to income-based CSRs and net premium (that is, premium minus the APTC), should also be taken into account. As discussed later, HHS is considering whether for future years it would be appropriate to modify the re-enrollment process to incorporate both net premium and out-of-pocket costs attributable to cost sharing (referred to in this preamble as total out-of-pocket cost) when both directing re-enrollment to a plan at the same metal level as the enrollee's current QHP and directing re-enrollment to a plan at a higher metal level than the enrollee's current QHP in all Exchanges.[161] [162]

In the 2014 Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges (79 FR 52994, 52998 through 53001), we established the Exchange re-enrollment hierarchy at § 155.335(j) with the goal of ensuring continuous coverage for consumers who opt not to make an active plan selection for the upcoming year. In paragraph (j)(1), we finalized that if an enrollee remains eligible for enrollment in a QHP through the Exchange upon annual redetermination, and the product under which the QHP in which the enrollee was enrolled remains available for renewal, consistent with § 147.106, such enrollee will have his or her enrollment in a QHP through the Exchange under the product renewed unless he or she terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430. We further finalized that the QHP in which the enrollee's coverage will be renewed will be selected according to the following order of priority: (1) in the same plan as the enrollee's current QHP, unless the current QHP is not available through the Exchange; (2) if the enrollee's current QHP is not available, the enrollee's coverage will be renewed in a QHP at the same metal level as the enrollee's current QHP within the same product; (3) if the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP at the same metal level as the enrollee's current QHP, the enrollee's coverage will be renewed in a plan that is one metal level higher or lower than the enrollee's current QHP (with the exception of when the enrollee's current QHP is a silver level

[160] Under § 144.103, a product is defined as a discrete package of health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity) within a service area.

[161] As defined at § 155.20, cost sharing means any expenditure required by or on behalf of an enrollee with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

[162] Total out-of-pocket costs could also include balance billing amounts, but for purposes of this preamble, we use the term total out-of-pocket costs to refer to net premium and out-of-pocket costs attributable to amounts such as coinsurance, copayments, and deductibles.

plan); or (4) if the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP that is at the same metal level as, or one metal level higher or lower, than the enrollee's current QHP, the enrollee's coverage will be renewed in any other QHP offered under the product in which the enrollee's current QHP is offered in which the enrollee is eligible to enroll.[163]

Under paragraph (j)(2), we finalized standards to address re-enrollment in situations in which no plans under the product under which an enrollee's QHP is offered are available through the Exchange for renewal. In this situation, the enrollee may be enrolled in a QHP under a different product offered by the same issuer, to the extent permitted by applicable State law, unless the enrollee terminates coverage including termination of coverage in connection with voluntarily selecting a different QHP. In such cases, the re-enrollment will occur according to the following order of priority: (1) in a QHP through the Exchange at the same metal level as the enrollee's current QHP in the product offered by the same issuer that is the most similar to the enrollee's current product; (2) if the issuer does not offer another QHP through the Exchange at the same metal level as the enrollee's current QHP, the enrollee will be re-enrolled in a QHP through the Exchange that is one metal level higher or lower than the enrollee's current QHP in the product offered by the same issuer through the Exchange that is the most similar to the enrollee's current product; or (3) if the issuer does not offer another QHP through the Exchange at the same metal level as, or one metal level higher or lower than the enrollee's current QHP, the enrollee will be re-enrolled in any other QHP offered through the Exchange by the same issuer in which the enrollee is eligible to enroll.

In the 2017 Payment Notice (81 FR 12203), we finalized the rule to provide for automatic re-enrollment in a QHP offered by another issuer through the Exchange in order to maintain coverage with APTC and income-based CSRs for the majority of Exchange enrollees who are receiving these subsidies, as opposed to permitting a QHP issuer that no longer has a QHP available to an enrollee through an Exchange to re-enroll the enrollee outside the Exchange. Specifically, we established that, beginning in PY 2017, if no QHP from the same issuer is available to enrollees through the Exchange, the Exchange could direct alternate enrollments for such enrollees to the extent permitted by applicable State law into a QHP from a different issuer. In such cases, the re-enrollment will occur as directed by the applicable State regulatory authority, or, if the applicable State regulatory authority declines to direct this activity, such alternate enrollments would be directed by the Exchange. This rule provides considerable flexibility to Exchanges to specify the logic that will be used to assign enrollees in this situation to specific plans.

In the 2023 Payment Notice (87 FR 27208, 27273), HHS announced it would consider proposing amendments to the Exchange re-enrollment hierarchy in future rulemaking and would take into account comments received. In the preamble to the 2023 Payment Notice proposed rule (87 FR 584, 652), we solicited comments on incorporating the net premium, maximum out-of-pocket amount (MOOP), deductible, and total out-of-pocket cost of a plan into the Exchange re-enrollment hierarchy.[164] We also solicited comments on additional criteria or mechanisms HHS could consider to ensure that the Exchange hierarchy for re-enrollment aligns with plan generosity and consumer needs (87 FR at 652). Additionally, we sought comment on the following examples: (1) re-enrolling a current bronze QHP enrollee into an available silver QHP with a lower net premium and higher plan generosity (that is, a higher metal level) offered by the same QHP issuer; and (2) re-enrolling a current silver QHP enrollee into another available silver QHP, under the enrollee's current product and with a service area that is serving the enrollee that is issued by the same QHP issuer, which has lower total out-of-pocket cost (87 FR at 652). As described in further detail later, we propose to codify example (1) described above by amending § 155.335(j)(1) and (2) to allow Exchanges, beginning for PY 2024, to modify their re-enrollment hierarchies such that enrollees who are eligible for CSRs in accordance with § 155.305(g) and who would otherwise be automatically re-enrolled in a bronze-level QHP without CSRs, would instead be automatically re-enrolled in a silver-level QHP (with income-based CSRs) in the same product with a lower or equivalent premium after APTC. We believe initially limiting the scope to only income-based CSR-eligible enrollees who are currently in a bronze QHP and have a lower cost silver CSR QHP available would allow issuers and Exchanges to incrementally update their processes, as opposed to incorporating net premium and out-of-pocket cost (OOPC) throughout the hierarchy for PY 2024.

We received substantial comments from diverse interested parties and have carefully considered these comments. Several commenters encouraged HHS to take net premium or total out-of-pocket cost into account for the re-enrollment hierarchy. Many commenters supported amending § 155.335(j)(1)(i) to allow the enrollee to be re-enrolled into a different plan with a lower net premium and higher generosity if there is no change in the issuer, product, service area, and provider network. Some commenters raised concerns with § 155.335(j)(1)(ii) through (iv) and (j)(2)(iii), which outline the re-enrollment rules when an enrollee's current QHP is no longer available, since they allow consumers to be re-enrolled in a plan with far higher costs if the issuer and provider networks types are prioritized. Commenters explained that the current policy does not provide flexibility for enrollees to be re-enrolled into a different plan even if a change in market conditions has significantly raised the old plan's cost to the enrollees. Further, commenters stated that the majority of enrollees who do not shop at all during the Open Enrollment Period (OEP) care more about cost than the issuer or provider network. More specifically, commenters cited research on plans sold through Covered California that showed, on average, families in California were charged an extra $466 a year in annual premiums as a result of remaining with a plan that no longer served their interests. Commenters stated that including total out-of-pocket cost and plan generosity into re-enrollment rules would be particularly beneficial for situations when enrollees are eligible for

[163] Under § 155.335(j)(1)(iii)(A), if the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP at the same metal level as the enrollee's current QHP and the enrollee's current QHP is a silver level plan, the enrollee will be re-enrolled in a silver level QHP under a different product offered by the same QHP issuer that is most similar to the enrollee's current product. If no such silver level QHP is available for enrollment through the Exchange, the enrollee's coverage will be renewed in a QHP that is one metal level higher or lower than the enrollee's current QHP under the same product.

[164] MOOP refers to the limit on cost sharing an enrollee has to pay for covered services in a plan year. After the enrollee spends this amount on cost sharing for in-network essential health benefits, the health plan pays 100 percent of the costs of covered essential health benefits. For purposes of this section of preamble, the term total out-of-pocket costs refers to net premium and out-of-pocket costs attributable to cost sharing and excludes any costs attributable to balance billing.

cost-sharing reductions and are not enrolled in a silver plan.

Commenters also recommended that provider network considerations be incorporated into any revised re-enrollment hierarchy. Specifically, commenters explained that a revised hierarchy that does not incorporate provider networks could result in enrollees losing access to their providers, increased out-of-network costs, and/or being placed in narrower network plan. Some commenters urged the Exchange to provide accessible notices and reasonable opportunities for the consumer to return to their former plan or drop coverage. Commenters also mentioned the importance of enhancing the consumer shopping experience and decision support tools to improve consumer understanding, particularly around cost sharing. In the 2023 Payment Notice, HHS did not finalize any changes to § 155.335(j).

HHS is aware of interested parties' concerns that enrollees in the Exchanges on the Federal platform may fail to return to the Exchange to make an active plan selection in situations in which changing plans could be beneficial to the enrollee, and that re-enrollment rules may default enrollees into less beneficial plans than other available plans. Currently, the Federal hierarchy for re-enrollment ensures an enrollee's coverage will be renewed in the same plan as the enrollee's current QHP, unless the current QHP is not available through the Exchange. If the enrollee's current QHP is no longer available through the Exchange, the Federal hierarchy prioritizes the same metal level and product network type in order to determine the most similar plans within the same service area. However, if that is not an option, an enrollee will be re-enrolled in a QHP that is one metal level lower or higher within the same service area (with the exception of silver plans). In the 2022 OEP, 28 percent of returning Exchange enrollees using the *HealthCare.gov* platform were auto re-enrolled.[165]

The current hierarchy assumes that the same metal level would be least disruptive to enrollees in terms of premium and coverage. However, in some instances it may be to the enrollee's advantage to move to a different metal level. For example, for PY 2022, approximately 110,000 consumers who were automatically re-enrolled also had available to them a plan at one metal level higher than their current plan in the same product from the same issuer with the same network that had a lower net premium [166] More specifically, approximately 38,000 consumers who were automatically re-enrolled into bronze plans also had available a silver-level plan in the same product from the same issuer with the same network that had lower total costs. Furthermore, the Federal hierarchy does not consider the availability of lower premium plans at the same metal level under the same product as the enrollee's current QHP. Directing re-enrollment into lower or same cost, higher metal level plans would place enrollees in more affordable plans with lower out-of-pocket costs, which would lower health insurance costs for those lower-income (CSR-eligible) individuals. Currently, a large majority of Hispanic, Black, and Asian enrollees using the *HealthCare.gov* platform are in the 94 or 87 percent CSR-eligible populations (68, 66, and 62 percent, respectively).[167] As such, re-enrolling enrollees who would otherwise be automatically re-enrolled in a bronze-level QHP without CSRs, into a silver-level QHP (with income-based CSRs) may also improve coverage and affordability for racial and ethnic minorities. Interested parties have emphasized the critical importance of automatic re-enrollment policies for immigrants and racial and ethnic minorities who may face greater challenges in understanding and accessing the active re-enrollment process, and who are disproportionately impacted by cost increases due often to lower wealth and discretionary income. While the vast majority of re-enrollees through *HealthCare.gov* actively select a plan for the upcoming year during the open enrollment period, some remain in their auto re-enrollment plan.

We are aware that some number of enrollees who are automatically re-enrolled are eligible for income-based CSRs (or become eligible for these CSRs through the annual redetermination process under this section), but remain enrolled in a bronze-level QHP, under which they cannot receive income-based CSRs. Further, we know that in some cases, a silver-level QHP in the same product, with the same issuer and network and lower or equivalent premiums, is available. In order to assist these enrollees in obtaining access to income-based CSRs given their eligibility, and without additional net premium, we propose revisions at § 155.335(j). All of these considerations informed our decision to propose the following revisions to the re-enrollment hierarchy at § 155.335(j), as well as our specific approach for implementing these requirements.

We propose revising § 155.335(j)(1)(i) and adding paragraphs (j)(1)(i)(A), (B), and (C) to amend the Exchange re-enrollment hierarchy for enrollment in coverage beginning in PY 2024. Specifically, we propose that, if the enrollee's current QHP is available and: (1) the enrollee is not CSR-eligible, in accordance with § 155.305(g), the Exchange will re-enroll the enrollee in the same plan as the enrollee's current QHP (paragraph (j)(1)(i)(A)); (2) the enrollee is CSR-eligible, in accordance with § 155.305(g), and the enrollee's current QHP is a bronze level plan, the Exchange will re-enroll the enrollee either in the same plan as the enrollee's current QHP, or, at the option of the Exchange, in a silver level QHP within the same product that has a lower or equivalent premium after APTC and that has the most similar network compared to the enrollee's current QHP (paragraph (j)(1)(i)(B)); and (3) the enrollee is CSR-eligible, in accordance with § 155.305(g), and the enrollee's current QHP is not a bronze level plan, the Exchange will re-enroll the enrollee in the same plan as the enrollee's current QHP (paragraph (j)(1)(i)(C)). With respect to current operations, the only effective change to the re-enrollment hierarchy would be the change proposed in paragraph (j)(1)(i)(B). HHS does not propose to shift enrollment out of the enrollee's current product or issuer if the enrollee's current product and/or issuer are available through the Exchange. We believe retaining coverage in the enrollee's current product when available is important in order to honor the various criteria the enrollee may have used to make the original selection and ensure there is no disruption to the enrollee's benefit coverage, such as the product network type (for example, HMO, PPO, etc.) and covered items and services. Furthermore, we believe it is of particular importance to ensure the enrollee's specific provider coverage is maintained beyond a product's provider network type when the enrollee is being auto re-enrolled into a different QHP than their current QHP.

We also propose amending paragraphs (j)(1)(ii) through (iv), which outline the steps for re-enrollment determinations when the enrollee's current QHP is no longer available and the enrollee's current product is still available through the Exchange for renewal. Specifically, we propose revising paragraph (j)(1)(ii) by adding

[165] CMS (2021, April 21). *2022 Marketplace Open Enrollment Public Use Files. https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files.*

[166] CMS. (2022). Internal Eligibility and Enrollment Data.

[167] CMS. (2021, October). Internal Eligibility and Enrollment Data.

paragraphs (j)(1)(ii)(A), (B), and (C) to specify for enrollment in coverage beginning in PY 2024, that if the enrollee's current QHP is not available through the Exchange and: (1) the enrollee is not CSR-eligible, in accordance with § 155.305(g), the Exchange will re-enroll the enrollee in a QHP within the same product, at the same metal level and that has the most similar network compared to the enrollee's current QHP (paragraph (j)(1)(ii)(A)); (2) the enrollee is CSR-eligible, in accordance with § 155.305(g), and the enrollee's current QHP is a bronze level plan, the Exchange will re-enroll the enrollee in a bronze level QHP within the same product, or, at the option of Exchange, in a silver level QHP within the same product that has a lower or equivalent premium after APTC and that has the most similar network compared to the enrollee's current QHP (paragraph (j)(1)(ii)(B)); and (3) the enrollee is CSR-eligible, in accordance with § 155.305(g), and the enrollee's current QHP is not a bronze level plan, the Exchange will re-enroll the enrollee in a QHP within the same product at the same metal level and that has the most similar network compared to the enrollee's current QHP (paragraph (j)(1)(ii)(C)).

We also propose amending paragraphs (j)(1)(iii)(A) through (B), which outline the re-enrollment rules when the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP at the same metal level as the enrollee's current QHP. Specifically, we propose, beginning for PY 2024, amending paragraphs (j)(1)(iii)(A) and (B) to require if: (1) the enrollee's current QHP is a silver level plan, the Exchange will re-enroll the enrollee in a silver level QHP under a different product offered by the same QHP issuer that is most similar to and that has the most similar network compared to the enrollee's current product; if no such silver level QHP is available for enrollment through the Exchange, the Exchange will re-enroll the enrollee in a QHP under the same product that is one metal level higher or lower than the enrollee's current QHP and that has the most similar network compared to the enrollee's current QHP (paragraph (j)(1)(iii)(A)); and (2) the enrollee's current QHP is not a silver level plan, the Exchange will re-enroll the enrollee in a QHP under the same product that is one metal level higher or lower than the enrollee's current QHP and that has the most similar network compared to the enrollee's current QHP (paragraph (j)(1)(iii)(A)).

We propose amending paragraph (j)(1)(iv), which outlines the re-enrollment rules when the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP at the same metal level as, or one metal level higher or lower than, the enrollee's current QHP. We propose, adding to paragraph (j)(1)(iv) which would provide, beginning for PY 2024, if the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP that is at the same metal level as, or one metal level higher or lower than the enrollee's current QHP, the Exchange will re-enroll the enrollee in any other QHP offered under the product in which the enrollee's current QHP is offered in which the enrollee is eligible to enroll that has the most similar network compared to the enrollee's current QHP.

We propose amending paragraphs (j)(2)(i) through (iii), which outlines the re-enrollment rules when the enrollee's current product is no longer available through the Exchange for renewal. Specifically, we propose to amend paragraph (j)(2)(i) to provide, beginning for the PY 2024, that if the enrollee is not CSR eligible, the Exchange will re-enroll the enrollee in a QHP in the product offered by the same issuer that is the most similar to the enrollee's current product at the same metal level as and with the most similar network compared to the enrollee's current QHP. We propose revising and redesignating paragraph (j)(2)(ii) as paragraph (j)(2)(iv), which would require, if the issuer does not offer another QHP at the same metal level as the enrollee's current QHP, the Exchange will re-enroll the enrollee in a QHP that is one metal level higher or lower than the enrollee's current QHP and that has the most similar network compared to the enrollee's current QHP in the product offered by the same issuer through the Exchange that is the most similar to the enrollee's current product. We propose to add a new paragraph (j)(2)(ii) to establish that if the enrollee is CSR-eligible, in accordance with § 155.305(g), and the enrollee's current QHP is a bronze level plan, the Exchange will re-enroll the enrollee in a bronze level QHP, or, at the option of the Exchange, in a silver level QHP that has a lower or equivalent premium after APTC and that has the most similar network compared to the enrollee's current QHP in the product offered by the same issuer through the Exchange that is most similar to the enrollee's current product.

We also propose, beginning for PY 2024, revising and redesignating paragraph (j)(2)(iii) as paragraph (j)(2)(v), which would state that if the issuer does not offer another QHP through the Exchange at the same metal level as, or one metal level higher or lower than the enrollee's current QHP, the Exchange will re-enroll the enrollee in any other QHP offered by the same issuer in which the enrollee is eligible to enroll in the product that is most similar to the enrollee's current product and in a QHP within that product that has the most similar network to the enrollee's current QHP. Lastly, we propose to add a new paragraph (j)(2)(iii) to establish that if the enrollee is CSR-eligible, in accordance with § 155.305(g), and the enrollee's current QHP is not a bronze level plan, the Exchange will re-enroll the enrollee in a QHP at the same metal level that has the most similar network compared to the enrollee's current QHP in the product offered by the same issuer that is the most similar to the enrollee's current product.

We believe that enrollees are best able to make plan selections themselves, and outreach from the Exchanges on the Federal platform always encourages enrollees to actively return, provide their latest eligibility information, and shop and compare Exchange plans to make the selection that best meets their needs. Income-based CSR-eligible enrollees in Exchanges on the Federal platform who are subject to the proposed policy would receive a notice from the Exchange advising them that they will be re-enrolled into a silver plan if they do not make an active selection on or before December 15th, and would also see the silver plan highlighted in the online shopping experience if they return on or before December 15th to review their options. The notice would also inform the enrollee that if they prefer to keep their bronze plan, they can actively select it through December 15th, for an effective date of January 1st. Enrollees in Exchanges on the Federal platform who do not make an active selection on or before December 15th would receive an additional communication from the Exchange after December 15th reminding them of their new plan enrollment for January 1st, as well as their ability to make a different plan selection by January 15th that would be effective starting February 1st.

This proposal is consistent with the 2014 Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health

Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges (79 FR 52994, 53001) explanation of the guaranteed renewability provisions at § 147.106. If a product remains available for renewal, including outside the Exchange, the issuer must renew the coverage within the product in which the enrollee is currently enrolled at the option of the enrollee, unless an exception to the guaranteed renewability requirements applies. However, to the extent that the issuer is subject to § 155.335(j) with regard to an enrollee's coverage through the Exchange, the issuer must, subject to applicable State law regarding automatic re-enrollments, automatically enroll the enrollee in accordance with the re-enrollment hierarchy, even where that results in re-enrollment in a plan under a different product offered by the same QHP issuer through the Exchange. Enrollments completed pursuant to § 155.335(j) will be considered to be a renewal of the enrollee's coverage, provided the enrollee also is given the option to renew coverage within his or her current product outside the Exchange. This proposal is intended to provide greater financial security to bronze plan enrollees who do not actively re-enroll and may not be aware that a more generous silver plan at the same or lesser cost may be available with dramatically more costs covered by the plan. Additionally, some of these consumers may have been initially enrolled before more generous APTC became available with the passage of the ARP,[168] and may not have been initially income-based CSR-eligible when they first enrolled, or may have been helped by an agent, broker or assister who did not adequately explain the benefits of silver enrollment for CSR-eligible enrollees. This proposal would assist bronze enrollees who may be less engaged and are not aware that a more generous version of their plan was available at the same or lesser cost.

Additionally, we note that HHS is not proposing any changes to SEP eligibility or duration in connection with the proposed changes at § 155.335(j). Currently, under § 155.420(d)(1)(i), a qualified individual is eligible for a SEP to enroll in or change from one QHP to another if the qualified individual loses MEC, which includes when an enrollee's current product is no longer available for renewal. As such, it is not considered a loss of MEC when an enrollee is re-enrolled from a bronze QHP to a silver QHP within the same product and their current plan is still available. We also note that consistent with longtime binder payment policy for Exchange enrollees, auto re-enrollment into a different plan or product with the same issuer that offers their current plan would not require enrollees with already effectuated coverage to make a new binder payment. This means, for example, that a CSR-eligible bronze plan enrollee receiving APTC who is auto re-enrolled in a silver plan offered by the same issuer as their current bronze plan would enter the 3-month APTC grace period if they were late on paying for January coverage in the future year.[169]

We acknowledge the operational complexities issuers and States may face as a result of these proposed changes. Issuers would continue to identify the re-enrollment plan for all enrollees still served by the issuer in the new plan year, except that the Exchange would identify the silver re-enrollment plan for bronze enrollees if those enrollees were redetermined CSR eligible in accordance with § 155.305(g). In order to ensure enrollees are auto re-enrolled in a plan with the most similar network to their current QHP, in the situations where the enrollee would not be auto re-enrolled into their current QHP, HHS would place enrollees into a plan with the same network ID as their current QHP, if possible. Similar to the current Plan ID Crosswalk process, issuers would be able to submit justifications for HHS review if they believed a different network ID in the following plan year had the most similar network to the enrollee's current QHP.[170] Exchanges and State regulators would have a more complicated analysis in assuring that the issuer-identified re-enrollment plan was consistent with the proposed premium and network requirements at § 155.335(j). However, we believe incorporating net premium and provider networks into re-enrollment determinations would help ensure the hierarchy for re-enrollment in all Exchanges takes into account plan generosity and consumer needs beyond merely the retention of the most similar plan available. The Exchanges would need to develop new Exchange notices to provide the enrollees advance and sufficient notice that their plan will change unless they return during open enrollment, and would seek to improve other existing notices, as applicable, to improve transparency and enrollees' understanding of their re-enrollment options. We believe it is important to ensure re-enrollment rules default consumers into lower-cost or more generous plans; promote consumer access to affordable, high-quality coverage; and increase consumer understanding of their re-enrollment options by developing additional consumer notices and guidance.

We seek comment on this proposal. We also seek comments on using network IDs to determine the most similar network. Consistent with the definition of a product at § 144.103, the product ID accounts for different product network types (for example, HMO, PPO, etc.) whereas network IDs account for specific provider differences. As discussed earlier, in situations where the enrollee would not be auto re-enrolled into their current QHP, HHS intends to place enrollees into a plan with the same network ID as their current QHP to ensure enrollee are being auto re-enrolled into plans with the most similar network. We particularly solicit comments on how States review network IDs and the criteria or thresholds States use to determine whether a new network ID is warranted, for example, whether States require that an issuer create a new network ID if there is a five percent difference in the providers covered under a network.

Additionally, HHS is considering whether for future years it would be appropriate to incorporate net premium and total out-of-pocket cost throughout the Exchange re-enrollment hierarchy. We solicit comments on amending the hierarchy at § 155.335(j), for future plan years, to also allow the Exchange take the following actions in the following circumstances: (1) if the enrollee's current plan is not available, regardless of income-based CSR eligibility, direct re-enrollment to a plan at a higher metal level than their current QHP, with a lower or equivalent net premium and total out-of-pocket cost, within the same product, network, and QHP issuer; (2) if the enrollee's current plan is not available and the enrollee does not have a plan at a higher metal level than their current QHP with a lower or equivalent net premium and total out-of-pocket cost, regardless of income-based CSR eligibility, direct re-enrollment to a plan at the same metal level as their current QHP, with a lower or equivalent net premium and total out-of-pocket cost, within the same product, network, and

[168] With the passage of the IRA, these enhanced subsidies have been extended for an additional three years (through 2025).

[169] Please refer to the following for further explanation on binder payments and re-enrollment: CMS. (2022, July 28). 2022 Federally-facilitated Exchange (FFE) and Federally-facilitated Small Business Health Options Program (FF–SHOP) Enrollment Manual. (Exhibit 12, pp. 33–37, and p. 87). *https://www.hhs.gov/guidance/document/2022-enrollment-manual.*

[170] CMS (2022). *Qualified Health Plan Certification Website. https://www.qhpcertification.cms.gov/s/Plan%20Crosswalk.*

QHP issuer; and (3) if a plan at the same metal level as their current QHP is not available and the enrollee is not income-based CSR eligible, direct re-enrollment to a QHP that is one metal level higher or lower than the enrollee's current QHP, with a lower or equivalent net premium and total out-of-pocket cost, under the same product, network, and issuer. For example, an Exchange could consider re-enrolling a current gold QHP enrollee into another available gold QHP, within the enrollee's service area and current product that is issued by the same QHP issuer that has a lower or equivalent net premium and out-of-pocket cost. We also solicit comments on re-enrolling consumers into the lowest cost silver plan in the following year if the consumer chose the lowest cost silver plan in the current plan year. Due to operational complexities, we seek comment on whether the actuarial value (AV) of a plan should be used as a proxy for estimating the total costs that an enrollee may be subject to under a given plan.[171] Specifically, we solicit comments on whether the Exchange should ensure that the net premium of the higher AV plan is less than or equal to the net premium of the default plan or use net premium and total out-of-pocket cost calculations to determine if enrollees should be upgraded to a higher metal level in future plan years.

We also seek comments on whether 73 percent CSR plan variation-eligible enrollees should be re-enrolled into silver plan variations or gold level plans since in some cases gold plans may be more affordable than silver plan variations for 73 percent CSR-eligible enrollees. Additionally, we solicit comments on the States' process for calculating total out-of-pocket cost to understand if, and to what extent, the States' methodology for calculating total out-of-pocket costs vary. Furthermore, we solicit comment on whether the re-enrollment hierarchy should also factor in potential out-of-pocket costs, not attributable to cost sharing, such as balance billing, and if so, how.

HHS also seeks broad comment on alternative auto-enrollment policies that we should consider in future years.[172] For example, we are curious about interested parties' thoughts on an auto-enrollment policy under which consumers who have entered delinquency on their QHP premiums would be auto-enrolled into QHPs with no net premium after application of APTC (referred to as zero-dollar plans). In accordance with §§ 155.430(b)(2)(ii) and 156.270, a QHP/SADP may terminate an enrollee's coverage for non-payment of premiums, subject to certain conditions. Specifically, § 156.270(d) requires issuers to observe a three-consecutive-month grace period before terminating coverage for those enrollees who are eligible for, and have elected to receive, APTC and who, upon failing to timely pay their premiums, are receiving APTC. Research suggests that even small net premiums can significantly decrease enrollment and that this could be because paying even a small premium requires enrollees to take additional action.[173] [174] Enrollees may experience life changes that make it challenging to pay their monthly premiums on an ongoing basis. Currently, the Exchanges on the Federal platform only track nonpayment once the three-month APTC grace period has expired, and do not know when the enrollee first becomes delinquent on payment of premiums. Since providers are notified when an individual is in the second and third month of the grace period, they know that claims may not be paid and may require that the enrollee pay in full at the point of service. A potential challenge with auto enrolling enrollees into zero-dollar premium plans, with retroactive coverage, if they go into delinquency is that re-processing any claims for those enrollees able to self-pay during the pended months would be difficult if the zero-dollar premium auto-assignment was to the original issuer and would be especially burdensome if the new plan was issued by another issuer. We solicit comments on if auto enrolling enrollees into zero-dollar premium plans if they go into delinquency should be prospective or retroactive. In order to mitigate the barriers enrollees face to enroll, effectuate, and maintain coverage, HHS is considering enrolling consumers who enter delinquency into zero-dollar plans.

We also solicit comments on enrolling consumers into zero dollar plans if they fail to make a binder payment. Sometimes QHP applicants select plans, but fail to make a binder payment to effectuate coverage, and thus have their coverage canceled by the issuer. As mentioned previously in this proposed rule, enrollees face non-financial burdens that cause them to miss these payments or in some cases fail to complete the enrollment process. As such, it is likely that by alleviating or eliminating these non-financial burdens, some enrollees would choose to enroll in coverage. We request comments on these proposals.

7. Special Enrollment Periods (§ 155.420)

a. Use of Special Enrollment Periods by Enrollees

We propose two technical corrections to § 155.420(a)(4)(ii)(A) and (B) to align the text with § 155.420(d)(6)(i) and (ii). The proposed revisions would clarify that only one person in a tax household applying for coverage or financial assistance through the Exchange must qualify for a special enrollment period under paragraphs (d)(6)(i) and (ii) in order for the entire household to qualify for the special enrollment period.

As discussed in previous rulemaking, certain SEPs under § 155.420(d) are available to an entire tax household applying for coverage or financial assistance through the Exchange when a qualified individual *or* the qualified individual's dependent satisfies specified requirements (rather than when the qualified individual *and* the qualified individual's dependent satisfy such requirements).[175] In the 2022 Payment Notice (86 FR 24140), we finalized revisions to § 155.420(a)(4)(ii)(C) to update the language from ''if an enrollee *and* his or her dependents'' to ''if an enrollee *or* his or her dependents'' to align with the regulatory text for triggering events under § 155.420(d)(6)(i) and (ii), but we neglected to propose and finalize similar but necessary changes to the text of § 155.420(a)(4)(ii)(A) and (B) and noted that we intended to propose these changes in future rulemaking. Therefore, to align the text of § 155.420(a)(4)(ii)(A) and (B) with the triggering event provisions under § 155.420(d)(6)(i) and (ii), we are

[171] Actuarial value refers to the percentage of total average costs for covered benefits that a plan will cover. However, the enrollee could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on their actual health care needs and the terms of the insurance policy.

[172] HHS seeks comment on all auto-enrollment policies that could better ensure consumer's continuous access to health coverage, including policies that may require additional grants of authority from Congress to HHS.

[173] Fiedler, M., & McIntyre, A. (2022, September 13). *Tweaking the marketplace enrollment process could magnify effects of larger premium tax credits.* Brookings. *https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2022/09/13/tweaking-the-marketplace-enrollment-process-could-magnify-effects-of-larger-premium-tax-credits/.*

[174] Drake, C., Cai, S., Anderson, D., and Sacks, D. (2021, October 22). Financial Transaction Costs Reduce Benefit Take-Up: Evidence from Zero-Premium Health Plans in Colorado. SSRN. *https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3743009.*

[175] *See* 78 FR 42262. Also, the 2017 Market Stabilization Rule used the phrase ''if an enrollee *or* his or her dependent'' when describing the rule that would be finalized at what is now paragraph § 155.420(a)(4)(ii)(A), *See* 82 FR 18359.

proposing two technical corrections to § 155.420(a)(4)(ii)(A) and (B) by updating the sentence at paragraph (a)(4)(ii)(A) from ''if an enrollee *and* his or her dependents'' to ''if an enrollee *or* his or her dependents'' and by updating the sentence at paragraph (a)(4)(ii)(B) from ''if an enrollee *and* his or her dependents'' to ''if an enrollee *or* his or her dependents.'' Because these are two technical changes, we do not anticipate that it will impact Exchanges' operations or messaging.

We seek comment on this proposal.

b. Effective Dates for Qualified Individuals Losing Other Minimum Essential Coverage (§ 155.420(b))

We are proposing amendments to the coverage effective date rules at § 155.420(b)(2)(iv) to permit Exchanges the option to offer earlier coverage effective start dates for consumers attesting to a future loss of MEC. Doing so could mitigate coverage gaps when consumers lose forms of MEC (other than Exchange coverage) mid-month and allow for more seamless transitions from other coverage to Exchange coverage. We are aware that consumers may face gaps in coverage because current coverage effective date rules do not allow for retroactive or mid-month coverage effective dates for consumers whose other coverage ends mid-month. Under current rules, the earliest start date for Exchange coverage is the first day of the month following the date of loss of MEC. We are aware that in some States, Medicaid or CHIP is regularly terminated mid-month, so we are soliciting input on whether the proposed change would help consumers, especially those impacted by Medicaid/CHIP unwinding, to seamlessly transition from another form of MEC to Exchange coverage.

Consumers losing MEC, such as coverage through an employer, Medicaid, or CHIP, already qualify for a special enrollment period under § 155.420(d)(1) and may report a loss of MEC to Exchanges and select a QHP up to 60 days before or 60 days after their loss of MEC. Exchanges must generally provide a regular coverage effective date as described in § 155.420(b)(1): for a QHP selection received by the Exchange between the 1st and the 15th day of any month, the Exchange must ensure a coverage effective date of the 1st day of the following month; and for a QHP selection received by the Exchange between the 16th and the last day of any month, the Exchange must ensure a coverage effective date of the 1st day of the second following month. However, Exchanges must provide special coverage effective dates for certain special enrollment period types including loss of MEC, as described in § 155.420(b)(2), and may elect to provide coverage effective dates earlier than those specified in § 155.420(b)(1) and (2)(i), as described in § 155.420(b)(3). The loss of MEC coverage effective dates are generally governed by § 155.420(b)(2)(iv). Currently, for all Exchanges, consumers who report a future loss of MEC and select a plan on or before the loss of MEC are provided an Exchange coverage effective date of the 1st of the month after the date of loss of MEC, pursuant to § 155.420(b)(2)(iv). For example, if a consumer reports on June 1st that they will lose MEC on July 15th and they make a plan selection on or before July 15th, Exchange coverage will be effective August 1st. The consumer in this case cannot avoid a gap in coverage of more than two weeks.

For consumers reporting a loss of MEC that occurred up to 60 days in the past, Exchanges must ensure that coverage is effective in accordance with § 155.420(b)(1) (the regular coverage effective dates described above) [176] through a cross reference from § 155.420(b)(2)(iv). Alternatively, Exchanges can offer prospective coverage effective dates so that coverage is effective the first of the month following plan selection, at the option of the Exchange. *See* § 155.420(b)(2)(i). For example, if a consumer reports on July 1st a past loss of MEC that occurred on June 30th and selects a plan on July 15th, Exchange coverage is effective August 1st.

Because current regulation at § 155.420(b)(2)(iv) does not allow for retroactive or mid-month coverage effective dates, consumers may experience gaps in coverage, especially those consumers who live in States that allow mid-month terminations of Medicaid or CHIP coverage. Further, after the COVID–19 PHE comes to an end, HHS expects to see a higher than usual volume of individuals transitioning from Medicaid and CHIP coverage to the Exchange. This is because States will be required to return to normal eligibility and enrollment operations after the expiration of the continuous enrollment condition that provided a temporary increase in Federal Medicaid matching funds authorized by the Families First Coronavirus Response Act (FFCRA),[177] and we expect that many individuals experienced changes in income or household size since the continuous enrollment condition took effect. Consumers who become ineligible for Medicaid are at risk of being uninsured for a period of time and postponing use of health care services, which can lead to poorer health outcomes, if they are not able to successfully transition between coverage programs without coverage gaps.

Therefore, to ensure that qualifying individuals whose prior MEC ends mid-month are able to seamlessly transition from non-Exchange MEC to Exchange coverage as quickly as possible with no coverage gaps, we are proposing to revisions to paragraph (b)(2)(iv). Specifically, we propose to add additional language to paragraph (b)(2)(iv) that if a qualified individual, enrollee, or dependent, as applicable, loses coverage as described in paragraph (d)(1), experiences a change in eligibility for APTC per paragraph (d)(6)(iii), or experiences a loss of government contribution or subsidy per paragraph (d)(15), and if the plan selection is made on or before the day of the triggering event, the Exchange must ensure that the coverage effective date is the 1st day of the month following the date of the triggering event (as currently required under paragraph (b)(2)(iv)) and, at the option of the Exchange, if the plan selection is made on or before the last day of the month preceding the triggering event, the Exchange must ensure that coverage is effective on the first of the month in which the triggering event occurs. For example, if a consumer attests between May 16th and June 30th that they will lose MEC on July 15th and selects a plan on or before June 30th, coverage would be effective on August 1st (first of the month after the last day of prior MEC), or at the option of the Exchange, on July 1st (the first of the month in which the triggering event occurs).

We acknowledge that this proposed change may have a limited impact because many types of coverage do not typically have end dates in the middle of the month. However, for those that it does impact, the proposed change would provide earlier access to coverage and APTC and CSR. Under the current rule at paragraph (b)(2)(iv), consumers reporting a future loss of MEC may have to wait weeks for their coverage to start, even if they were proactive and attested to a coverage loss as soon as they became aware. We do not believe that this proposed change introduces

[176] For example, if a consumer selects a plan on May 2nd, coverage will be effective June 1st, if a consumer selects a plan on May 16th, coverage will be effective July 1st.

[177] FFCRA. Public Law 116–127 (2020). These provisions enabled States to receive the temporary Federal Medical Assistance Percentage increase under that section.

program integrity concerns because it only applies to those consumers who report a future loss of MEC and have been determined eligible for an SEP and found eligible for an Exchange QHP, fall within their 60-day reporting window for reporting a future loss of MEC, and select a plan on or before the last day of the month preceding the loss of MEC.

We believe this proposed change would provide additional flexibilities for Exchanges as the proposed changes to paragraph (b)(2)(iv) would provide Exchanges with the option to use the current coverage effective dates available under current paragraph (b)(2)(iv) as well as the option to provide earlier coverage effective dates for some consumers who attest to a future loss of MEC. We also acknowledge that if Exchanges do elect an earlier coverage effective date as we propose, this would result in some consumers paying for both an Exchange QHP and their other MEC for a short period of dual enrollment. However, we do not believe the partial-month period of dual enrollment should bar an enrollee from APTC or CSR benefits for the Exchange coverage if otherwise eligible. Given that consumers impacted by the proposed change to § 155.420(b)(2) will have other MEC for only part of the first month of their QHP coverage, Exchanges could look to the definition of coverage month in 26 CFR 1.36B–3, which states that a consumer may qualify when not eligible for the full calendar month for minimum essential coverage, to find a consumer who receives an earlier effective date under this rule as eligible for APTC and CSRs for the first month of their QHP coverage, despite the brief period of overlapping coverage. In order to clarify our interpretation that consumers may be eligible for APTC and CSRs as of the earlier SEP effective date proposed in this rulemaking, we are considering whether any corresponding amendments to APTC eligibility rules may be necessary and plan to codify such changes in the final rule as needed. For example, since Exchange regulations regarding APTC eligibility do not reference the statutory definition of a coverage month, we seek comment on whether Exchange regulations at § 155.305(f) should be revised to correspond with the statutory definition of a coverage month.

We believe the largest beneficiaries of these proposed changes would be consumers whose States permit mid-month terminations of Medicaid or CHIP coverage. We seek comment from interested parties on the frequency of mid-month coverage end dates, potential program integrity issues associated with earlier effective dates, and on instances when the expedited effective date would or would not mitigate coverage gaps or introduce coordination of benefits issues.

Under § 147.104(b)(5), applicable to health insurance issuers that offer health insurance coverage in the individual, small group, or large group market in a State, coverage elected during limited open and special enrollment periods described in § 147.104(b)(2) and (3) must become effective consistent with the dates described in § 155.420(b) (this excludes the special enrollment period under § 155.420(d)(6) which is explicitly excepted from § 147.104(b)(2)). Therefore, with the exception of the triggering event in § 155.420(d)(6), which is limited to coverage purchased through an Exchange, these proposed changes to the effective date for future loss of MEC would be effective for individual market coverage purchased off an Exchange, as well as for coverage purchased through an Exchange, and the proposed option of the Exchange to specify the effective date would refer to an option of the applicable State authority with respect to individual market coverage purchased off an Exchange.

While we also considered proposing retroactive coverage effective dates for consumers reporting past loss of MEC, we decided to limit these proposed changes to future loss of MEC to avoid adverse selection and reduce burden on Exchanges, States, and issuers, as allowing for retroactive coverage start dates can be operationally complex for Exchanges to implement and for issuers to process. Also, we believe the proposed changes would limit the financial burden on consumers, as consumers who report a loss of MEC in the past 60 days may not want or be able to afford to pay past premiums to effectuate coverage retroactively. While we also considered providing mid-month coverage effective dates for consumers who lose MEC mid-month, this would have been disadvantageous to affording coverage given that IRS regulations at 26 CFR 1.36B–3 generally provide that PTC is only available for a month when, as of the first day of the month, the individual is enrolled in a plan through the Exchange. We seek comment on additional regulatory changes that would improve transitions to Exchange coverage and minimize periods of uninsurance for consumers who report a loss of MEC to the Exchange.

We seek comment on these proposals.

c. Special Rule for Loss of Medicaid or CHIP Coverage (§ 155.420(c))

In order to mitigate coverage gaps when consumers lose Medicaid or CHIP coverage and to allow for a more seamless transition into Exchange coverage, we are proposing a new special rule under § 155.420(c)(6) to provide more time for consumers who lose Medicaid or CHIP coverage that is considered MEC as described in § 155.420(d)(1)(i) to report their loss of coverage and enroll in Exchange coverage. The proposed regulation would align the special enrollment period window following loss of Medicaid or CHIP with the reconsideration period available under 42 CFR 435.916(a).

Currently, qualified individuals or their dependents who lose MEC, such as coverage through an employer or most kinds of Medicaid or CHIP, qualify for a special enrollment period under § 155.420(d)(1)(i) and may report a loss of MEC to Exchanges up to 60 days before and up to 60 days after their loss of MEC. 45 CFR 155.420(c)(2). When these qualified individuals or their dependents are disenrolled from Medicaid or CHIP based on modified adjusted gross income (MAGI) following an eligibility redetermination, 42 CFR 435.916 requires that the State Medicaid agency provide a 90-day reconsideration window, which allows former beneficiaries to provide the necessary information to their State Medicaid agency to re-establish their eligibility for Medicaid or CHIP without having to complete a new application. During the 90 days following a Medicaid or CHIP denial or disenrollment, it would be reasonable for a consumer who becomes uninsured to proceed first by attempting to regain coverage through Medicaid or CHIP. However, because the special enrollment period for loss of MEC at § 155.420(d)(1)(i) currently lasts only 60 days after the loss of Medicaid or CHIP coverage, by the time that a consumer exhausts their attempt to regain coverage through Medicaid or CHIP (which they must do within 90 days of loss of Medicaid or CHIP), they may have missed their window to enroll in Exchange coverage through a special enrollment period based on loss of MEC (60 days after loss of Medicaid or CHIP).

In further support of this proposal, we are aware that most consumers losing Medicaid or CHIP may not transition to Exchange coverage in a timely manner. A recent report published by the Medicaid and CHIP Payment and Access Commission (MACPAC) [178]

[178] Medicaid and CHIP Payment Access Commission. (2022, July). *Transitions Between*

found that only about three percent of beneficiaries who were disenrolled from Medicaid or CHIP in 2018 enrolled in Exchange coverage within 12 months. The 2018 data also showed that more than 70 percent of adults and children moving from Medicaid to Exchange coverage had gaps in coverage for an average of about three months.[179] While there are likely several reasons that consumers did not transition directly from Medicaid or CHIP coverage to Exchange coverage in 2018, the proposed special rule at § 155.420(c)(6) has the potential to mitigate an administrative hurdle that may pose a barrier to enrolling in Exchange coverage in a timely manner and with little to no coverage gaps.

Therefore, to ensure that qualifying individuals are able to seamlessly transition from Medicaid or CHIP coverage to Exchange coverage as quickly as possible to and mitigate the risk of coverage gaps, we propose to create new paragraph (c)(6) which would add language stating that effective January 1, 2024, Exchanges will have the option to implement a new special rule that consumers eligible for an SEP under § 155.420(d)(1)(i) due to loss of Medicaid or CHIP coverage that is considered MEC will have up to 90 days after their loss of Medicaid or CHIP coverage to enroll in an Exchange QHP. This proposal would align the special enrollment period window following loss of Medicaid or CHIP with the reconsideration period available under 42 CFR 435.916(a). We also propose adding language to paragraph (c)(2) to clarify that a qualified individual or his or her dependent who is described in paragraph (d)(1)(i) continues to have 60 days after the triggering event to select a QHP unless an Exchange exercises the option proposed in new paragraph (c)(6). We believe these proposed changes would have a positive impact on consumers while providing additional flexibilities for Exchanges as they can choose whether to offer this special rule or not, depending on enrollment trends for their respective populations.

We seek comment on this proposal.

d. Plan Display Error Special Enrollment Periods (§ 155.420(d))

We propose amending § 155.420(d)(12) to align the policy of the Exchanges for granting SEPs to persons who are adversely affected by a plan display error with current plan display error SEP operations. We propose amending paragraph (d)(12) by changing the subject of the regulation to focus on the affected enrollment, not the affected qualified individual or enrollees.[180]

In accordance with § 155.420, SEPs allow a qualified individual or enrollee who experiences certain qualifying events to enroll in, or change enrollment in, a QHP through the Exchange outside of the annual OEP. In 2016, CMS added warnings on *HealthCare.gov* about inappropriate use of SEPs, and tightened certain eligibility rules.[181] We sought comment on these issues in the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018 proposed rule (81 FR 61456), especially on data that could help distinguish misuse of SEPs from low take-up of SEPs among healthier eligible individuals; evidence on the impact of eligibility verification approaches, including pre-enrollment verification, on health insurance enrollment, continuity of coverage, and risk pools (whether in the Exchange or other contexts); and input on what SEP-related policy or outreach changes could help strengthen risk pools. We examined attrition rates in our enrollment data and have found that the attrition rate for any particular cohort is no different at the end of the year than at points earlier in the year, suggesting that any such gaming, if it is occurring, does not appear to be occurring at sufficient scale to produce statistically measurable effects.

In the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program (81 FR 94058, 94127 through 94129), CMS codified the plan display error SEP in § 155.420(d)(12) to reflect that plan display error SEP may be triggered when a qualified individual or enrollee, or their dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium (hereinafter ''plan display error'') influenced the qualified individual's, enrollee's, or their dependents' decision to purchase a QHP through the Exchange. This generally allowed consumers who enrolled in a plan for which *HealthCare.gov* displayed incorrect plan benefits, service area, cost-sharing, or premium, and who could demonstrate that such incorrect information influenced their decision to purchase a QHP through the Exchange, to select a new plan that better suited their needs.

In the same final rule, CMS also finalized the policies at § 147.104(b)(2) to make clear that the plan display error SEP only creates an opportunity to enroll in coverage through the Exchange, and clarified that the special enrollment period is limited to plan display errors presented to the consumer by the Exchange at the point at which the consumer enrolls in a QHP (81 FR at 94128 through 94129). By this we meant that the consumer must have already completed their Exchange application, the Exchange must have determined that the consumer is eligible for QHP coverage and any applicable APTC or CSRs, and the consumer must have viewed the material error while making a final selection to enroll in the QHP.

Currently, § 155.420(d)(12) requires the qualified individual, enrollee, or their dependent, to adequately demonstrate to the Exchange that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP through the Exchange. However, we have found that consumers may benefit when other interested parties, besides a qualified individual, enrollee, or their dependents, can demonstrate to the Exchange that a material plan error influenced the qualified individual's, enrollee's, or their dependents' enrollment decision to purchase a QHP through the Exchange. In our experience, plan display errors may not be obvious or detectable to the consumer and the Exchange until after the enrollment has been impacted by the error related to plan benefits, service area, premiums, or even cost-sharing. In majority of the plan display errors, the issuer or State regulator has identified the display error. For example, a plan display error can influence a consumer's enrollment without the consumer's knowledge when a consumer enrolls in a QHP, pays an incorrect premium amount that was submitted to and displayed on *HealthCare.gov,* and the plan display error regarding the premium amount is not known until the enrollment is cancelled by the issuer for non-payment of premiums. In this case, the plan display error would not be discovered until the issuer investigates the reason for cancellation. The issuer is the only party that can identify that the plan display error was caused by

Medicaid, CHIP, and Exchange Coverage. https://www.macpac.gov/wp-content/uploads/2022/07/Coverage-transitions-issue-brief.pdf.

[179] Ibid.

[180] In this section, ''consumer'' may be used as shorthand for ''qualified individual, enrollee, or their dependents.''

[181] February 25, 2016. Fact Sheet: Special Enrollment Confirmation Process. Available online at *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-24.html.*

incorrect premium amounts between the issuer's records and data submitted to *HealthCare.gov,* and that can notify CMS of the plan display error. CMS can then work with the issuer to implement its established data correction processes to make the necessary corrections to the *Healthcare.gov.* This process includes CMS investigating the plan display error to determine if it is reasonable to expect that the material error has influenced the enrollment or the consumer's purchasing decision. In this example, CMS is likely to determine that the plan display error impacted the consumer's purchasing decision because the consumer was presented erroneous information when purchasing the plan and likely made an enrollment decision based on the premium and cost-sharing amount. Issuers that submit a data change request that adversely impacts the consumers' enrollment on *HealthCare.gov* are required to notify consumers of the plan display error and the remediation.

Since qualified individuals, enrollees, and their dependents are not always the parties best suited to demonstrate to the Exchange that a material plan display has influenced their enrollment, we propose revising paragraph (d)(12) to remove the burden solely from the qualified individual, enrollee, and their dependents. We propose adding cost-sharing to the list of plan display errors which is displayed on *HealthCare.gov* alongside plan benefits, service area, and premiums, and equally influence the consumer's purchasing decision or enrollment. Specifically, we propose revising § 155.420(d)(12) to reflect that an SEP is available when the enrollment in a QHP through the Exchange was influenced by a material error related to plan benefits, cost-sharing, service area, or premium. We propose to consider a material error to be one that is likely to have influenced a qualified individual's, enrollee's, or their dependent's enrollment in a QHP.

It should be noted that an error related to plan benefits, service area, cost-sharing or premium does not trigger an SEP when the error is not material, such as when the error is honored as it was displayed. Errors related to plan benefits, service area, cost-sharing or premium include situations where coding on *HealthCare.gov* causes benefits to display incorrectly, or where CMS identifies incorrect QHP data submission or discrepancy between an issuer's QHP data and its State-approved form filings.[182] If the error involves information that displays on *HealthCare.gov,* CMS works with the issuer and applicable State's regulatory authority to arrive at a solution that has minimal impact on consumers and affirms, to the extent possible, that they are not negatively affected by the error. Generally, the most straightforward and consumer-friendly resolution is for issuers to honor the benefit as it was displayed incorrectly for affected enrollees, if permitted by the applicable State regulatory authority. If the issuer chooses to honor the error and administers the plan as it was incorrectly displayed for the affected consumers, CMS will not provide the consumers with an SEP. The proposed revision to the regulation would be consistent with this approach, as the issuer's honoring of the error would effectively eliminate the materiality of the error.

Our proposal would have minimal operational impact, as interested parties currently have the infrastructure to demonstrate to the Exchange that a plan display error influenced a qualified individual's, enrollee's, or their dependents' decision to purchase a QHP through the Exchange. CMS currently engages with partners and interested parties throughout the plan display error SEP process, ensuring that issuers and States are notified of CMS decisions as appropriate. States have access to the status of all applicable plan display error SEPs and can track the progress of the plan display error SEPs until remediation. In addition, under § 156.1256, issuers ''must notify their enrollees of material plan or benefit display errors and the enrollees' eligibility for an [SEP] . . . within 30 calendar days after being notified by the [FFE] that the error has been fixed, if directed to do so by the [FFE].'' Thus, impacted consumers are also currently being notified and made aware of plan display error SEPs policies if their plan data had a significant, material error. We expect that this experience is similar on all Exchanges, and therefore are proposing that this amendment to the description of the SEP trigger would apply for all Exchanges.

We request comment on this proposal.

Additionally, HHS is considering for future years, whether consumers whose providers leave their network mid-year should be eligible for an SEP. Significant network changes, whether it is initiated by the QHP issuer or the provider, can occur at any point during the year. Under Medicare Advantage regulation 42 CFR 422.62(b)(23), individuals affected by a significant change in their plan's provider network are eligible for an SEP that permits re-enrollment into another Medicare Advantage plan or to original Medicare. CMS is seeking comments on whether QHP consumers similarly affected by a significant change in their plan's provider network should be eligible for an SEP. We also solicit comment on whether we should consider an enrollee who is impacted by a provider contract termination to be someone who is experiencing an exceptional circumstance, as specified in § 155.420(d)(9), or should be eligible for a new SEP for provider contract terminations, and what standards for when termination of a provider from the network should serve as a basis for SEP eligibility.

8. Termination of Exchange Enrollment or Coverage (§ 155.430)

a. Prohibition of Mid-Plan Year Coverage Termination for Dependent Children Who Reach the Maximum Age

We propose to add § 155.430(b)(3) to explicitly prohibit QHP issuers participating in Exchanges on the Federal platform from terminating coverage of dependent children before the end of the coverage year because the child has reached the maximum age at which issuers are required to make coverage available under Federal or State law. The ACA amended the PHS Act to require at section 2714 (implemented at § 147.120) that group health plans and health insurance issuers offering group or individual health insurance coverage that offer dependent child coverage must make such coverage available for an adult child until age 26. The ACA also adds section 9815(a)(1) to the Code and section 715(a)(1) to the Employee Retirement Income Security Act to incorporate the provisions of part A of title XXVII of the PHS Act (including section 2714) and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. This proposal to amend § 155.430 would not change the requirements under § 147.120 nor would it affect parallel provisions in 26 CFR 54.9815–2714 and 29 CFR 2590.715–2714. Some States have established higher age limits, and some issuers adopt higher than legally required age limits as a business decision.

In operationalizing this regulation on the Federal eligibility and enrollment platform, HHS has required issuers that

[182] See the following: CMS. (2022, July 28). *2022 Federally-facilitated Exchange (FFE) and Federally-facilitated Small Business Health Options Program (FF–SHOP) Enrollment Manual.* (Section 6.8.1, p. 82). *https://www.cms.gov/files/document/ffeffshop-enrollment-manual-2022.pdf.*

cover dependent children to provide coverage to dependent children until the end of the plan year in which they turn 26 (or the maximum age under State law), although this is not specifically required under § 147.120. Nevertheless, interested parties have requested that HHS' policy be codified in regulation for clarity. Doing so would reduce uncertainty for Federally-facilitated Exchange issuers regarding their obligation under § 155.430 to maintain coverage for a dependent child who has turned 26 (or the maximum age under State law) until the end of the plan year (unless coverage is otherwise permitted to be terminated). Likewise, it would provide clarity for enrollees themselves who may be uncertain about the rules governing their ability to remain enrolled as a dependent child until the end of the plan year in which they reach the maximum age (that is, age 26 or the maximum age under State law). This proposal would codify the current implementation of the Federal platform.

Payment of APTC on the Exchange, in addition to the way the Federal eligibility and enrollment platform has operationalized Exchange eligibility determinations, warrants a different policy for issuers of individual market QHPs on the Exchanges with regard to child dependents turning age 26 (or the maximum age under State law). This is especially true when comparing individual market Exchange coverage to the employer market, where the employer is typically contributing toward the cost of child dependent coverage, but only until the child dependent attains the maximum dependent age under the group health plan; in the Exchange, the dependent child can receive a portion of the family's APTC for the entire plan year. Exchange eligibility determinations for enrollment through the Exchange and for APTC are based on the tax household, and the determination is made for the entire plan year unless it is replaced by a new determination of eligibility, such as when a change is reported by the enrollee or identified by the Exchange in accordance with § 155.330. The annual basis of Exchange eligibility determinations, absent a new determination, is made clear by the annual eligibility redetermination requirements in § 155.335. Eligibility standards for enrollment through the Exchange and for APTC make no mention of an issuer's business rules regarding dependent relationships, or otherwise regarding the specific relationships between applicants. Additionally, Exchange eligibility criteria do not prohibit allocation of APTC to dependent children enrollees over the age of 26. Every family member who is part of the tax household must be listed on the Exchange application for coverage, and the IRS has no maximum age cap for tax dependents. Because eligibility determinations are made for the entire plan year, the Exchange will generally continue to pay the issuer APTC, including the portion attributable to the dependent child, through the end of the plan year in which the dependent child turns 26, or through the end of the plan year in which the dependent reaches the maximum age required under State law.

In developing the Federal eligibility and enrollment platform, HHS directed QHP issuers on Exchanges that use the Federal platform to honor the eligibility determination made by the Exchange. This requirement applies whether or not the enrollees are determined eligible for APTC. The situation for issuers on these Exchanges thus differs from those in the off-Exchange insurance market, where enrollees do not receive APTC, and in the group insurance market, where contributions by employers may end on the day in which the dependent child turns 26 (or the maximum age under State law).

To clarify, in Exchanges on the Federal platform, during the annual re-enrollment process, enrollees who, during the plan year, have reached age 26 (or the maximum age under State law) are, if otherwise eligible, re-enrolled into a separate policy (following the re-enrollment hierarchy at § 155.335(j)) beginning January 1st of the following plan year, with APTC, if applicable.

Additionally, consistent with existing policy, in circumstances in which a household with an dependent child who has reached age 26 (or the maximum age under State law) reports a change in circumstance to the Exchanges on the Federal platform during the plan year after having reached that age and becomes eligible for an SEP, the dependent child who has exceeded age 26 (or the maximum age under State law) will have their eligibility redetermined in accordance with § 155.330, the dependent child's coverage under that policy will be terminated, and they will be enrolled into their own policy, subject to payment of a binder payment. If, however, the household is not eligible for an SEP as a result of the change, the original eligibility determination from the initial enrollment will remain in place and the dependent child will remain as a covered dependent on the original policy.

Therefore, we propose to add new paragraph (b)(3) to § 155.430 to expressly prohibit QHP issuers participating in Exchanges on the Federal platform from terminating coverage until the end of the plan year for dependent children because the dependent child has reached age 26 (or the maximum age under State law). This change would provide clarity to issuers participating in Exchanges on the Federal platform regarding their obligation to maintain coverage for dependent children, as well as to enrollees themselves regarding their ability to maintain coverage. In addition, we propose to make implementation optional for State Exchanges that wish to establish a similar prohibition.

We request comments on this proposal.

9. General Eligibility Appeals Requirements (§ 155.505)

We propose revising § 155.505(g) to acknowledge the ability of the CMS Administrator to review Exchange eligibility appeals decisions prior to judicial review. Section 155.505 describes the general Exchange eligibility appeals process, including applicants' and enrollees' right to appeal certain Exchange eligibility determinations specified in § 155.505(b), and the obligation of the HHS appeals entity and State Exchange appeals entities to conduct certain Exchange eligibility appeals as described in § 155.505(c). In accordance with § 155.505(g), appellants may seek judicial review of an Exchange eligibility appeal decision made by the HHS appeals entity and State Exchange appeals entities to the extent it is available by law. Currently, the regulation specifies no other administrative opportunities for appellants to appeal Exchange eligibility appeal decisions made by the HHS appeals entity. We propose revising this regulation to acknowledge the ability of the CMS Administrator to review Exchange eligibility appeals decisions prior to judicial review.

This proposed change would ensure that accountability for the decisions of the HHS appeals entity is vested in a principal officer, as well as to bring § 155.505(g) of the appeals process to a more similar posture as other CMS appeals entities that provide Administrator review.[183] Revising the

[183] Examples include: 42 CFR 405 subpart R (Provider Reimbursement Review Board); 42 CFR 412 subpart L (Medicare Geographic Classification Review Board); 42 CFR 430.60–430.104 (Medicaid State Plan Materials/Compliance Determinations);

Continued

regulation would also provide appellants and other parties with accurate information about the availability of administrative review by the CMS Administrator if they are dissatisfied with their Exchange eligibility appeal decision.

We seek comment on this proposal.

10. Improper Payment Pre-Testing and Assessment (IPPTA) for State Exchanges (§§ 155.1500 Through 155.1515)

We propose the establishment of the IPPTA, an improper payment measurement program of APTC, that will include State Exchanges. The proposed IPPTA would prepare State Exchanges for the planned measurement of improper payments of APTC, would test processes and procedures that support HHS' review of determinations of APTC made by State Exchanges, and would provide a mechanism for HHS and State Exchanges to share information that would aid in developing an efficient measurement process. To codify the IPPTA requirements, we propose to establish new subpart P under 45 CFR part 155.

The Payment Integrity Information Act of 2019 (PIIA) [184] requires Federal agencies to annually identify, review, measure, and report on the programs they administer that are considered susceptible to significant improper payments. HHS determined that APTC are susceptible to significant improper payments and are subject to additional oversight. In accordance with 45 CFR part 155, FFEs, SBE–FPs, and State Exchanges that operate their own eligibility and enrollment systems determine the amount of APTC to be paid to qualified applicants. Only improper payments of APTC made by FFEs and SBE–FPs will be measured and reported in the Annual Financial Report beginning in 2022 as part of the Exchange Improper Payment Measurement (EIPM) program. We stated in the 2023 Payment Notice proposed rule (87 FR 654 through 655) that HHS was in the planning phase of establishing an improper payment measurement program that would include State Exchanges—the SEIPM program. We also stated in the 2023 Payment Notice proposed rule that HHS had intended to implement the proposed SEIPM program beginning with the 2023 benefit year. In response to that proposed rule, HHS received several comments from State Exchanges that indicated concerns with the proposed requirements, particularly with respect to the SEIPM program's implementation timeline and proposed data collection processes. For example, some State Exchanges commented that they would need more time and information from HHS to prepare for the implementation of the SEIPM program. We decided not to finalize the proposed rule due to commenters' concerns surrounding the proposed implementation timeline and other burdens that would be imposed by the proposed SEIPM program (87 FR 27281). HHS is now proposing the IPPTA to provide State Exchanges with more time to prepare for the planned measurement of improper payments of APTC, to test processes and procedures that support HHS' review of determinations of APTC made by State Exchanges, and to provide a mechanism for HHS and State Exchanges to share information that would aid in developing an efficient measurement process.

In 2019, HHS developed an initiative to provide the State Exchanges with an opportunity to voluntarily engage with HHS to prepare for future measurement of improper payments of APTC. HHS provided three options to State Exchanges—program analysis, program design, and piloting—designed to accommodate the State Exchanges' schedules and availability to participate in the initiative. Currently, of the 18 State Exchanges, 10 have participated in various levels of engagement.

HHS proposes that the proposed IPPTA would replace the current, voluntary State engagement initiative. HHS additionally proposes that activities already completed by State Exchanges as part of the current voluntary engagement may be used to satisfy elements of the proposed IPPTA. HHS has determined that participation from all State Exchanges is required in order to test processes and procedures that would prepare the State Exchanges for the planned measurement of improper payments of APTC.

Therefore, we propose to establish a new subpart P under 45 CFR part 155 (containing §§ 155.1500 through 155.1515) to codify the proposed IPPTA requirements. The proposed regulations at subpart P would be applicable beginning in 2024 with each State Exchange being selected to participate for a period of one calendar year which would occur either in 2024 or 2025.

a. Purpose and Scope (§ 155.1500)

We are proposing to add new subpart P to part 155, which would address various State Exchange and HHS responsibilities. HHS may use Federal contractors as needed to support the performance of IPPTA.

We are proposing to add new § 155.1500 to convey the purpose and scope of the IPPTA.

At paragraph (a), we are proposing the purpose and scope of subpart P as setting forth the requirements of the IPPTA for State Exchanges. The proposed IPPTA is an initiative between HHS and State Exchanges. The proposed requirements are intended to prepare State Exchanges for the planned measurement of improper payments, test processes and procedures that support HHS' review of determinations of APTC made by State Exchanges, and provide a mechanism for HHS and State Exchanges to share information that would aid in developing an efficient measurement process.

b. Definitions (§ 155.1505)

We are proposing to codify the definitions that are specific to IPPTA and key to understanding the processes and procedures of IPPTA.

- We are proposing the definition of ''business rules'' to mean the State Exchange's internal directives defining, guiding, or constraining the State Exchange's actions when making eligibility determinations and related APTC calculations. For example, the internal directives, methodologies, algorithms, or policies that a State Exchange applies or executes on its own data to determine whether an applicant meets the eligibility requirements for a QHP and any associated APTC would be considered to be a business rule.
- We are proposing the definition of ''entity relationship diagram'' to mean a graphical representation illustrating the organization and relationship of the data elements that are pertinent to applications for QHP and associated APTC payments.
- We are proposing the definition of ''Pre-testing and assessment'' to mean the process that uses the procedures specified in § 155.1515 to prepare State Exchanges for the planned measurement of improper payments of APTC.
- We are proposing the definition of ''Pre-testing and assessment checklist'' to mean the document that contains criteria that HHS will use to review a State Exchange's completion of the requirements of the IPPTA.
- We are proposing the definition of ''Pre-testing and assessment data request form'' to mean the document that

42 CFR 423.890 (Retiree Drug Subsidy (RDS) Appeals); 42 CFR 411.120–124 (Group Health Plan Non-conformance Appeals); 42 CFR 417.640, 417.492. 417.500, 417.494 (Health Maintenance Organization Competitive Medical Plan (HMO/CMP) Contract Related Appeals); 42 CFR 423.2345 (Termination of Discount Program Agreement Appeals).

[184] PIIA, 31 U.S.C. 3352 (2020).

specifies the structure for the data elements that HHS would require each State Exchange to submit.

• We are proposing the definition of ''Pre-testing and assessment period'' to mean the timespan during which HHS will engage in the pre-testing and assessment procedures with a State Exchange. The pre-testing and assessment period will cover one calendar year.

• We are proposing the definition of ''Pre-testing and assessment plan'' to mean the template developed by HHS in collaboration with each State Exchange enumerating the procedures, sequence, and schedule to accomplish the pre-testing and assessment.

• We are proposing the definition of ''Pre-testing and assessment report'' to mean the summary report provided by HHS to each State Exchange at the end of the State Exchange's pre-testing and assessment period that will include, but not be limited to, the State Exchange's status regarding completion of each of the pre-testing and assessment procedures specified in proposed § 155.1515, as well as observations and recommendations that result from processing and testing the data submitted by the State Exchange to HHS. At § 155.1515(g), we are proposing that the pre-testing and assessment report is intended to be used internally by HHS and each State Exchange as a reference document for performance improvement. The pre-testing and assessment report will not be released to the public by HHS unless otherwise required by law.

c. Data Submission (§ 155.1510)

We are proposing to add new § 155.1510 which would address the data submission requirements to support the IPPTA. Consistent with this, we are proposing to establish a pre-testing and assessment data request form to collect and compile information from each State Exchange. As explained below in section IV., Collection of Information Requirements, the pre-testing and assessment data request form has been submitted to OMB for review and approval. As described below, HHS proposes that each State Exchange submit to HHS a sample of no fewer than 10 tax household identification numbers (that is, the record of a tax household that applied for and was determined eligible to enroll in a QHP and was determined eligible to receive APTC in an amount greater than $0).

• At paragraph (a)(1), we are proposing that a State Exchange would be required to submit to HHS by the deadline in the pre-testing and assessment plan the following documentation for their data: (i) the State Exchange's data dictionary including attribute name, data type, allowable values, and description; (ii) an entity relationship diagram, which shall include the structure of the data tables and the residing data elements that identify the relationships between the data tables; and (iii) business rules and related calculations.

• At paragraph (a)(2), we are proposing that the State Exchange must use the pre-testing and assessment data request form, or other method as specified by HHS, to submit to HHS the application data associated with no fewer than 10 tax household identification numbers and the associated policy identification numbers that address scenarios specified by HHS to allow HHS to test all of the pre-testing and assessment processes and procedures. The proposed scenarios would include various application characteristics such as household composition, data matching inconsistencies (for example, SSN, citizenship, lawful presence, annual income) identified for the applications, special enrollment period application types (for example, relocation, marriage), periodic data matching (for example, Medicaid/CHIP, Medicare, death), application status (for example, policy terminated, policy canceled), and application types (for example, initial application). HHS understands that it is unlikely that the application data associated with a singular tax household could address all of the characteristics contained in all of the scenarios specified. Therefore, HHS proposes that while the application data for each tax household does not need to address all of the scenarios specified, the application data submitted for no fewer than 10 tax households should, when taken together as a whole, address all of the characteristics in all of the scenarios specified. For example, the application data for one tax household may address lawful presence inconsistency adjudication but not special enrollment eligibility verification. Accordingly, the application data for another tax household should address special enrollment eligibility verification. After receiving the application data associated with no fewer than 10 tax households from the State Exchange, HHS would test the data from each of the tax households against its review procedures to determine if the respective policy applications fulfill the scenarios. If the submitted application data does not collectively fulfill the scenarios, HHS would coordinate with the State Exchange to select additional tax households. For the data submitted, HHS would also require the State Exchange to provide digital copies such as PDFs of supporting consumer-submitted documentation (for example, proof of residency, proof of citizenship).

• In proposed § 155.1515(e)(2), HHS proposes that for each of the tax households, the State Exchange would align and populate the data in the pre-testing and assessment data request form with the assistance of HHS. HHS would require that the State Exchange electronically transmit the completed pre-testing and assessment data request form to HHS within the deadline specified in the pre-testing and assessment plan. Once HHS receives the transmission from the State Exchange, HHS then would execute the pre-testing and assessment processes and procedures on the application data.

• At paragraph (b), we are proposing the requirement that a State Exchange must submit the data documentation as specified in § 155.1510(a)(1) and the application data associated with no fewer than 10 tax households as specified in § 155.1510(a)(2) within the timelines in the pre-testing and assessment plan specified in § 155.1515.

d. Pre-Testing and Assessment Procedures (§ 155.1515)

We are proposing to add new § 155.1515 which would address the requirements associated with the pre-testing and assessment procedures that underlie and support the IPPTA. The pre-testing and assessment procedures are the activities of the IPPTA that are, in part, designed to test HHS' review processes and procedures that support HHS' review of determinations of the APTC made by State Exchanges, to improve the State Exchange's understanding of the IPPTA, to prepare State Exchanges for the planned measurement of improper payments, and to provide HHS and the State Exchanges with a mechanism to share information that would aid in developing an efficient measurement process.

• At paragraph (a), we are proposing the general requirement that the State Exchange must participate in the IPPTA for a period of one calendar year that would occur in either 2024 or 2025, and that the State Exchange and HHS would work together to execute the IPPTA procedures in accordance with timelines in the pre-testing and assessment plan.

• At paragraph (b), we are proposing the requirements for the orientation and planning processes.

• At paragraph (b)(1), we are proposing HHS would provide State Exchanges with an overview of the pre-testing and assessment procedures as part of the orientation process. We are also proposing that, during the orientation process, HHS would identify the documentation that a State Exchange must provide to HHS for pre-testing and assessment. For example, if data use agreements or information exchange agreements need to be executed, HHS would inform State Exchanges about that documentation requirement.

• At paragraph (b)(2), we are proposing that HHS, in collaboration with each State Exchange, would develop a pre-testing and assessment plan as part of the orientation process. The pre-testing and assessment plan would be based on a template that enumerates the procedures, sequence, and schedule to accomplish pre-testing and assessment. While HHS would need to meet milestones specified in the schedule and applicable deadlines due to the time span allotted for this proposed program, HHS would take into account feedback from the State Exchanges in an effort to minimize burden. The pre-testing and assessment plan would take into consideration relevant activities, if any, that were completed during a prior, voluntary, State engagement. The pre-testing and assessment plan would include the pre-testing and assessment checklist.

• At paragraph (b)(3), we are proposing that HHS will issue a pre-testing and assessment plan specific to a State Exchange at the conclusion of the pre-testing and assessment planning process. The pre-testing and assessment plan would be for HHS and State Exchange internal use only and would not be made available to the public by HHS unless otherwise required by law.

• At paragraph (c), we are proposing the requirements associated with notifications and updates.

• At paragraph (c)(1), we are proposing the requirements associated with HHS' responsibility to notify State Exchanges, as needed throughout the pre-testing and assessment period, concerning information related to the pre-testing and assessment processes and procedures.

• At paragraph (c)(2), we are proposing the requirements associated with information State Exchanges must provide to HHS throughout the pre-testing and assessment period regarding any operational, policy, business rules (for example, data elements and table relationships), information technology, or other changes that may impact the ability of the State Exchange to satisfy the requirements of the IPPTA during the pre-testing and assessment period. For example, HHS would need to be made aware of changes to the State Exchange's technical platform or modifications to its policies or procedures as these changes may impact specific pre-testing and assessment processes or procedures, the data to be reviewed, and ultimately a State Exchange's determinations of an applicant's eligibility for APTC. We are proposing that other decisions or changes made by a State Exchange, which could affect the pre-testing and assessment including any changes regarding items such as naming conventions or definitions of specific data elements used in the pre-testing and assessment, must be submitted to HHS. We propose this requirement because any lack of clarity in how State Exchanges make eligibility determinations and payment calculations could impact HHS' ability to assist the State Exchange in understanding the pre-testing and assessment processes and procedures and could affect HHS' recommendations in the pre-testing and assessment report.

• At paragraph (d), we are proposing the requirements regarding the submission of required data and data documentation by State Exchanges, and we state that, as specified in § 155.1510(a) of this subpart, HHS will inform State Exchanges about the form and manner for State Exchanges to submit required data and data documentation to HHS in accordance with the pre-testing and assessment plan.

• At paragraph (e), we are proposing the general requirements regarding coordination between HHS and the State Exchanges to facilitate HHS' processing of data and data documentation submitted by State Exchanges.

• At paragraph (e)(1), we are proposing the requirements associated with HHS' responsibility to coordinate with each State Exchange to track and manage the data and data documentation submitted by a State Exchange as specified in § 155.1510(a)(1) and (a)(2).

• At paragraph (e)(2), we are proposing the requirements associated with HHS' responsibility to coordinate with each State Exchange to provide assistance in aligning the data specified in § 155.1510(a)(2) from the State Exchange's existing data structure to HHS' standardized set of data elements.

• At paragraph (e)(3), we are proposing the requirement that HHS will coordinate with each State Exchange to interpret and validate the data specified in § 155.1510(a)(2).

• At paragraph (e)(4), we are proposing the requirement that HHS would use the data and data documentation submitted by the State Exchange to execute the pre-testing and assessment procedures.

• At paragraph (f), we are proposing the requirements that HHS would issue the pre-testing and assessment checklist in conjunction with and as part of the pre-testing and assessment plan. The pre-testing and assessment checklist criteria we are proposing would include but would not be limited to:

++ At paragraph (f)(1), the State Exchange's submission of the data documentation as specified in § 155.1510(a)(1);

++ At paragraph (f)(2), the State Exchange's submission of the data for processing and testing as specified in § 155.1510(a)(2); and

++ At paragraph (f)(3), the State Exchange's completion of the pre-testing and assessment processes and procedures related to the IPPTA program.

• At paragraph (g), we are proposing that, subsequent to the completion of a State Exchange's pre-testing and assessment period, HHS will prepare and issue a pre-testing and assessment report specific to that State Exchange. The report would be for HHS and State Exchange internal use only and would not be made available to the public by HHS unless otherwise required by law.

We seek comments on these proposals.

C. 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 2024 Benefit Year (§ 156.50)

For the 2024 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 the total monthly premiums. Section 1311(d)(5)(A) of the ACA 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 ACA 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 A–25 established Federal policy regarding user fees and what the fees can be used for. In particular, it specifies 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 Rates for the 2024 Benefit Year

Based on estimated costs, enrollment (including anticipated establishment of State Exchanges in certain States in which FFEs currently are operating), and premiums for the 2023 plan year, we propose a 2024 user fee rate for all participating FFE issuers of 2.5 percent of total monthly premiums.

In § 156.50(c)(1), 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 2023, issuers seeking to participate in an FFE in the 2024 benefit year will receive two special benefits not available to the general public: (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 2024 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 2024 benefit year of costs for operating the Federal Exchanges, premiums, enrollment, and transitions in Exchange models (from the FFE and SBE–FP models to either the SBE–FP or State Exchange models). To develop the proposed 2024 benefit year FFE user fee rates, we considered a range of costs, premium and enrollment projections.[185] We estimated stable contract costs on FFE user fee eligible costs from the 2023 benefit year. We took a number of factors into consideration in choosing which premium and enrollment projections should inform the proposed 2024 FFE user fee rates. The enhanced PTC subsidies in section 9661 of the ARP were extended in section 12001 of the IRA through the 2025 benefit year. The extension of enhanced PTC subsidies significantly influenced our development of the 2024 enrollment and premium projections. We expect this provision of the IRA to sustain the higher enrollment levels observed in the 2021 benefit year after the ARP was established and as a result, we expect the projected total premiums where the user fee applies to increase, thereby increasing the amount of user fee that will be collected. Our 2024 enrollment estimates also account for the 2022 benefit year transition (and projected transitions through the 2024 benefit year) of States from FFEs or SBE–FPs to State Exchanges, as well as the enrollment impacts of section 1332 State innovation waivers. We project that 2024 benefit year premiums will generally increase at the rate of medical inflation. After considering the range of costs, premium and enrollment projections, we propose a 2024 user fee rate that will exert downward pressure on consumer premiums when compared to the user fee rate from prior years, and that also ensures adequate funding for Federal Exchange operations. The proposed FFE user fee rates for 2024 are slightly lower than the 2.75 percent FFE user fee rate that we established for the 2023 benefit year. After accounting for the impact of the lower user fee rate, we estimate that we would have sufficient funding available to fully fund user-fee eligible Exchange activities.

We seek comment on the proposed 2024 FFE user fee rate.

b. SBE–FP User Fee Rates for the 2024 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 2024 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–FP, unless the SBE–FP and HHS agree on an alternative mechanism to collect the funds from the SBE–FP or State instead of direct collection from SBE–FP issuers. SBE–FPs enter into a Federal platform agreement with HHS to leverage the systems established for the FFEs to perform certain Exchange functions, and to 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 Federal Exchange 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 ACA, 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 user fee eligible FFE costs that are associated with the FFE information technology infrastructure, the consumer call center infrastructure, and eligibility and enrollment services, and allocating a share of those costs to issuers in the relevant SBE–FPs.

To calculate the proposed SBE–FP rates for the 2024 benefit year, we used the same assumptions on contract costs, enrollment, and premiums as the proposed FFE user fee rates. The user fee rate for SBE–FPs is calculated based on the proportion of the total FFE costs utilized by SBE–FPs, such as the costs associated with the FFE information technology infrastructure, the consumer call center infrastructure, and eligibility and enrollment services and other applicable State health subsidy programs, which we estimate to be approximately 80 percent. Based on this methodology, the proposed 2024 SBE–FP user fee rate is lower than the user fee rate of 2.25 percent of premiums that we established for the 2023 benefit year. The lower proposed user fee rate for SBE–FP issuers for the 2024 benefit year reflects our estimates of costs for operating the Federal Exchanges, premiums, enrollment, as well as State Exchange transitions for the 2024 benefit year, and the costs associated

[185] We used the most recent projections from the Congressional Budget Office (*https://www.cbo.gov/publication/57962*) and our own internal data.

with performing these services that benefit SBE–FP issuers.

We seek comment on the proposed 2024 SBE–FP user fee rate.

2. Publication of the 2024 Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage in Guidance (§ 156.130)

As established in part 2 of the 2022 Payment Notice, HHS will publish the premium adjustment percentage, the required contribution percentage, maximum annual limitations on cost-sharing, and reduced maximum annual limitation on cost-sharing, in guidance annually starting with the 2023 benefit year. We note that these parameters are not included in this rulemaking, as HHS does not propose to change the methodology for these parameters for the 2024 benefit year, and therefore, HHS is required to publish these parameters in guidance no later than January 2023.

3. Standardized Plan Options (§ 156.201)

HHS proposes to exercise its authority under sections 1311(c)(1) and 1321(a)(1)(B) of the ACA to make minor updates to its approach with respect to standardized plan options for PY 2024 and subsequent PYs. Section 1311(c)(1) of the ACA directs the Secretary to establish criteria for the certification of health plans as QHPs. Section 1321(a)(1)(B) of the ACA directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the ACA with respect to, among other things, the offering of QHPs through such Exchanges.

Standardized plan options were first introduced in the 2017 Payment Notice, and defined at § 155.20. In the first iteration of standardized plan options, HHS finalized one set of standardized plan options designed to be similar to the most popular QHPs in the 2015 individual market FFEs at the bronze, silver, and gold metal levels. Issuers were not required to offer these standardized plan options. To facilitate plan shopping and to educate consumers about the distinctive cost-sharing features of standardized plan options, these plans were differentially displayed on *HealthCare.gov* under the authority at § 155.205(b)(1). Specifically, consumers had the ability to filter plan options to view only standardized plan options and received an accompanying message explaining how standardized plan options differed from non-standardized plan options.

In the 2018 Payment Notice, HHS finalized three new sets of standardized plan options. The original standardized plan options from the 2017 Payment Notice were updated to reflect changes in QHP enrollment data in 2016, to include SBE–FP data, and to account for State cost-sharing laws. Standardized plan options were once more differentially displayed, but this time, they were also labeled ''Simple Choice'' plans to make them more easily distinguishable from non-standardized plan options. HHS also established display requirements for approved web-brokers and QHP issuers using a direct enrollment pathway to facilitate enrollment through an FFE or SBE–FP—including both the Classic DE and EDE Pathways—at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv), respectively (81 FR 94117 through 94118, 94148; 45 CFR 155.220(l) and 155.221(i)). Under these requirements, these entities must differentially display standardized plan options in accordance with the requirements under § 155.205(b)(1) in a manner consistent with how standardized plan options are displayed on *HealthCare.gov,* unless HHS approved a deviation.

Standardized plan options were then discontinued in the 2019 Payment Notice, but 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.[186] The court reviewed nine separate policies HHS had promulgated in the 2019 Payment Notice, vacating four of them. The court specifically vacated the portion of the 2019 Payment Notice that ceased HHS' practice of designating some plans in the FFEs as ''standardized options,'' a policy that the 2019 Payment Notice stated was seeking to maximize innovation by issuers in designing and offering a wide range of plans to consumers (83 FR 16974 and 16975). Subsequently, HHS announced its intent to engage in rulemaking under which it would propose to resume standardized plan options in time for PY 2023.[187] Relatedly, President Biden's Executive Order on Promoting Competition in the American Economy directed HHS to implement standardized plan options in order to facilitate the plan selection process for consumers on the Exchanges.[188]

More recently, in the 2023 Payment Notice, HHS finalized the requirement for PY 2023 and beyond that issuers offering QHPs through FFEs and SBE–FPs must offer through the Exchange standardized QHP options designed by HHS at every product network type (as described in the definition of ''product'' at § 144.103), at every metal level, and throughout every service area that they offer non-standardized QHP options in the individual market. HHS did not require issuers in the small group market to offer these standardized plan options. Furthermore, HHS did not subject issuers in State Exchanges to these requirements. HHS also exempted issuers in FFEs and SBE–FPs that are 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,[189] from the requirement to offer the standardized plan options finalized in the 2023 Payment Notice.

In the 2023 Payment Notice, HHS finalized two sets of standardized plan options for two different sets of States 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. HHS did not finalize standardized plan option designs for the Indian CSR plan variations as provided for at § 156.420(b) given that the cost-sharing parameters for these plan variations are already largely specified, but HHS still required issuers to offer these plan variations for standardized plan options.[190]

In the 2023 Payment Notice, HHS also elaborated upon the methodology it utilized in creating the standardized plan options designs. Specifically, HHS explained that it designed these plans to be similar to the most popular QHPs in FFEs and SBE–FPs in PY 2021. This was done based on an examination of the proportion of consumers enrolled in plans with different cost sharing types (including copayment exempt from the deductible, copayment subject to the deductible, coinsurance exempt from

[186] 523 F. Supp. 3d 731 (D. Md. 2021).

[187] In part 3 of the 2022 Payment Notice, we explained that we would not be able to fully implement those aspects of the court's decision regarding standardized plan options in time for issuers to design plans and for Exchanges to be prepared to certify such plans as QHPs for PY 2022, and therefore, intended to address these issues in time for plan design and certification for PY 2023. See 86 FR 24140, 24264.

[188] Executive Order 14036 on Promoting Competition in the American Economy, July 9, 2021. See 86 FR 36987.

[189] See Or. Admin. R. 836–053–0009.

[190] See QHP Certification Standardized Plan Options FAQs, *https://www.qhpcertification.cms.gov/s/Standardized%20Plan%20Options%20FAQs.*

the deductible, and coinsurance subject to the deductible) for every benefit category in the actuarial value (AV) calculator at each metal level.

HHS chose the cost-sharing type with the majority or plurality of enrollees. HHS then chose the enrollee-weighted median values for this cost-sharing type as the copayment amount or coinsurance rate for each benefit category before modifying these plans to have an AV near the lower end of the de minimis range for each metal level to ensure the competitiveness of these plans. HHS applied this methodology in selecting the deductibles and MOOPs for these plans, as well.

HHS also explained that it designed two separate sets of standardized plan options in order to accommodate applicable cost-sharing laws in different sets of FFE and SBE–FP States, similar to the approach previously taken for standardized plan options. Specifically, in the 2018 Payment Notice, HHS designed three sets of standardized plan options tailored to unique cost-sharing laws in different States. The second and third sets of these standardized plan options differed from the first set only to the extent necessary to comply with State cost sharing laws.

The second set of standardized plan options in the 2018 Payment Notice was designed to work in States that: (1) require that cost sharing for physical therapy, occupational therapy, and speech therapy be no greater than the cost sharing for primary care visits; (2) limit the cost-sharing amount that can be charged for a 30-day supply of prescription drugs by tier; or (3) require that all drug tiers carry a copayment rather than coinsurance. The second set of standardized plan options applied to Arkansas, Delaware, Iowa, Kentucky, Louisiana, Missouri, Montana, and New Hampshire. The third set was designed to work in a State with maximum deductible requirements and other cost sharing standards. The third set of standardized plan options was designed to work in the Exchange in New Jersey, which has since transitioned to become a State Exchange and was thus outside the scope of this particular rulemaking.

HHS explained that it included several of the defining features of the second set of standardized plan options from the 2018 Payment Notice in the first set of standardized plan options in the 2023 Payment Notice. As a result, in the first set of standardized plan options, there was cost sharing parity between the primary care visit, the speech therapy, and the occupational and physical therapy benefit categories. There were also copayments for all prescription drug tiers, including the non-preferred brand and specialty tiers, instead of coinsurance rates. Finally, the copayment for the mental health/substance use disorder in-network outpatient office visit sub-classification was equal to the least restrictive level for copayments for medical/surgical benefits in the in-network, outpatient office visit sub-classification (and copayments applied to substantially all medical/surgical benefits in this sub-classification), to ensure issuers were able to design plans that comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its implementing regulations.[191] This first set of standardized plan options applied to all FFE and SBE–FP issuers, excluding those in Delaware and Louisiana.

HHS further explained that it included all of the defining features of the second set of standardized plan options from the 2018 Payment Notice in the second set of standardized plan options in the 2023 Payment Notice. As a result, in this set of standardized plan options, similar to the first set of standardized plan options, there was cost-sharing parity between the primary care visit, the speech therapy, and the occupational and physical therapy benefit categories, and there were copayments for all prescription drug tiers, including the non-preferred brand and specialty tiers, instead of coinsurance rates. Additionally, the copayment for the mental health/substance use disorder in-network outpatient office visit sub-classification was equal to the least restrictive level for copayments for medical/surgical benefits in the in-network, outpatient office visit sub-classification (and copayments applied to substantially all medical/surgical benefits in this sub-classification), to ensure issuers were able to design plans that comply with MHPAEA and its implementing regulations.

The feature that distinguished the first set of standardized plan options from the second is that the second set of standardized plan options had copayments of $150 or less for the specialty drug tiers of standardized plan options at all metal levels. This feature was included in the second set of standardized plan options in order to accommodate relevant specialty tier prescription drug cost sharing laws in Delaware and Louisiana (87 FR 674 through 676; 87 FR 27311 through 27313).[192]

In the 2023 Payment Notice, HHS also exercised the authority under § 155.205(b)(1) to resume the differential display of standardized plan options, including those standardized plan options required under State action taking place on or before January 1, 2020, on *HealthCare.gov* beginning with the PY 2023 open enrollment period. Similarly, also beginning with the PY 2023 open enrollment period, HHS resumed enforcement of the existing standardized plan options display requirements under §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv) for approved web-brokers and QHP issuers using a direct enrollment pathway to facilitate enrollment through an FFE or SBE–FP—including those using the Classic DE and EDE Pathways—meaning these entities were required to differentially display standardized plan options in a manner consistent with how standardized plan options were displayed on *HealthCare.gov,* unless HHS approved a deviation, beginning with the PY 2023 open enrollment period.

Most recently, after publishing the 2023 Payment Notice, HHS conducted extensive interested party engagement with a range of participants, including issuers, agents, brokers, web-brokers, States, State Exchanges, researchers, disease advocacy groups, and consumer support groups (87 FR 27318). HHS discussed a range of topics related to standardized plan options in these engagement sessions, including plan designs, cost sharing, pre-deductible coverage of particular benefits, formulary tiering, enhancing choice architecture, plan display on *HealthCare.gov,* reducing the risk of plan choice overload (either through direct limits on the number of non-standardized plan options or a revised version of the meaningful difference standard), and advancing health equity.

For PY 2024 and subsequent PYs, we would maintain a large degree of continuity with our approach to standardized plan options in the 2023 Payment Notice, except for minor updates as proposed in this section. First, in contrast to the policy finalized in the 2023 Payment Notice, we propose, for PY 2024 and subsequent PYs, to no longer include a standardized

[191] In general, MHPAEA requires that the financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on mental health or substance use disorder benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits in a classification.

[192] See 87 FR 674 through 676 and 87 FR 27311 through 27313 for a more detailed discussion on the methodology HHS used to create the standardized plan options in the 2023 Payment Notice.

plan option for the non-expanded bronze metal level. Accordingly, we propose at new § 156.201(b) that for PY 2024 and subsequent PYs, FFE and SBE–FP issuers offering QHPs through the Exchanges must offer standardized QHP options designed by HHS at every product network type (as described in the definition of ''product'' at § 144.103), at every metal level except the non-expanded bronze level, and throughout every service area that they offer non-standardized QHP options. We propose to re-designate the current regulation text at § 156.201 as paragraph (a) and revise it to apply only to PY 2023.

Thus, for PY 2024 and subsequent PYs, we propose standardized plan options for the following metal levels: 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. Consistent with our approach in the 2023 Payment Notice, we are not proposing standardized plan options for the Indian CSR plan variations as provided for at § 156.420(b) given that the cost-sharing parameters for these plan variations are already largely specified. We would continue to require issuers to offer these plan variations for all standardized plan options offered, and we propose to remove the regulation text language stating that standardized plan options for these plan variations are not required to clarify that while issuers must, under § 156.420(b), continue to offer such plan variations based on standardized plan options, those plan variations will themselves not be standardized plan options based on designs we will specify in this rulemaking.[193]

We propose to discontinue standardized plan options for the non-expanded bronze metal level mainly due to AV constraints. Specifically, it is not feasible to design a non-expanded bronze plan that includes any pre-deductible coverage while maintaining an AV within the permissible AV de minimis range for the non-expanded bronze metal level. Furthermore, few issuers chose to offer non-expanded bronze standardized plan options in PY 2023, with the majority of issuers offering bronze plans instead choosing to offer only expanded bronze standardized plan options. Thus, we believe discontinuing non-expanded bronze standardized plan options would minimize burden without any deleterious consequences. We also clarify that issuers would still be permitted to offer non-standardized plan options at the non-expanded bronze metal level, meaning consumers would still have the ability to choose these plan options if they so choose. We also clarify that if an issuer offers a non-standardized plan option at the bronze metal level, whether expanded or non-expanded, it would need to also offer an expanded bronze standardized plan option.

Similar to the approach taken in the 2023 Payment Notice, we propose to create standardized plan options that resemble the most popular QHP offerings that millions are already enrolled in by selecting the most popular cost-sharing type for each benefit category; selecting enrollee-weighted median values for each of these benefit categories based on refreshed PY 2022 cost-sharing and enrollment data; modifying these plans to be able 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.

Furthermore, consistent with the approach taken in the 2023 Payment Notice, we propose to create two sets of standardized plan options at the previously proposed metal levels, with the same sets of designs applying to the same sets of States as in the 2023 Payment Notice. Specifically, the first set of standardized plan options would continue to apply to FFE and SBE–FP issuers in all FFE and SBE–FP States, excluding those in Delaware, Louisiana, and Oregon, and the second set of standardized plan options would continue to apply to Exchange issuers specifically in Delaware and Louisiana. See Table 10 and Table 11 for the two sets of standardized plan options we propose for PY 2024.

In addition, since SBE–FPs use the same platform as the FFEs, we would continue to apply the standardized plan option requirements equally on FFEs and SBE–FPs. We continue to believe that proposing a distinction between FFEs and SBE–FPs for purposes of these requirements would create a substantial financial and operational burden that we believe outweighs the benefit of permitting such a distinction.

Also, consistent with our policy in PY 2023, we would continue to apply these requirements to applicable issuers in the individual market but not in the small group market. We also would continue to exempt issuers offering QHPs through FFEs and SBE–FPs that are 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,[194] from the requirement to offer the standardized plan options included in this rule. In addition, we would continue to exempt issuers in State Exchanges from these requirements for several reasons. First, we do not wish to impose duplicative standardized plan option requirements on issuers in the eight State Exchanges that already have standardized plan option requirements. Additionally, we continue to believe that State Exchanges are best positioned to understand both the nuances of their respective markets and consumer needs within those markets. Finally, we continue to believe that States that have invested the necessary time and resources to become State Exchanges have done so in order to implement innovative policies that differ from those on the FFEs, and we do not wish to impede these innovative policies so long as they comply with existing legal requirements.

Furthermore, consistent with the policy finalized in the 2023 Payment Notice, we would continue to differentially display standardized plan options, including those standardized plan options required under State action taking place on or before January 1, 2020, on *HealthCare.gov* under the authority at § 155.205(b)(1). We would also continue enforcement of the standardized plan options display requirements for approved web-brokers and QHP issuers using a direct enrollment pathway to facilitate enrollment through an FFE or SBE–FP—including both the Classic DE and EDE Pathways—at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv), respectively. This means that these entities would be required to differentially display the 2024 benefit year standardized plan options in accordance with the requirements under § 155.205(b)(1) in a manner consistent with how standardized plan options are displayed on *HealthCare.gov,* unless HHS approves a deviation, beginning with the 2024 benefit year open enrollment period. Consistent with our PY 2023 policy, any requests from web-brokers and QHP issuers seeking approval for an alternate differentiation format would continue to be reviewed based on whether the same or similar level of differentiation and clarity is being

[193] See QHP Certification Standardized Plan Options FAQs, *https://www.qhpcertification.cms.gov/s/Standardized%20Plan%20Options%20FAQs.*

[194] See Or. Admin. R. 836–053–0009.

provided under the requested deviation as is provided on *HealthCare.gov.*

Consistent with the approach to plan designs in the 2023 Payment Notice, we would also continue to use the following four tiers of prescription drug cost sharing in the proposed standardized plan options: generic drugs, preferred brand drugs, non-preferred brand drugs, and specialty drugs. We believe the use of four tiers of prescription drug cost-sharing in the standardized plan options will continue to allow for predictable and understandable drug coverage. We believe the use of four tiers of prescription drug cost-sharing will also play an important role in facilitating the consumer decision-making process by allowing consumers to more easily compare formularies between plans, and allow for easier year-to-year comparisons with their current plan. The continued use of four tiers will also minimize issuer burden since, for PY 2023, issuers have already created standardized plan options with formularies that include only four tiers of prescription drug cost-sharing. We will consider including additional drug tiers for future years, and invite comment on the appropriate number of drug tiers to use in standardized plan options in the future. However, we would continue to use four tiers of prescription drug cost-sharing in standardized plan options for PY 2024 and subsequent PYs to maintain continuity with our approach to standardized plan options in PY 2023.

We are aware of concerns that issuers may not be including specific drugs at appropriate cost-sharing tiers for the standardized plan options; for example, some issuers may be including brand name drugs in the generic drug cost-sharing tier, while others include generic drugs in the preferred or non-preferred brand drug cost-sharing tiers. We believe that consumers understand the difference between generic and brand name drugs, and that it is reasonable to assume that consumers expect that only generic drugs are covered at the cost-sharing amount in the generic drug cost-sharing tier, and that only brand name drugs are covered at the cost-sharing amount in the preferred or non-preferred brand drug cost-sharing tiers.

Accordingly, we propose to revise § 156.201 to add a new paragraph (c) specifying that issuers of standardized plan options must (1) place all covered generic drugs in the standardized plan options' generic drug cost-sharing tier, or the specialty drug tier if there is an appropriate and non-discriminatory basis in accordance with § 156.125 for doing so, and (2) place brand name drugs in either the standardized plan options' preferred brand or non-preferred brand tiers, or specialty drug tier if there is an appropriate and non-discriminatory basis in accordance with § 156.125 for doing so. For purposes of this proposal, ''non-discriminatory basis'' means there must be a clinical basis for placing a particular prescription drug in the specialty drug tier in accordance with § 156.125.

We also specify that within the Prescription Drug Template, for standardized plan options, issuers should enter zero cost preventive drugs for tier one, generic drugs for tier two, preferred brand drugs for tier three, non-preferred drugs for tier four, specialty drugs for tier five, and medical services drugs for tier six, if applicable.

We propose the approach described in this section for PY 2024 and subsequent PYs for several reasons. To begin, we are continuing to require FFE and SBE–FP issuers to offer standardized plan options in large part due to continued plan proliferation, which has only increased since the standardized plan option requirements were finalized in the 2023 Payment Notice. With this continued plan proliferation, it is increasingly important to continue to attempt to streamline and simplify the plan selection process for consumers on the Exchanges. We believe these standardized plan options can continue to play a meaningful role in that simplification by reducing the number of variables that consumers have to consider when selecting a plan option, thus allowing consumers to more easily compare available plan options. More specifically, with these standardized plan options, consumers will continue to be able to take other meaningful factors into account, such as networks, formularies, and premiums, when selecting a plan option. We further believe these standardized plan options include several distinctive features, such as enhanced pre-deductible coverage for several benefit categories, that will continue to play an important role in reducing barriers to access, combatting discriminatory benefit designs, and advancing health equity. Including enhanced pre-deductible coverage for these benefit categories will ensure consumers are more easily able to access these services without first meeting their deductibles. Furthermore, including copayments instead of coinsurance rates for a greater number of benefit categories will enhance consumer certainty and reduce the risk of unexpected financial harm sometimes associated with high coinsurance rates.

Additionally, given that insufficient time has passed to assess all the impacts of the standardized plan option requirements finalized in the 2023 Payment Notice, we propose to maintain a high degree of continuity with respect to many of the standardized plan option policies previously finalized to reduce the risk of disruption for all involved interested parties, including issuers, agents, brokers, States, and enrollees. We believe making major departures from the methodology used to create the standardized plan options as finalized in the 2023 Payment Notice could result in drastic changes in these plan designs that could potentially create undue burden for these interested parties. Furthermore, if the standardized plan options that HHS creates vary significantly from year to year, those enrolled in these plans could experience unexpected financial harm if the cost-sharing for services they rely upon differs substantially from the previous year. Ultimately, we believe consistency in standardized plan options is important to allow both issuers and enrollees to become accustomed to these plan designs.

We seek comment on our proposed approach to standardized plan options for PY 2024 and subsequent PYs. We also seek comment on the specific approach to tiering for these standardized plan options within the Prescription Drug Template.

TABLE 10: 2024 Proposed Standardized Plan Options Set One (For All FFE and SBE-FP Issuers, Excluding Issuers in Delaware, Louisiana, and Oregon)

	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Actuarial Value	64.39%	70.00%	73.00%	87.03%	94.06%	78.02%	88.10%
Deductible	$7,500	$6,000	$5,700	$700	$0	$1,500	$0
Annual Limitation on Cost Sharing	$9,400	$9,100	$7,200	$3,000	$1,800	$8,700	$3,200
Emergency Room Services	50%	40%	40%	30%	25%*	25%	$100*
Inpatient Hospital Services (Including Mental Health & Substance Use Disorder)	50%	40%	40%	30%	25%*	25%	$350*
Primary Care Visit	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Urgent Care	$75*	$60*	$60*	$30*	$5*	$45*	$15*
Specialist Visit	$100*	$80*	$80*	$40*	$10*	$60*	$20*
Mental Health & Substance Use Disorder **Outpatient** ***Office Visit***	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Imaging (CT/PET Scans, MRIs)	50%	40%	40%	30%	25%*	25%	$100*
Speech Therapy	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Occupational, Physical Therapy	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Laboratory Services	50%	40%	40%	30%	25%*	25%	$30*
X-rays/Diagnostic Imaging	50%	40%	40%	30%	25%*	25%	$30*
Skilled Nursing Facility	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Facility Fee (Ambulatory Surgery Center)	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Surgery Physician & Services	50%	40%	40%	30%	25%*	25%	$150*
Generic Drugs	$25*	$20*	$20*	$10*	$0*	$15*	$5*
Preferred Brand Drugs	$50	$40*	$40*	$20*	$15*	$30*	$10*
Non-Preferred Brand Drugs	$100	$80	$80	$60	$50*	$60*	$50*
Specialty Drugs	$500	$350	$350	$250	$150*	$250*	$150*

*Benefit category not subject to the deductible.

TABLE 11: 2024 Proposed Standardized Plan Options Set Two (For Exchange Issuers in Delaware and Louisiana)

	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Actuarial Value	64.39%	70.00%	73.00%	87.04%	94.08%	78.04%	88.11%
Deductible	$7,500	$6,000	$5,700	$700	$0	$1,500	$0
Annual Limitation on Cost Sharing	$9,400	$9,100	$7,200	$3,000	$1,900	$8,700	$3,200
Emergency Room Services	50%	40%	40%	30%	25%*	25%	$100*
Inpatient Hospital Services (Including Mental Health & Substance Use Disorder)	50%	40%	40%	30%	25%*	25%	$350*
Primary Care Visit	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Urgent Care	$75*	$60*	$60*	$30*	$5*	$45*	$15*
Specialist Visit	$100*	$80*	$80*	$40*	$10*	$60*	$20*
Mental Health & Substance Use Disorder **Outpatient** ***Office Visit***	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Imaging (CT/PET Scans, MRIs)	50%	40%	40%	30%	25%*	25%	$100*
Speech Therapy	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Occupational, Physical Therapy	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Laboratory Services	50%	40%	40%	30%	25%*	25%	$30*
X-rays/Diagnostic Imaging	50%	40%	40%	30%	25%*	25%	$30*
Skilled Nursing Facility	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Facility Fee (Ambulatory Surgery Center)	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Surgery Physician & Services	50%	40%	40%	30%	25%*	25%	$150*
Generic Drugs	$25*	$20*	$20*	$10*	$0*	$15*	$5*
Preferred Brand Drugs	$50	$40*	$40*	$20*	$5*	$30*	$10*
Non-Preferred Brand Drugs	$100	$80	$80	$60	$10*	$60*	$50*
Specialty Drugs	$150	$125	$125	$100	$20*	$100*	$75*

*Benefit category not subject to the deductible.

4. Non-Standardized Plan Option Limits (§ 156.202)

At § 156.202, HHS proposes to exercise the authority under sections 1311(c)(1) and 1321(a)(1)(B) of the ACA to limit the number of non-standardized plan options that issuers of QHPs can offer through Exchanges on the Federal platform (including State-based Exchanges on the Federal Platform) to two non-standardized plan options per product network type (as described in the definition of ''product'' at § 144.103) and metal level (excluding catastrophic plans), in any service area, for PY 2024 and beyond, as a condition of QHP certification. Section 1311(c)(1) of the ACA directs the Secretary to establish criteria for the certification of health plans as QHPs. Section 1321(a)(1)(B) of the ACA directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the ACA with respect to, among other things, the offering of QHPs through such Exchanges.

Under this proposed requirement, an issuer would, for example, be limited to offering through an Exchange two gold HMO and two gold PPO non-standardized plan options in any service area in PY 2024 or any subsequent PY. As an additional clarifying example, if an issuer wanted to offer two Statewide bronze HMO non-standardized plan options as well as two additional bronze HMO non-standardized plan options in one particular service area that covers less than the entire State, in the service areas that all four plans would cover, the issuer could choose to offer through the Exchange either the two bronze HMO non-standardized plan options offered Statewide or the two bronze HMO non-standardized plan options offered in that particular service area (or any combination thereof, so long as the total number of non-standardized plan options does not exceed the limit of two per issuer, product network type, and metal level in the service area).

Similar to the approach taken with respect to standardized plan options in the 2023 Payment Notice and in this proposed rule, HHS proposes to not apply this requirement to issuers in State Exchanges for several reasons. First, HHS does not wish to impose duplicative requirements on issuers in the State Exchanges that already limit the number of non-standardized plan options. Additionally, HHS believes that State Exchanges are best positioned to understand both the nuances of their respective markets and consumer needs within those markets. Finally, HHS

believes that States that have invested the necessary time and resources to become State Exchanges have done so in order to implement innovative policies that differ from those on the FFEs, and HHS does not wish to impede these innovative policies, so long as they comply with existing legal requirements.

However, consistent with the approach taken with respect to standardized plan options in the 2023 Payment Notice and in this this proposed rule, since SBE–FPs use the same platform as the FFEs, HHS proposes to apply this requirement equally on FFEs and SBE–FPs. HHS believes that proposing a distinction between FFEs and SBE–FPs for purposes of this requirement would create a substantial financial and operational burden that HHS believes outweighs the benefit of permitting such a distinction.

Finally, also in alignment with the approach taken with standardized plan options in the 2023 Payment Notice as well as the approach taken in this proposed rule, HHS proposes that this proposed requirement would not apply to plans offered through the SHOPs or to SADPs, given that the nature of these markets differ substantially from the individual medical QHP market, in terms of issuer participation, plan offerings, plan enrollment, and services covered. For example, the degree of plan proliferation observed in individual market medical QHPs over the last several plan years is not evident to the same degree for QHPs offered through the SHOPs or for SADPs offered in the individual market. For these reasons, HHS does not believe the same requirements should be applied to these other markets.

HHS believes that given the large number of plan offerings that would continue to exist on the Exchanges, a sufficiently diverse range of plan offerings would still exist for consumers to continue to select innovative plans that meet their unique health needs, even if HHS did ultimately choose to limit the number of non-standardized plan options that issuers can offer. Thus, even if consumers believe that their health needs may not be best met with the standardized plan options included in this current rulemaking, they would still have the option to select from a sufficient number of other non-standardized plan options.

Under this proposed limit, we estimate that the weighted average number of non-standardized plan options (which does not take into consideration standardized plan options) available to each consumer would be reduced from approximately 107.8 in PY 2022 to 37.2 in PY 2024, which we believe still provides consumers with a sufficient number of plan offerings.[195] Additionally, we estimate that of a total of 106,037 non-standardized plan option plan-county combinations offered in PY 2022, approximately 60,949 (57.5 percent) of these plan-county combinations would no longer be permitted to be offered, a number we believe would still provide consumers with a sufficient degree of choice during the plan selection process.[196]

Finally, if this limit were adopted, we estimate that of the approximately 10.21 million enrollees in the FFEs and SBE–FPs in PY 2022, approximately 2.72 million (26.6 percent) of these enrollees would have their current plan offerings affected, and issuers would therefore be required to select another QHP to crosswalk these enrollees into for PY 2024.[197] CMS would utilize the existing discontinuation notices and process as well as the current re-enrollment hierarchy at § 155.335(j) to ensure a seamless transition and continuity of coverage for affected enrollees. In addition, CMS would ensure that the necessary consumer assistance would be made available to affected enrollees as part of the expanded funding for Navigator programs.

In the 2023 Payment Notice, HHS solicited comment on enhancing choice architecture and on preventing plan choice overload for consumers on *HealthCare.gov* (87 FR 689 through 691 and 87 FR 27345 through 27347). In this comment solicitation, HHS noted that although it continues to prioritize competition and choice on the Exchanges, it was concerned about plan choice overload, which can result when consumers have too many choices in plan options on an Exchange. HHS 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 information.[198] HHS 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.[199]

With this concern in mind, HHS explained in the 2023 Payment Notice that it was interested in exploring possible methods of improving choice architecture and preventing plan choice overload. HHS expressed interest in exploring the feasibility and utility of limiting the number of non-standardized plan options that FFE and SBE–FP issuers can offer through the Exchanges in future plan years 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 Exchanges. Accordingly, HHS sought comment on the impact of limiting the number of non-standardized plan options that issuers can offer through the Exchanges, on effective methods to achieve this goal, the advantages and disadvantages of these methods, and if there were alternative methods not considered.

In response to this comment solicitation, many commenters agreed that the number of plan options that consumers can choose from on the Exchanges has increased beyond a point that is productive for consumers. Many of these commenters further explained that consumers do not have the time, resources, our health literacy to be able to meaningfully compare all available plan options. These commenters also agreed that when consumers are faced with an overwhelming number of plan options, many of which are similar with only minor differences between them, the risk of plan choice overload is significantly exacerbated.

Similarly, during the standardized plan option interested party engagement

[195] Utilizing weighted as opposed to unweighted 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 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. Weighting averages allows a more representative metric to be calculated that more closely resembles the actual experience of enrollees.

[196] Plan-county combinations are the count of unique plan ID and FIPS code combinations. This measure is 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 service area, for example.

[197] These calculations assume that the non-standardized plan options removed due to the proposed limit would be those with the fewest enrollees based on PY 2022 data, which includes individual market medical QHPs for Exchanges using the *HealthCare.gov* eligibility and enrollment platform, including SBE–FPs.

[198] Taylor EA, Carman KG, Lopez A, Muchow AN, Roshan P, and Eibner C. Consumer Decisionmaking in the Health Care Marketplace. RAND Corporation. 2016.

[199] 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.

sessions HHS conducted after publishing the 2023 Payment Notice, many participants agreed that the number of plan options was far too high and supported taking additional action to prevent plan choice overload. In short, many 2023 Payment Notice commenters and interested party engagement participants supported limiting the number of non-standardized plan options that issuers can offer to streamline the plan selection process for consumers on the Exchanges.

In addition, current QHP submission data provide support for the argument that enacting such a limit would be beneficial for consumers. For example, it is estimated that there will be a weighted average of 113.6 plans available per enrollee on *HealthCare.gov* in PY 2023 compared to a weighted average of 107.8 plans available per enrollee in PY 2022 and a weighted average of 25.9 plans available per enrollee in PY 2019.[200] Similarly, it is expected that there will be a weighted average of 18.3 plan offerings per issuer in PY 2023 compared to 17.1 plan offerings per issuer in PY 2022 and 9.7 plan offerings per issuer in PY 2019.[201] With this continued plan proliferation for both enrollees and issuers, HHS believes that limiting the number of non-standardized plan options that FFE and SBE–FP issuers of QHPs can offer through the Exchanges beginning in PY 2024 could greatly enhance the consumer experience on *HealthCare.gov.*

To reduce the risk of plan choice overload, HHS also considered solely focusing on enhancing choice architecture on *HealthCare.gov,* instead of enhancing choice architecture in conjunction with limiting the number of non-standardized plan options that issuers can offer, an approach recommended by several commenters in the 2023 Payment Notice. HHS agrees that enhancements to the consumer experience on *HealthCare.gov* are critical in ensuring that consumers are able to more meaningfully compare plan choices and more easily select a health plan that meets their unique health needs. As such, HHS made several enhancements to *HealthCare.gov* for the open enrollment period for PY 2023. HHS also intends to continue conducting research to inform further enhancements to the consumer experience on *HealthCare.gov* for PY 2024 and subsequent plan years.

That said, HHS believes that enhancing choice architecture on *HealthCare.gov* is necessary but, alone, insufficient to reduce the risk of plan choice overload for several reasons. First, *HealthCare.gov* is not the only pathway for consumers to search for, compare, select, and enroll in a QHP, and it is not the only information resource consumers seek when considering Exchange coverage. Instead, consumers shop through a multitude of channels, sometimes utilizing a mix of customer service channels including the Marketplace Call Center; online on *HealthCare.gov;* through assisters, agents, and brokers; and through certified enrollment partners (such as Classic DE and EDE web brokers and issuers). Thus, HHS believes that consumers enrolling in QHPs through these alternative pathways would not benefit to the same degree as those enrolling through *HealthCare.gov* if HHS focused on reducing plan choice overload solely by making enhancements to *HealthCare.gov.* Moreover, considering that an increasingly greater portion of QHP enrollment is occurring through these alternative enrollment pathways, HHS believes that a more comprehensive approach to reducing plan choice overload that would also benefit those utilizing these alternative enrollment pathways is required.

Furthermore, while enhancements to choice architecture and the plan comparison experience can play a critical role in streamlining the plan selection process and reducing the risk of plan choice overload, the number of plans available per enrollee has increased beyond a number that is beneficial for consumers, and this high number of plan choices makes it increasingly difficult to meaningfully manage choice architecture on *HealthCare.gov* and through other Exchange customer service channels.

Relatedly, HHS believes that low-income consumers would particularly benefit from a policy that limits the number of plans. This is because silver plans deliver the most value to low-income consumers, but it is exactly these consumers—who often have the lowest health insurance literacy—who now face choosing among the highest number of near-duplicate silver plans, which will continue unless limits on the number of these plans are set. Near-duplicate plans are the most difficult to filter and sort out by interface improvements.

As such, HHS believes that having an excessive number of plans (particularly those at the silver metal level) places an inequitable burden on those who need insurance the most, those who face the greatest challenges in selecting the most suitable health plan, and those who can least withstand the consequences of choosing a plan that costs too much and delivers too little. For this reason, HHS believes that reducing the number of available plans (particularly silver plans) by limiting the number of non-standardized plan options that issuers can offer, can play an important role in advancing the agency's commitments to health equity.

In short, HHS believes that limiting the number of non-standardized plan options that issuers can offer in conjunction with enhancing the plan comparison experience on *HealthCare.gov* is the most effective method to streamline the plan selection process and to reduce the risk of plan choice overload for consumers on the *HealthCare.gov* Exchanges.

As an alternative to limiting the number of non-standardized plan options that issuers in FFEs and SBE–FPs can offer through the Exchanges to reduce the risk of plan choice overload, HHS could also apply a meaningful difference standard. Such a standard was previously codified at § 156.298.

The original meaningful difference standard was introduced in the 2015 Payment Notice, revised in the 2017 Payment Notice, and discontinued and removed from regulation in the 2019 Payment Notice. The meaningful difference standard was originally intended to enhance the consumer experience on the Exchanges by preventing duplicative plan offerings. The decision to discontinue the meaningful difference standard in the 2019 Payment Notice was made largely due to the decreased number of plan offerings on the Exchanges (that is, there was a weighted average of 25.9 plans available per enrollee in PY 2019), as well as the low number of plans flagged under the prior review.

Under the original meaningful difference standard introduced in the 2015 Payment Notice, a plan was considered to be ''meaningfully different'' from another plan in the same service area and metal tier (including catastrophic plans) if a reasonable consumer would be able to identify one or more material differences among the following characteristics between the plan and other plan offerings: (1) cost sharing; (2) provider networks; (3) covered benefits; (4) plan type; (5) Health Savings Account eligibility; or (6) self-only, non-self-only, or child only plan offerings (79 FR 13813, 13840). Additionally, CMS believed that a

[200] Weighted averages were calculated by accounting for the number of enrollees in particular service areas, with service areas with a higher number of enrollees having a more significant impact on the overall average than service areas with a lower number of enrollees.

[201] Ibid.

reasonable consumer would be likely to identify a difference in MOOP of $100 or more or a difference in deductible of $50 for purposes of the meaningful difference standard.[202] The 2017 Payment Notice eliminated the Health Savings Account eligibility element, and revised the self-only, non-self-only, or child-only plan offerings element (87 FR 27208, 27345). In the 2017 Letter to Issuers, the MOOP and deductible dollar difference thresholds were increased to $500 and $250, respectively.[203]

In the 2023 Payment Notice comment solicitation on enhancing choice architecture and preventing plan choice overload (87 FR 27208, 27345), in addition to soliciting comment on limiting the number of non-standardized plan options that issuers can offer, HHS also solicited comment on resuming the meaningful difference standard as one potential method it could use to reduce the risk of plan choice overload. In response to this comment solicitation, many commenters and standardized plan option interested party engagement participants supported resuming the meaningful difference standard, with the caveat that the standard should be strengthened since the original version of the standard from the 2015 Payment Notice as well as the updated version of the standard from the 2017 Payment Notice both failed to meaningfully reduce duplicative plan offerings.

These commenters and workgroup participants further explained that earlier versions of the meaningful difference standard relied on several criteria and difference thresholds (that is, only having one difference among the following attributes: cost sharing, provider networks, covered benefits, plan type, Health Savings Account eligibility, or self-only, non-self-only, or child only plan offerings) which allowed issuers to more easily meet the standard. Several of these commenters and workgroup participants noted that no State Exchange currently utilizes the meaningful difference standard to reduce the risk of plan choice overload.

As such, HHS proposes, as an alternative to our proposal to limit the number of non-standardized plan options that an FFE or SBE–FP issuer may offer on the Exchange, to impose a new meaningful difference standard, which would be more stringent than the previous standard, for PY 2024 and subsequent PYs. Specifically, instead of including all of the criteria from the original standard from the 2015 Payment Notice (that is, cost sharing, provider networks, covered benefits, plan type, Health Savings Account eligibility, or self-only, non-self-only, or child only plan offerings), HHS proposes grouping plans by issuer ID, county, metal level, product network type, and deductible integration type, and then evaluating whether plans within each group are ''meaningfully different'' based on differences in deductible amounts.

With this proposed approach, two plans would need to have deductibles that differ by more than $1,000 to satisfy the new proposed meaningful difference standard. We believe that adopting this approach for a new meaningful difference standard would more effectively reduce the risk of plan choice overload and streamline the plan selection process for consumers on the Exchanges. With a dollar deductible difference threshold of $1,000, we estimate that the weighted average number of non-standardized plan options (which does not take into consideration standardized plan options) available to each consumer would be reduced from approximately 107.8 in PY 2022 to 53.2 in PY 2024, which we believe still provides consumers with a sufficient number of plan offerings. In addition, we estimate that of a total of 106,037 non-standardized plan option plan-county combinations offered in PY 2022, approximately 49,629 (46.8 percent) of these plan-county combinations would no longer be permitted to be offered, a number we believe would still provide consumers with a sufficient degree of choice during the plan selection process.[204] If this dollar deductible difference threshold were adopted, we estimate that of the approximately 10.21 million enrollees in the FFEs and SBE–FPs in PY 2022, approximately 2.64 million (25.9 percent) of these enrollees would have their current plan offerings affected.[205]

We seek comment on the feasibility and utility of limiting the number of non-standardized plan options that FFE and SBE–FP issuers can offer through the Exchanges beginning in PY 2024. We also seek comment on whether the limit of two non-standardized plan options per issuer, product network type, and metal level in any service area is the most appropriate approach, or if a stricter or more relaxed limit should be adopted instead. In addition, we seek comment on the advantages and disadvantages of utilizing a phased approached of limiting the number of non-standardized plan options (for example, if there were a limit of three non-standardized plan options per issuer, product network type, metal level, and service area for PY 2024, two for PY 2025, and one for PY 2026). We also seek comment on the effect that adopting such a limit would have on particular product network types, and whether this limit would cause a proliferation of product network types that are not actually differentiated for consumers.

Furthermore, we seek comment on whether we should consider additional factors, such as variations of products or networks, when limiting the number of non-standardized plan options—which would mean that issuers would be limited to offering two non-standardized plan options per product network type, metal level, product, and network variation (for example, by network ID) in any service area (or some combination thereof). If we were to adopt such an approach, issuers would be permitted to offer two non-standardized gold HMOs within one product as well as an additional two non-standardized gold HMOs within a second product in a particular service area, for example. This would also mean that issuers would be permitted to offer two non-standardized gold HMOs with one particular network ID as well as two additional non-standardized gold HMOs with a different network ID in a particular service area, for example.

We also seek comment on whether permitting additional variation only for specific benefits, such as adult dental and adult vision benefits, instead of permitting any variation in a product (for example, by product ID) would be more appropriate—which would mean,

[202] 2015 Letter to Issuers in the Federally-facilitated Marketplaces, chapter 3, section 3. Available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf.*

[203] 2017 Letter to Issuers in the Federally-facilitated Marketplaces, chapter 2, section 12. Available at *https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/final-2017-letter-to-issuers-2-29-16.pdf.*

[204] Plan-county combinations are the count of unique plan ID and FIPS code combinations. This measure is used because a single plan may be available in multiple counties, and specific limits on non-standardized plan options or specific dollar deductible difference thresholds 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.

[205] These calculations assume that the non-standardized plan options removed due to the proposed limit would be those with the fewest enrollees based on PY 2022 data, which includes individual market medical QHPs for Exchanges using the *HealthCare.gov* eligibility and enrollment platform, including SBE–FPs.

for example, that issuers could offer two gold HMO non-standardized plan options without adult vision and dental benefits and two gold HMO non-standardized plan options with adult vision and dental benefits in the same service area.

In addition, we seek comment on imposing a new meaningful difference standard in place of limiting the number of non-standardized plan options that issuers can offer. We also seek comment on additional or alternative specific criteria that would be appropriate to include in the meaningful difference standard to determine whether plans are ''meaningfully different'' from one another, including whether the same criteria and difference thresholds from the original standard from the 2015 Payment Notice or the updated difference thresholds from the 2017 Payment Notice should be instituted, or some combination thereof. Finally, we seek comment on the specific deductible dollar difference thresholds that would be appropriate to determine whether plans are considered to be ''meaningfully different'' from other plans in the same grouping, and whether a deductible threshold of $1,000 would be most appropriate and effective, or if a stricter or more relaxed threshold should be adopted instead.

5. QHP Rate and Benefit Information (§ 156.210)

a. Age on Effective Date for SADPs

We propose at new § 156.210(d)(1) to require issuers of stand-alone dental plans (SADPs), as a condition of Exchange certification, to use an enrollee's age at the time of policy issuance or renewal (referred to as age on effective date) as the sole method to calculate an enrollee's age for rating and eligibility purposes, beginning with Exchange certification for PY 2024. We propose that this requirement apply to Exchange-certified SADPs, whether sold on- or off-Exchange.

Since PY 2014, the process the FFEs use in QHP certification allows SADP issuers seeking certification of their SADPs to enter multiple options to explain how age is determined for rating and eligibility purposes. Because the Federal eligibility and enrollment platform operationalizes the rating and eligibility standards when an applicant seeks SADP coverage through an SBE–FP, issuers in SBE–FPs have also been required to comply with this part of the process. While market rules at § 147.102(a)(1)(iii) require medical QHP issuers to enter age on effective date as the method to calculate an enrollee's age for rating and eligibility purposes, SADP issuers have been able to enter any of the following four options in the Business Rules Template: (1) Age on effective date; (2) Age on January 1st of the effective date year; (3) Age on insurance date (age on birthday nearest the effective date); or (4) Age on January 1st or July 1st.[206]

Despite the availability of these other options for SADPs, age on effective date is the most commonly used age rating methodology; the vast majority of individual market SADP issuers have used the age on effective date method since PY 2014. Not only is it the most commonly used method, but it is also the most straightforward methodology for consumers to understand. For example, under the age on effective date method, if an enrollee is age 30 at the time of a plan's effective date, the enrollee is rated at age 30 for the rest of the plan year. The less commonly used options are likely more confusing for consumers, who may experience a mismatch between their age on the date on which they enrolled into an SADP versus the age on which the rate charged to them is based, due to the alternate age calculation methodologies. Thus, consumers can more easily understand the premium rate they are charged when the age on effective date method is used instead of the other methods, reducing consumers confusion.

Allowing Exchange-certified SADPs to rate by other methods imposes unnecessary complexity, not only to CMS as operator of the FFEs and the Federal eligibility and enrollment platform, but also to enrollment partners and consumers in the Exchanges on the Federal platform. For example, the added complexity results in occasional inability to effectuate enrollment due to the unclear logic used to support the uncommon and alternative Exchange-certified SADP rating methods, which require expensive manual workarounds for the Exchanges on the Federal platform and Exchange-certified SADP issuers. Using the other methods also affects the efficiency of Classic DE and EDE partners, who rely more on Application Programming Interfaces (APIs) and must account for these alternate Exchange-certified SADP age calculation methods. It is more challenging for the Classic DE and EDE partners to replicate the logic needed for enrolling consumers into Exchange-certified SADPs using methods other than the conventional age on effective date method. Additionally, the more complicated alternative age calculation methods currently in use make it more difficult for consumers to understand the premium rate they are charged. Thus, requiring Exchange-certified SADPs to use the age on effective date methodology to calculate an enrollee's age as a condition of QHP certification, and consequently removing the less commonly used and more complex age calculation methods, will reduce consumer confusion and promote operational efficiency.

By helping to reduce consumer confusion and promote operational efficiency during the QHP certification process, this proposed policy would help facilitate more informed enrollment decisions and enrollment satisfaction. Accordingly, we believe it is appropriate to extend this proposed certification requirement to SADPs seeking certification on the FFEs as well as the SBE–FPs and SBEs. We seek comment on any anticipated challenges that this proposal could present for SBEs using their own platform, and whether and to what extent we should, if this proposal is finalized, limit or delay this proposed certification requirement for those SBEs.

We acknowledge the potential that Exchange-certified SADPs whose issuers use the alternative age calculation methods could withdraw from the Exchanges rather than comply with this new requirement. However, we do not anticipate that any such issuers would choose to withdraw from the Exchanges because of this proposal; and even if an issuer were to withdraw, we would expect that any such withdrawal would cause minimal disruption to consumers and other Exchange-certified plans. Given that a large majority of Exchange-certified SADP issuers are already using the age on effective date method, and based on the current availability of such plans in all service areas, we do not anticipate that consumers or other Exchange-certified plans would be materially affected.[207]

We seek comment on this proposal to require Exchange-certified SADPs, whether sold on- or off-Exchange, to use age on effective date as the sole method

[206] See, for example, Qualified Health Plan Issuer Application Instructions, Plan Year 2023, Extracted section: Section 3B: Business Rules. *https://www.qhpcertification.cms.gov/s/Business%20Rules.*

[207] In the EHB Rule (78 FR at 12853), we operationalized section 1302(b)(4)(F) of the ACA to permit QHP issuers to omit coverage of the pediatric dental EHB if an Exchange-certified SADP exists in the same service area in which they intend to offer coverage. As a corollary, if no such SADP is offered through an Exchange in that service area, then all health plans offered through the Exchange in that service area would be required to provide coverage of the pediatric dental EHB, as section 2707(a) of the PHS Act requires all non-grandfathered plans in the individual and small group markets to provide coverage of the EHB package described at section 1302(a) of the ACA.

to calculate an enrollee's age for rating and eligibility purposes, beginning with PY 2024.

b. Guaranteed Rates for SADPs

We propose at new § 156.210(d)(2) to require issuers of SADPs, as a condition of Exchange certification, to submit guaranteed rates beginning with Exchange certification for PY 2024. We propose that this requirement apply to Exchange-certified SADPs, whether they are sold on- or off-Exchange.

SADPs are excepted benefits, as defined by section 2791(c)(2)(A) of the PHS Act and HHS implementing regulations at §§ 146.145(b)(3)(iii)(A) and 148.220(b)(1), and are not subject to the PHS Act insurance market reform provisions that generally apply to non-grandfathered health plans in the individual and group markets inside and outside the Exchange.[208] In particular, because SADP issuers are not required to comply with the premium rating requirement under section 2701 of the PHS Act applicable to non-grandfathered individual and small group health insurance coverage, we have permitted SADP issuers in the FFEs and SBE–FPs to comply with the rate information submission requirements at § 156.210 under a modified standard.[209] Specifically, CMS has historically granted SADP issuers the flexibility to offer guaranteed or estimated rates. By indicating the rate is a guaranteed rate, the SADP issuer commits to charging the consumer the approved premium rate, which has been calculated using consumers' geographic location, age, and other permissible rating factors. Estimated rates require enrollees to contact the issuer to determine a final rate.

This flexibility for SADPs to offer estimated rates was effective for SADP issuers beginning with PY 2014. It was necessary because the relevant certification template was originally designed to support medical QHPs, which forced operational limits that prevented the accurate collection of rating rules for SADPs. Since PY 2014, we have improved the certification templates to allow SADPs to set the maximum age for dependents to 18, and to rate all such dependents. Thus, the FFEs and SBE–FPs can now accommodate dental rating rules properly in most reasonable circumstances.

We believe this proposal would significantly benefit enrollees. Consistent with §§ 156.440(b) and 156.470, APTC may be applied to the pediatric dental EHB portion of SADP premiums. If SADP issuers submit estimated rates and subsequently modify their actual rates, the Exchanges, including State Exchanges (including State Exchanges on the Federal platform) and FFEs, could incorrectly calculate APTC for the pediatric dental EHB portion of a consumer's premium, which could potentially cause consumer harm. Thus, since low-income individuals may qualify for APTC[210] and are disproportionately impacted by limited access to affordable health care,[211] we believe this proposed policy change would help advance health equity by helping ensure that low-income individuals who qualify for APTC are charged the correct premium amount when enrolling in SADPs on the Exchange.

We acknowledge that requiring guaranteed rates presents a small risk that SADP issuers that offer estimated rates could cease offering SADPs on the Exchanges. While we recognize this risk, we strongly believe that the benefits of this proposal far exceed the disadvantages. Specifically, as discussed previously, we believe this proposed policy change would significantly reduce the risk of consumer harm by reducing the risk of incorrect APTC calculation for the pediatric dental EHB portion of premiums. Thus, we believe this proposed policy would have a positive financial impact by ensuring that SADP enrollees receive the correct APTC calculation for the pediatric dental EHB portion of premiums, and therefore, are charged the correct premium rate.

We also note that although the FFEs and SBE–FP issuers currently allow SADP issuers to submit estimated rates, the vast majority elect to submit guaranteed rates. The vast majority of SADP issuers offering on-Exchange and off-Exchange Exchange-certified SADPs also elect to submit guaranteed rates. Given that most SADP issuers already submit guaranteed rates, the majority of SADP issuers are unlikely to be impacted by this proposal.

Because we believe this proposed policy would significantly benefit enrollees by ensuring that SADP enrollees receive the correct APTC calculation for the pediatric dental EHB portion of premiums, and therefore, are charged the correct premium rate, we believe it is appropriate to apply this proposed certification requirement to SADPs seeking certification on the FFEs as well as the SBE–FPs and SBEs. We seek comment on any anticipated challenges that this proposal could present for SBEs using their own platform, and whether and to what extent we should, if this proposal is finalized, limit or delay this proposed certification requirement for those SBEs.

We seek comment on this proposal to require Exchange-certified SADP issuers to submit guaranteed rates as a condition of Exchange certification beginning with Exchange certification for PY 2024.

6. Plan and Plan Variation Marketing Name Requirements for QHPs (§ 156.225)

We propose to add a new paragraph (c) to § 156.225 to require that QHP plan and plan variation[212] marketing names include correct information, without omission of material fact, and do not include content that is misleading. If finalized as proposed, CMS would review plan and plan variation marketing names during the annual

[208] See 42 U.S.C. 300gg–21(b) and (c) and 42 U.S.C. 300gg–63(b). Examples of PHS Act insurance market reforms added by the ACA that do not apply to stand-alone dental plans include but are not limited to section 2702 guaranteed availability standards, section 2703 guaranteed renewability standards, and section 2718 medical loss ratio standards.

[209] See, for example, the 2014 Final Letter to Issuers on Federally-facilitated and State Partnership Exchanges for more information on how SADPs in the FFEs and SBE–FPs have flexibility to comply with the rate information submission requirements at § 156.210.

[210] The PTC is generally available to people who buy Marketplace coverage and who have a household income that equals or exceeds the Federal poverty level, and who meet other eligibility criteria.

[211] Research and policy analysis has shown that low-income individuals are disproportionately impacted by lack of access to affordable health care. According to a 2018 Health Affairs Health Policy Brief, compared to higher-income Americans, low-income individuals face greater barriers to accessing medical care. More specifically, low-income individuals are less likely to have health insurance, receive new drugs and technologies, and have ready access to primary and specialty care. *See* Khullar, D., & Chokshi, D. A. (2018). Health, Income, And Poverty: Where We Are And What Could Help. *Health Affairs. https://doi.org/10.1377/hpb20180817.901935.* Additionally, a 2007 study found that barriers to health care can be insurmountable for low-income families, even those with insurance coverage. In particular, this study found that families reported three major barriers to health care: lack of insurance coverage, poor access to services, and unaffordable costs. *See* DeVoe, J. E., Baez, A., Angier, H., Krois, L., Edlund, C., Carney, P. A. (2007). Insurance + Access ≠ Health Care: Typology of Barriers to Health Care Access for Low-Income Families. *Annals of Family Medicine, 5*(6), 511–518. *https://doi.org/10.1370/afm.748.*

[212] In practice, CMS and interested parties often use the term ''plan variants'' to refer to ''plan variations.'' Per § 156.400, plan variation means a zero-cost sharing plan variation, a limited cost sharing plan variation, or a silver plan variation. Issuers may choose to vary plan marketing name by the plan variant—for example, use one plan marketing name for a silver plan that meets the actuarial value (AV) requirements at § 156.140(b)(2), and a different name for that plan's equivalent that meets the AV requirements at § 156.420(a)(1), (2), or (3).

QHP certification process in close collaboration with State regulators in States with Exchanges on the Federal platform.

Section 1311(c)(1)(A) of the ACA states that the Secretary shall establish QHP certification criteria, which must include, at a minimum, that a QHP meet marketing requirements and not employ marketing practices or benefit designs that have the effect of discouraging enrollment by individuals with significant health needs. CMS, States, and QHP issuers work together to ensure that consumers can make informed decisions when selecting a health insurance plan based on factors such as QHP benefit design, cost-sharing requirements, and available financial assistance. In PY 2022, Exchanges on the Federal platform saw a significant increase in the number of plan and plan variation marketing names that included cost-sharing information and other benefit details. Following Open Enrollment for PY 2022, CMS received complaints from consumers in multiple States who misunderstood cost-sharing information in their QHP's marketing name.

Upon further investigation, CMS and State regulators determined that this language was often incorrect or could be reasonably interpreted by consumers as misleading based on information in corresponding plan benefit documentation submitted as part of the QHP certification process.[213] CMS's review of QHP data for PY 2023 indicates continued use of cost-sharing information in plan and plan variation marketing names.

This proposed policy would require all information included in plan and plan variation marketing names that relates to plan attributes to correspond to and match information that issuers submit for the plan in the Plans & Benefits Template, and in other materials submitted as part of the QHP certification process, such as any content that is part of the Summary of Benefits and Coverage. If necessary, this information can be included in the ''Benefit Explanation'' field of the Plans & Benefits Template. Consumers applying for coverage should be able to understand references to benefit information in plan and plan variation marketing names, and they should be able to confirm any information from a plan or plan variation marketing name in the plan's publicly available benefit descriptions. Also, plan benefit or cost sharing information in a plan or plan variation marketing name should not conflict with plan or plan variation information displayed on *HealthCare.gov* during the plan selection process in terms of dollar amount and, where applicable, terminology.

Under this proposal, as an example, CMS would flag plan and plan variation marketing names for revision to help consumers understand the cost-sharing and coverage implications. The following are examples of information that should be validated to ensure accuracy and consistency across the plan or plan variation marketing name, Plans & Benefits Template, *HealthCare.gov* plan selection information, and other applicable QHP certification materials. These examples are not all-inclusive, but they illustrate the kinds of information in plan and plan variation marketing names that could mislead consumers through inaccurate information or omission of material facts.

- Cost-sharing amounts that do not specify limitations the plan or plan variation includes, such as whether the cost-sharing amount is only available for drugs in a certain prescription drug category/tier, providers in a specific network or tier, or for a certain number of provider visits following which a higher cost-sharing amount will apply;
- Dollar amounts that do not specify what they refer to (for example, deductible, maximum out-of-pocket, or something else), whether they apply only to medical, drug, or another type of benefit, or whether, in cases of deductible or maximum out-of-pocket amounts, they apply to an individual or a family;
- Benefits, such as adult dental care, that are listed in a plan or plan variation marketing name to indicate that they are covered, but that plan documents indicate are not covered; and
- Reference(s) to health savings accounts (HSAs) in marketing names of plans or plan variations that do not permit enrollees to set up an HSA.[214]

We seek comment on this proposal and whether there are additional methods of preventing consumer confusion and market disruption related to this issue. In particular, we seek comment on the potential to identify components of plan and plan variation marketing names that could be uniformly structured and defined across QHPs, so as to consistently communicate information and ensure that plan and plan variation marketing names complement and do not contradict other sources of plan detail, such as cost-sharing and benefit information, displayed during the plan selection process on *HealthCare.gov* and other enrollment platforms. For example, we seek comment on whether, to address this, CMS should establish a required format for plan and plan variation marketing names that specifies elements such as name of issuer, metal level, and limited cost-sharing information.

7. Plans That Do Not Use a Provider Network: Network Adequacy (§ 156.230) and Essential Community Providers (§ 156.235)

We propose to revise the network adequacy and ECP standards at §§ 156.230 and 156.235 to state that all individual market QHPs and SADPs and all SHOP QHPs across all Exchanges must use a network of providers that complies with the standards described in those sections, and to remove the exception that these sections do not apply to plans that do not use a provider network.

In the Exchange Establishment Rule, we established the minimum network adequacy criteria that health and dental plans must meet to be certified as QHPs at § 156.230. In the 2016 Payment Notice, we modified § 156.230(a), in part, to specify that network adequacy requirements apply only to QHPs that use a provider network 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

[213] For example, in some cases a plan marketing name described a limited benefit in a way that could be understood as being unlimited, such as a ''$5 co-pay'' when the $5 co-pay was only available for an initial visit. Consumers were concerned upon learning the full extent of the cost-sharing for which they would be responsible during the plan year.

[214] An HSA is a tax-exempt trust or custodial account that a taxpayer may set up with a qualified HSA trustee to pay or reimburse certain medical expenses they incur. (*See* IRS Publication 969 (2021), Health Savings Accounts and Other Tax-Favored Health Plans: *https://www.irs.gov/publications/p969#en_US_2021_publink1000204030*.) Taxpayers must meet certain requirements to qualify for an HSA, including being enrolled in a High Deductible Health Plan (HDHP) as defined in Section 223(c)(2) of the U.S. Tax Code. HDHP requirements include minimum levels for family and individual deductible amounts—for example, for calendar year 2022, an HDHP was defined as a health plan with an annual deductible not less than $1,400 for self-only coverage or $2,800 for family coverage, with annual out-of-pocket expenses not more than $7,050 for self-only coverage or $14,100 for family coverage. (*See* IRS Rev. Proc. 2021–25: *https://www.irs.gov/pub/irs-drop/rp-21-25.pdf*.) Plan variants with limited or no cost sharing, such as those described at § 156.420(a)(1) and (b)(1), by definition do not meet the requirements to be HDHPs, and enrollees in these plans therefore cannot set up an HSA. CMS will consider references to HSAs in the names of plans that do not qualify as HDHPs to be incorrect and misleading.

Payment Notice (86 FR 6138), we added section (f) to § 156.230 to state that a plan for which an issuer seeks QHP certification or any certified QHP that does not use a provider network (meaning that the plan or QHP does not condition or differentiate benefits based on whether the issuer has a network participation agreement with a provider that furnishes covered services) 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. In that rule, we also stated that plans that do not utilize a provider network must still comply with all applicable QHP certification requirements to obtain QHP certification, which ensures that any plan that does not comply with applicable QHP certification requirements will be denied QHP certification (86 FR 6138).

Since 2016, only a single issuer has sought a certification on an FFE for a plan that does not use a network. Despite lengthy negotiations with this issuer, our experience with this plan convinced us that commenters to Part 1 of the 2022 Payment Notice who raised concerns about the burden plans without networks place on enrollees appear to have been correct, and so, for that reason and the other reasons explained below, we are proposing to revisit this policy.

Section 1311(c)(1)(B) and (C) of the ACA directs HHS to establish by regulation certification criteria for QHPs, including criteria that require QHPs to ensure a sufficient choice of providers (in a manner consistent with applicable provisions under section 2702(c) of the PHS Act, which governs insured health plans that include a provider network), provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers, and to include within health insurance plan provider networks those ECPs that serve predominantly low income, medically underserved individuals. HHS carries out this directive through establishing network adequacy and ECP requirements and reviewing QHP compliance with such requirements.

When we added section (f) to § 156.230 in Part 1 of the 2022 Payment Notice to except plans that do not use a provider network from meeting the network adequacy standards described at § 156.230(a) through (e), we did not intend to allow a plan to ignore the minimum statutory criteria for QHP certification. Plans without provider networks still are required by section 1311(c)(1)(B) of the ACA to ensure sufficient choice of providers and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers to obtain certification, even though they are not currently subject to §§ 156.230 and 156.235. Whether a plan that does not use a network provides sufficient a choice of providers is a more nuanced inquiry than a simple assertion that an enrollee can receive benefits for any provider. For a prospective enrollee, a ''sufficient choice of providers'' likely involves factors like the burden of accessing those providers, including whether there are providers nearby that they can see without unreasonable delay that would accept such a plan's benefit amount as payment in full, or whether they are able to receive all of the care for a specific health condition from a single provider without incurring additional out-of-pocket costs. These are among the factors involved in determining whether a network plan is in compliance with the network adequacy and ECP standards at §§ 156.230 and 156.235; a plan's compliance with these regulatory standards is one way that HHS can verify that plans meet the statutory criteria that QHPs ensure a sufficient choice of providers, including ECPs.

To more effectively ensure that all plans provide sufficient choice of providers and to provide for consistent standards across all QHPs, we believe it would be appropriate to revise the network adequacy and ECP standards at §§ 156.230 and 156.235 to state that all QHPs, including SADPs, must use a network of providers that complies with the standards described in those sections and to remove the exception at § 156.230(f). Consistent standards also would allow for easier comparability across all QHPs in a more comprehensible manner for prospective enrollees. The benefits of easier comparability between plans and other challenges posed by plan choice overload are discussed in more detail in the preamble sections about Standardized Plan Options and Non-Standardized Plan Option Limits.

We have previously stated that ''nothing in [the ACA] requires a QHP issuer to use a provider network,'' (84 FR at 6154) and it is true that the ACA includes no standalone network requirement. However, after revisiting the statute, we now doubt that a plan without a network can comply with the statutory requirement at section 1311(c)(1)(C) of the ACA that ''a plan shall, at a minimum . . . include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.'' We have always understood Section 1311(c)(1)(C) of the ACA to require all plans to provide sufficient access to ECPs, where available, whether or not the plan included a provider network. But we have not previously considered whether this specific statutory text is consistent with a policy exempting plans without a network from network adequacy regulations. We now understand the statute's text to best support a reading that access to ECPs will be provided ''within health insurance networks.''

Additionally, under section 1311(e)(1)(B) of the ACA and § 155.1000(c)(2), an Exchange may certify plans only if it determines that making the plans available through the Exchange is in the interests of qualified individuals. Section 155.1000 provides Exchanges with broad discretion to certify health plans that may otherwise meet the QHP certification standards specified in part 156. When we implemented section 1311(e)(1)(B) of the ACA at § 155.1000(c)(2) in the Exchange Establishment Rule, we noted that ''an Exchange could adopt an 'any qualified plan' certification, engage in selective certification, or negotiate with plans on a case-by-case basis'' (77 FR 18405). Under this authority, we believe that requiring QHPs to use a provider network would be in the interests of qualified individuals and would better protect consumers from potential harms that could arise in cases where QHPs do not use provider networks. For example, the implementation of a provider network can help mitigate against risks of substantial out-of-pocket costs, ensure access without out-of-pocket costs to preventive services that must be covered without cost sharing, and, in the individual market, facilitate comparability of standardized plan options. Furthermore, studies have found that provider networks allow for insurer-negotiated prices and controlled (that is, reduced) costs in the form of reduced patient cost sharing, premiums, and service price, as compared with such services obtained out of network.[215] [216]

This proposed revision would assure HHS that all plans certified as QHPs

[215] Benson NM, Song Z. Prices And Cost Sharing For Psychotherapy In Network Versus Out Of Network In The United States. Health Aff (Millwood). 2020 Jul;39(7):1210–1218. *https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01468.*

[216] Song, Z., Johnson, W., Kennedy, K., Biniek, J. F., & Wallace, J. Out-of-network spending mostly declined in privately insured populations with a few notable exceptions from 2008 to 2016. Health Aff. 2020;39(6), 1032–1041. *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01776.*

offer sufficient choice of providers in compliance with a consistent set of criteria for easier comparability across all QHPs and better ensure substantive consumer protections afforded by the ACA without undue barriers to access those protections. This consistency would be valuable to consumers as it ensures all consumers will have access to a set of providers with whom their plan has contracted in accordance with our established network adequacy and ECP requirements and allows for easier comparison between plans for prospective enrollees. This will also allow consumers to seek care from providers with whom their plan has negotiated a rate, limiting their potential exposure to out-of-pocket costs under the plan.

Accordingly, pursuant to the authority delegated to HHS to establish criteria for the certification of health plans as QHPs, we propose to remove the exception at § 156.230(f) and to revise §§ 156.230 and 156.235 to state that all individual market QHPs and SADPs and all SHOP plan QHPs across all Exchanges-types must use a network of providers that complies with the standards described in those sections, beginning with PY 2024. Under this proposal, an Exchange could not certify as a QHP a health plan that does not use a network of providers. However, we solicit comment on whether it is possible to design a plan that does not use a network in a way that would address our concerns about the plan's ability to offer a sufficient choice of providers without excessive burden on consumers, or what regulatory standards such a plan could meet to ensure a sufficient choice of providers without excessive burden on consumers.

This proposal would also generally apply to SADPs. Since 2014, the FFEs have received, and approved, QHP certification applications for SADPs that do not use a provider network in every plan year. However, the number of SADPs that do not use a provider network has never accounted for a significant number of SADPs approved as QHPs on the FFEs. At their most prevalent in PY 2014, only 50 of the 1,521 SADPs certified as QHPs on the FFEs were plans that do not use a provider network. In PY 2022, only 8 of the 672 SADPs certified as QHPs on the FFEs were plans that do not use a provider network.

Further, the number of SADPs on the FFEs that do not use a provider network appears to be limited since 2017 to fewer and fewer States; while 9 FFE States had SADPs that do not use a provider network certified as QHPs in PY 2014, only 2 FFE States still had SADPs that do not use a provider network certified in PY 2022. Since PY 2021, only 85 counties in Alaska and Montana still have SADPs that do not use a provider network certified as QHPs. We assume that the few SADP issuers that still offer SADPs that do not use a provider network on the FFEs in Alaska and Montana only do so because of difficulty in maintaining a sufficient provider network in those States. We believe it is reasonable to assume that consumers increasingly gravitate towards SADPs that use a network, given this overall decrease in the availability of SADPs that do not use a provider network. We invite comment to confirm these understandings, as well as comment on the prevalence of SADPs that do not use a provider network offered outside of the FFEs in the non-grandfathered individual and small group markets.

TABLE 12: Prevalence of SADPs that Do Not Use a Provider Network on the FFEs, Plan Years 2014-2023 *

Plan Year	SADPs Without Provider Networks	SADPs With Provider Networks	FFE States with SADPs Without Provider Networks	Counties (#) with SADPs Without Provider Networks	% Counties in Affected FFE States with Only SADPs Without Provider Networks
2023	15	684	2; Alaska and Montana	85	AK: 90%, MT: 0% (every county had plans with provider network options)
2022	8	672	2; Alaska and Montana	85	AK: 90%, MT: 0% (every county had plans with provider network options)
2021	17	688	4; Alaska, Montana, North Dakota, Wyoming	85	0% in all affected FFE States
2020	17	736	4; Alaska, Montana, North Dakota, Wyoming	161	100% in all affected FFE States (the only SADP options in affected counties were plans without provider networks)
2019	38	893	5; Alaska, Montana, Nebraska, North Dakota, Wyoming	162	100% in all affected FFE States (the only SADP options in affected counties were plans without provider networks)
2018	40	932	6; Alaska, Montana, Nebraska, North Dakota, Utah, Wyoming	163	100% in all affected FFE States (the only SADP options in affected counties were plans without provider networks)
2017	41	1,053	5; Alaska, Montana, Nebraska, North Dakota, Oregon, Wyoming	197	0% in all affected FFE States (every county had plans with provider network options)
2016	15	1,045	5; Alaska, Montana, Oregon, South Dakota, Wyoming	210	0% in all affected FFE States (every county had plans with provider network options)
2015	17	1,128	4; Montana, Ohio, South Dakota, Wyoming	233	0% in all affected FFE States (every county had plans with provider network options)
2014	50	1,521	9; Alaska, Iowa, Idaho, Missouri, Montana, Nebraska, South Carolina, South Dakota, Wyoming	571	0% in all affected FFE States (every county had plans with provider network options)

* Data for the number of SADPs sourced from Health Insurance Exchange Public Use Files (Exchange PUFs), available at: https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.

Given the overall lack of popularity of SADPs that do not use a provider network, we believe that consumers find that such plans do not offer the same levels of protections against out-of-pocket costs as network plans. Thus, we believe it would be appropriate to revise §§ 156.230 and 156.235 so that all SADPs must use a network of providers that complies with the standards described in those sections as a condition of QHP certification, beginning with PY 2024.

However, we are cognizant that it can be more challenging for SADPs to establish a network of dental providers based on the availability of nearby dental providers, and we are aware this proposal could result in no SADPs offered through Exchanges in States like Alaska and Montana, which have historically offered SADPs without

provider networks (see Table 12). Further, we are aware that having no Exchange-certified SADPs offered through an Exchange in an area would impact all non-grandfathered individual and small group plans in such areas. Without an SADP available on the respective Exchange, all non-grandfathered individual and small group health plans in impacted areas would be required to cover the pediatric dental EHB. We note that section 1302(b)(4)(F) of the ACA states that if such an SADP is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a QHP solely because the plan does not offer coverage of pediatric dental benefits offered through the SADP.

In the EHB Rule (78 FR at 12853), we operationalized this provision at section 1302(b)(4)(F) of the ACA to permit QHP issuers to omit coverage of the pediatric dental EHB if an Exchange-certified SADP exists in the same service area in which they intend to offer coverage. As a corollary, if no such SADP is offered through an Exchange in that service area, then all health plans offered through the Exchange in that service area would be required to provide coverage of the pediatric dental EHB, as section 2707(a) of the ACA requires all non-grandfathered plans in the individual and small group markets to provide coverage of the EHB package described at section 1302(a) of the ACA. However, to our knowledge, at least one Exchange-certified SADP has been offered in all service areas nationwide since implementation of this requirement in 2014, and no Exchange has required a medical QHP to provide coverage of the pediatric dental EHB in this manner. We solicit comment to confirm this understanding.

To prevent a situation where this proposal would require health plans in those areas to cover the pediatric dental EHB, we solicit comment on the extent to which we should finalize a limited exception to this proposal only for SADPs that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers; this exception would not be applicable to health plans. Under such an exception, we could consider an area to be ''prohibitively difficult'' for the SADP issuer to establish a network of dental providers on a case-by-case basis, taking into account a number of non-exhaustive factors, such as the availability of other SADPs that use a provider network in the service area, and prior years' network adequacy data to identify counties in which SADP issuers have struggled to meet standards due to a shortage of dental providers. Other factors could include an attestation from the issuer about extreme difficulties in developing a dental provider network, or data provided in the ECP/NA template or justification forms during the QHP application submission process that reflect such extreme difficulties. We seek comment on whether it would be appropriate to finalize such an exception in this rule, other factors that we might consider in evaluating whether an exception is appropriate, as well as alternative approaches to such an exception.

We seek comment on this proposal, as well as on other topics included in this section.

Compliance With Appointment Wait Time Standards

In the 2023 Payment Notice, HHS finalized the requirement that issuers demonstrate compliance with appointment wait time standards via attestation, beginning in PY 2024. Issuers must work with their network providers to collect the necessary data to assess appointment wait times and determine if their provider network meets the wait time standards detailed in the 2023 Letter to Issuers, as CMS will begin conducting such reviews of issuer attestations for PY 2024.

8. Essential Community Providers (§ 156.235)

We propose to expand access to care for low-income and medically underserved consumers by strengthening ECP standards for QHP certification, as discussed in this section. First, HHS proposes to establish two additional stand-alone ECP categories at § 156.235(a)(2)(ii)(B) for PY 2024 and beyond: Mental Health Facilities and Substance Use Disorder (SUD) Treatment Centers. In doing so, two provider types currently categorized as ''Other ECP Providers'' (Community Mental Health Centers and Substance Use Disorder (SUD) Treatment Centers) would be recategorized within these new proposed stand-alone ECP categories. We propose to crosswalk the Community Mental Health Centers provider type into the newly created stand-alone Mental Health Facilities category and the SUD Treatment Centers provider type into the newly created stand-alone SUD Treatment Centers category. Additionally, we propose to add Rural Emergency Hospitals (REHs) as a provider type in the Other ECP Providers ECP category. This addition reflects the fact that on or after January 1, 2023, REHs may begin participating in the Medicare program. As CMS noted in July of this year, ''[t]he REH designation provides an opportunity for Critical Access Hospitals (CAHs) and certain rural hospitals to avert potential closure and continue to provide essential services for the communities they serve.'' [217] HHS believes that the inclusion of REHs on the ECP List may increase access to needed care for low-income and medically underserved consumers in rural communities.

ECPs include providers that serve predominantly low-income and medically underserved individuals, and specifically include providers described in section 340B(a)(4) of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act (the Act). Section 156.235 establishes the requirements for the inclusion of ECPs in QHP provider networks. Section 156.235(a) requires QHP issuers to include a sufficient number and geographic distribution of ECPs in their networks, where available. Each plan year, HHS releases a final list of ECPs to assist issuers with identifying providers that qualify for inclusion in a QHP issuer's plan network toward satisfaction of the ECP standard under § 156.235. The list is not exhaustive and does not include every provider that participates or is eligible to participate in the 340B drug program, every provider that is described under section 1927(c)(1)(D)(i)(IV) of the Act, or every provider that may otherwise qualify under § 156.235. CMS endeavors to continue improving the ECP list for future years. These efforts include direct provider outreach to ECPs themselves, as well as reviewing the provider data with Federal partners.

Section 156.235(b) establishes an Alternate ECP Standard for QHP issuers that provide a majority of their covered professional services through physicians employed directly by the issuer or a single contracted medical group. We note that the above proposal establishing two additional ECP categories and the proposed threshold requirements discussed later in this section would affect all QHP issuers, regardless of whether they are subject to the General ECP Standard under § 156.235(a) or Alternate ECP Standard under § 156.235(b). However, SADP issuers would only be subject to such requirements as applied to provider types that offer dental services, as reflected in § 156.235(a)(2)(ii)(B).

Currently, QHPs that utilize provider networks are required to contract with at least 35 percent of available ECPs in each plan's service area to participate in the plan's provider network. In

[217] *https://www.cms.gov/newsroom/fact-sheets/rural-emergency-hospitals-proposed-rulemaking.*

addition, under § 156.235(a)(2)(ii)(B), medical QHPs must offer a contract in good faith to at least one ECP in each of the available ECP categories in each county in the plan's service area and offer a contract in good faith to all available Indian health care providers in the plan's service area. Under § 156.235(a)(2)(ii)(B), the six ECP categories currently include Federally Qualified Health Centers, Ryan White Program Providers, Family Planning Providers, Indian Health Care Providers, Inpatient Hospitals, and Other ECP Providers (currently defined to include Substance Use Disorder Treatment Centers, Community Mental Health Centers, Rural Health Clinics, Black Lung Clinics, Hemophilia Treatment Centers, Sexually Transmitted Disease Clinics, and Tuberculosis Clinics).

The proposed establishment of two new stand-alone ECP categories (Mental Health Facilities and SUD Treatment Centers) would strengthen the ECP standard in two ways: (1) by requiring that medical QHP issuers offer a contract in good faith to at least one SUD Treatment Center and at least one Mental Health Facility that qualify as ECPs in each county in the plan's service area, as opposed to being blended with other provider types in the existing ''Other ECP Provider'' category; and (2) by decreasing the number of provider types remaining in the ''Other ECP Provider'' category, thereby increasing the likelihood that remaining provider types included in the ''Other ECP Provider'' category will receive a contract offer from a medical QHP issuer to satisfy the requirement that they must offer a contract in good faith to at least one provider in each ECP category in each county in the plan's service area.

Given that the ECP standard is facility-based, if finalized as proposed, the inclusion of SUD Treatment Centers and Mental Health Facilities on the HHS ECP List would be limited to those facilities identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and/or CMS as providing such services, in addition to fulfilling other ECP qualification requirements as specified at § 156.235(c).

If finalized as proposed, the eight available stand-alone ECP categories would consist of the following: (1) Federally Qualified Health Centers; (2) Ryan White Program Providers; (3) Family Planning Providers; (4) Indian Health Care Providers; (5) Inpatient Hospitals, (6) Mental Health Facilities; (7) SUD Treatment Centers, and (8) Other ECP Providers, to include Rural Health Clinics, Black Lung Clinics, Hemophilia Treatment Centers, Sexually Transmitted Disease Clinics, and Tuberculosis Clinics. The proposed ECP categories and ECP provider types within those categories in the FFEs for PY 2024 and beyond are set forth in Table 13.

TABLE 13: ECP Categories and Provider Types in FFEs, as proposed for PY 2024 and beyond

Major ECP category	ECP provider types
Federally Qualified Health Centers (FQHC)	FQHC and FQHC ''Look-Alike'' Clinics
Ryan White Program Providers	Ryan White HIV/AIDS Providers
Family Planning Providers	State-owned family planning service sites, governmental family planning service sites, including Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics, Not-for-profit family planning service sites that do not receive Federal funding under special programs, including under Title X of the PHS Act or other 340B-qualifiying funding
Indian Health Care Providers	Tribes, Tribal Organization and Urban Indian Organization Providers, Indian Health Service Facilities
Inpatient Hospitals	Disproportionate Share Hospital (DSH), Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals,
Substance Use Disorder Treatment Centers	Substance Use Disorder Treatment Providers
Mental Health Facilities	Community Mental Health Centers, Other Mental Health Providers
Other ECP Providers	Black Lung Clinics, Hemophilia Treatment Centers, Rural Health Clinics, Sexually Transmitted Disease Clinics, Tuberculosis Clinics, Rural Emergency Hospitals

In addition, HHS proposes to revise § 156.235(a)(2)(i) to require QHPs to contract with at least a minimum percentage of available ECPs in each plan's service area within certain ECP categories, as specified by HHS. Specifically, HHS proposes to require QHPs to contract with at least 35 percent of available FQHCs that qualify as ECPs in the plan's service area and at least 35 percent of available Family Planning Providers that qualify as ECPs in the plan's service area. Furthermore, HHS proposes to revise § 156.235(a)(2)(i) to clarify that these proposed requirements would be in addition to the existing provision that QHPs must satisfy the overall 35 percent ECP threshold requirement in the plan's service area. We note that HHS would retain its current overall ECP provider participation standard of 35 percent of available ECPs based on the applicable PY HHS ECP list, including approved ECP write-ins that would also count toward a QHP issuer's satisfaction of the 35 percent threshold.

HHS is proposing that only two ECP categories, FQHCs and Family Planning Providers, be subject to the additional 35 percent threshold in PY 2024 and beyond. These two categories were selected, in part, because they represent the two largest ECP categories; together, these two categories comprise roughly 62 percent of all facilities on the ECP List. Applying an additional 35 percent threshold to these two categories could increase consumer access in low-income areas that could benefit from the additional access to the broad range of health care services that these particular providers offer. HHS may consider applying a specified threshold to other ECP categories in future rulemaking, if HHS finds that additional ECP categories contain a sufficient number and geographic distribution of providers to allow for application of the threshold without inflicting undue burden on issuers by effectively forcing them to contract with a few specific providers.

Based on data from PY 2023, it is likely that a majority of issuers would be able to meet or exceed the threshold requirements for FQHCs and Family Planning Providers without needing to contract with additional providers in these categories. To illustrate, if these requirements had been in place for PY 2023, out of 137 QHP issuers on the FFEs, 76 percent would have been able to meet or exceed the 35 percent FQHC threshold, while 61 percent would have been able to meet or exceed the 35 percent Family Planning Provider threshold without contracting with additional providers. For SADP issuers, 84 percent would have been able to meet the 35 percent threshold requirement for FQHCs offering dental services without contracting with additional providers. In PY 2023, for medical QHPs, the mean and median percentages of contracted ECPs for the FQHC category were 74 and 83 percent, respectively. For the Family Planning Providers category, the mean and median percentages of contracted ECPs were 66 and 71 percent, respectively. For SADPs, the mean and median percentages of contracted ECPs for the FQHC category were 61 and 64 percent, respectively.

We acknowledge challenges associated with a general shortage and uneven distribution of SUD Treatment Centers and Mental Health Facilities. However, the ACA requires that a QHP's network include ECPs where available. As such, the proposal to require QHPs to offer a contract to at least one available SUD Treatment Center and one available Mental Health Facility in every county in the plan's service area does not unduly penalize issuers facing a lack of certain types of ECPs within a service area, meaning that if there are no provider types that map to a specified ECP category available within the respective county, the issuer is not penalized. Further, as outlined in prior Letters to Issuers, HHS prepares the applicable PY HHS ECP list that potential QHPs use to identify eligible ECP facilities. The HHS ECP list reflects eligible providers (that is, the denominator) from which an issuer may select for contracting to count toward satisfying the ECP standard. As a result, issuers are not disadvantaged if their service areas contain fewer ECPs. HHS anticipates that any QHP issuers falling short of the 35 percent threshold for PY 2024 and beyond could satisfy the standard by using ECP write-ins and justifications. As in previous years, if an issuer's application does not satisfy the ECP standard, the issuer would be required to include as part of its application for QHP certification a satisfactory justification.

We seek comment on these proposals.

9. Termination of Coverage or Enrollment for Qualified Individuals (§ 156.270)

a. Establishing a Timeliness Standard for Notices of Payment Delinquency

We propose to amend § 156.270(f) by adding a timeliness standard to the requirement for QHP issuers to send enrollees notice of payment delinquency. Specifically, we propose to revise § 156.270(f) to require issuers to send notice of payment delinquency promptly and without undue delay. HHS has long required issuers to send notices of non-payment of premium (77 FR 18469), so that enrollees who become delinquent on premium payments are aware and have a chance to avoid termination of coverage. In accordance with § 156.270(a), issuers may terminate coverage for the reasons specified in § 155.430(b), which under paragraph (2)(ii) includes termination of coverage due to non-payment of premiums. Enrollees who are receiving APTC and who fail to timely pay their premiums are entitled to a 3-month grace period, described at § 156.270(d), during which they may return to good standing by paying all outstanding premium before the end of the 3 months. Enrollees who are not receiving APTC may also be entitled to a grace period under State law, if applicable.

HHS has an interest in helping enrollees maintain coverage by establishing basic standards of communication between the QHP issuer and enrollee regarding premium payment status, especially at the start of an enrollment and when an enrollment has entered delinquency for failure to timely pay premium and is at risk for termination. For example, before Exchange coverage is effectuated, the Exchanges on the Federal platform generally require that the enrollee make a binder payment (first month's premium) by prescribed due dates.[218] At § 156.270(f), HHS has also regulated on communicating to an enrollee when they have become delinquent on premium payment and when their coverage has been terminated. But while the regulation at § 156.270(f) requires that issuers notify enrollees when they become delinquent on premium payments, CMS currently sets no timeliness requirements for issuers. In conducting oversight of issuers, HHS is aware that in some instances, issuers have delayed notifying enrollees of delinquency. HHS is concerned that there may be situations in which enrollees are not timely informed that they have become delinquent on premium payments, thus limiting the amount of time they have available to rectify the delinquency and avoid termination of coverage. In extreme cases, an enrollee may not become aware that they have become delinquent until termination of coverage has already occurred. For example, if an enrollee (who was not receiving APTC) failed to pay August's premium but was not informed by the issuer they had become delinquent until September, they would have already lost coverage and would not have an opportunity to

[218] *See* § 155.400(e).

restore it. There may also be uncertainty among issuers regarding their requirement to send notices of delinquency, since HHS has not provided guidance on when this notice must be sent.

Modifying § 156.270(f) to require issuers to send notices of payment delinquency promptly and without undue delay would ensure that issuers are promptly sending these notices when enrollees fail to make premium payments, so that enrollees are aware they are at risk of losing coverage, including when they are entering a grace period (either the 3-month grace period for enrollees who are receiving APTC, or a State grace period if applicable). It would also provide clarity to issuers regarding their obligation to send a notice when an enrollee becomes delinquent on premium payment. Finally, updating this regulation would serve HHS' goal of promoting continuity of coverage by ensuring enrollees are aware they have become delinquent on premium payment and have a chance to pay their outstanding premium to avoid losing coverage. To further help ensure that notices are sent in a timely and uniform manner, HHS also believes it would be important to specify the number of days within which the issuer must send notice from the time an enrollee becomes delinquent on payment. However, we also recognize that issuers have a variety of practices for sending delinquency notices, and thus we request comment on what a reasonable timeframe would be for sending notices of delinquency to enrollees.

We seek comments on this proposal.

10. Final Deadline for Reporting Enrollment and Payment Inaccuracies Discovered After the Initial 90-Day Reporting Window (§ 156.1210(c))

We propose to amend § 156.1210(c) to remove the alternate deadline at § 156.1210(c)(2) that allows an issuer to describe all data inaccuracies identified in a payment and collection report by the date HHS notifies issuers that the HHS audit process with respect to the plan year to which such inaccuracy relates has been completed, in order for these data inaccuracies to be eligible for resolution.

In prior rulemakings (78 FR 65080 through 65081, 85 FR 29254, and 86 FR 24256 through 24258), we established provisions at § 156.1210 related to the review and identification of inaccuracies in the monthly payment and collection reports provided by HHS for Exchange coverage. These reports currently include information on APTC the Federal Government is paying to the issuer for each policy listed on the report, any amounts owed by the issuer for FFE and SBE–FP user fees, as well as any adjustments from previous payments under those programs. This process is intended to confirm that accurate payments are made and to facilitate adjustments where inaccuracies are identified. The policies and standards governing this process have evolved over time as HHS, State Exchanges, and issuers have gained experience with handling payment errors and enrollment reconciliation activities for Exchange coverage. Issuers are generally required to review these detailed monthly reports against the payments they expect for each policy based on the eligibility and enrollment information transmitted by the Exchange, and any amounts it expects the Federal Government to collect for FFE and SBE–FP user fees. If an issuer identifies an inaccuracy in these amounts (including incorrect payment amounts, or extra or missing policies in the report), it must notify HHS or the State Exchange (as applicable) within certain timeframes. HHS works with issuers and State Exchanges (as applicable) to resolve any discrepancies between the amounts listed in the payment and collections report and the amounts the issuer believes it should receive for the time period(s) specified on the report. The prompt identification and correction of payment and enrollment errors protects enrollees from unanticipated tax liability that could result if the APTC is greater than the amount authorized by the Exchange and accepted by the enrollee. It also supports the efficient operation of Exchanges by aligning the Exchange's enrollment and eligibility data, payments provided by and collected by HHS for Exchange coverage, and the issuer's own records of payments due.

Section 156.1210(c) currently establishes the final deadline to report inaccuracies identified in a payment and collections report for discovered underpayments [219] as before the later of (1) the end of the 3-year period beginning at the end of the plan year to which the inaccuracy relates or (2) the date by which HHS notifies issuers that the HHS audit process with respect to the plan year to which such inaccuracy relates has been completed. The final 3-year or end of the HHS audit process deadline set forth in § 156.1210(c)(1) and (2) is significant because HHS will only provide payment to the issuer for identified data inaccuracies related to discovered underpayments reported before this deadline.[220] As we explained in part 2 of the 2022 Payment Notice (86 FR 24257), under section 1313(a)(6) of the ACA, ''payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729, *et. seq.*) if those payments include any Federal funds.'' As such, if any issuer has an obligation to pay back APTC or pay additional user fees, the issuer could be liable under the False Claims Act for knowingly and improperly avoiding the obligation to pay. Section 156.1210(c)(3) therefore states that if a payment error is discovered after the 3-year or end of audit reporting deadline as set forth at § 156.1210(c)(1) and (2), the issuer is obligated to notify HHS and the State Exchange (as applicable) and repay any overpayment.

After further consideration of the final deadline for reporting identified data inaccuracies for discovered underpayments, we propose, beginning with adjustments to APTC and user fee payments and collections for 2015 plan year coverage,[221] to remove the alternate deadline currently set forth at § 156.1210(c)(2) to ensure HHS and Exchange processes for handling payment and enrollment disputes related to discovered underpayments are completed before the existing IRS limitation on filing corrected tax returns. We further propose to revise § 156.1210(c) to generally include the final 3-year deadline to identify and report data inaccuracies for discovered underpayments.[222] As such, the first sentence in proposed new § 156.1210(c) would provide that to be eligible for resolution under § 156.1210(b), the issuer must describe all inaccuracies identified in a payment and collections report before the end of the 3-year period beginning at the end of the plan

[219] Underpayment refers to both APTC underpayments to the issuer and user fee overpayments to HHS, for which an issuer would be entitled to additional payment from HHS.

[220] HHS will work with the issuer or the State Exchange (as applicable) to resolve the inaccuracy in these situations as long as the issuer meets other applicable requirements. For example, the issuer must demonstrate that failure to identify the inaccuracy and submit it to HHS or the State Exchange (as applicable) in a timely manner (within the 90-day reporting window under § 156.1210(a)) was not unreasonable or due to the issuer's misconduct or negligence. See 45 CFR 156.1210(b)(2). In addition, once identified, the issuer must notify HHS or the State Exchange (as applicable) within 15 days of identifying the inaccuracy. See 45 CFR 156.1210(b)(1).

[221] The 2014 plan year is excluded because the alternative deadline for reporting inaccuracies closed upon completion of the 2014 audits. See CMS. (2019, April 1). CMS Issuer Audits of the Advanced Payments of the Premium Tax Credit. *www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2014-CMS-APTC-Audits.PDF.*

[222] See 45 CFR 156.1210(c)(1).

year to which the inaccuracy relates. By requiring all issuers in all Exchanges [223] to adhere to the final 3-year deadline for identifying and reporting discovered underpayments, HHS would be balancing the desire to continue to provide issuers flexibility to identify and report discovered underpayments after the initial 90-day reporting window at § 156.1210(a), to encourage the prompt reporting and timely resolution of data inaccuracies, and to establish a more consistent, predictable, and less operationally burdensome process for the identification and resolution of such inaccuracies for enrollees, issuers, HHS, and State Exchanges.

Under this proposal, and consistent with the deadline currently set forth in § 156.1210(c)(1), for 3 years after the end of the applicable plan year, HHS would accept and work with the issuer (or State Exchange, as applicable) to resolve the identified data inaccuracies for discovered underpayments, and would process resulting payment corrections through policy-level data, which would generate new Forms 1095–A for impacted enrollees', if other applicable requirements are met.[224] Establishing a firm 3-year timeframe to resolve data inaccuracies and make subsequent adjustments for discovered APTC underpayments ensures that new Forms 1095–A are generated and sent to enrollees and filed with the IRS with sufficient time for the enrollee to potentially amend their tax filing with the IRS. This change would therefore provide greater consistency and predictably for enrollees and reduce potential confusion caused by the receipt of Forms 1095–A outside of the allowable re-filing window with the IRS. In addition to reducing enrollee confusion, requiring adherence to a firm 3-year final deadline to report data inaccuracies for discovered APTC underpayments (or user fee overpayments) would also benefit issuers by ensuring a more consistent and predictable timeline for resolution of these data inaccuracies. Aligning the payment and enrollment final dispute timeline with the 3-year Form 1095–A timeline would limit administrative burden on issuers, State Exchanges, and HHS by standardizing these related processes for resolving errors and generating new Forms 1095–A for enrollees.

Under this proposal, beginning with the 2020 plan year coverage, HHS would not pay additional APTC payments or reimburse user fee payments for FFE, SBE–FP, and SBE issuers for data inaccuracies reported after the 3-year deadline. HHS would require issuers to adhere to the 3-year deadline to submit all disputes and address all errors, instead of utilizing the end of the audit process as an alternative timeframe to receive additional APTC or reimbursement of user fee payments beyond the 3-year deadline. Thus, HHS would not accept or take action that results in an outgoing payment on data inaccuracies or payment errors for 2020 plan year coverage that are reported after December 31, 2023. Similarly, HHS would not accept or take action that results in an outgoing payment on data inaccuracies or payment errors for 2021 plan year coverage that are reported after December 31, 2024, and so on.

Additionally, we propose that HHS would not accept or take action that results in an outgoing payment on data inaccuracies or payment errors for the 2015 through 2019 plan year coverage that are reported after December 31, 2023. If finalized, this proposal would grant issuers some additional time after this rule is finalized to submit any inaccuracies for the 2015 through 2019 plan year coverage, for which submission would no longer be permitted if this proposal was effective upon finalization.

We are not proposing any changes to the general framework outlined in § 156.1210(c)(3), which currently states that if a payment error is discovered after the final deadline set forth in § 156.1210(c)(1) and (2), the issuer must notify HHS, the State Exchange, or SBE–FP (as applicable) and repay any overpayments to HHS. We propose to retain this language as the last sentence of new proposed § 156.1210(c), except for the reference to the alternative deadline at § 156.1210(c)(2).

With regard to issuers in State Exchanges, we further affirm that this proposal would not change the requirement that issuers promptly identify and report data inaccuracies to the State Exchange.[225] Under the proposed revisions to § 156.1210(c), issuers in State Exchanges would be subject to the same final 3-year deadline to work with the State Exchange to resolve any enrollment or payment inaccuracies identified after the initial 90-day reporting window for discovered underpayments. Similarly, we also propose that HHS would not make any payments to issuers in State Exchanges on data inaccuracies or payment errors for 2015 through 2019 plan year coverage that are reported after December 31, 2023. Issuers in State Exchanges would also remain subject to the existing requirement to report data inaccuracies identified at any time when related to overpayments. We note that when HHS initially proposed the deadline of 3 years or the date by which the HHS audit process is completed, as currently described at § 156.1210(c), we requested comment on the ability of State Exchanges to resolve data inaccuracies and report payment adjustments to HHS under the 3-year deadline framework currently captured in § 156.1210(c)(1). We did not receive any comments objecting to this timeframe based on the ability of State Exchanges to resolve such disputes, and therefore, believe that the current proposal to set the final deadline to identify and report data inaccuracies for discovered underpayments at 3 years is reasonable and will not pose a challenge to State Exchanges or issuers.

We seek comment on this proposal.

11. Administrative Appeals (§ 156.1220)

As discussed in section III.A.7.d. of this preamble (HHS–RADV Discrepancy and Administrative Appeals Process), we propose amendments to § 156.1220(a)(4)(ii) to add a reference to new proposed § 153.630(d)(3). As discussed in section III.A.7.d of this preamble, under new proposed § 153.630(d)(3), we would retain the 30-calendar-day window to confirm, or file a discrepancy, regarding the calculation of the risk score error rate as a result of HHS–RADV. Under this proposal, the cross-reference to § 153.630(d)(2) in § 156.1220(a)(4)(ii) would be maintained and would capture the new proposed 15-calendar-day window to confirm, or file a discrepancy, for SVA findings (if applicable).

In addition, we propose to amend § 156.1220(b)(1) to address situations when the last day of the period to request an informal hearing does not fall on a business day. In these cases, we propose that the deadline to request an informal hearing would be extended to the next applicable business day. This proposal is consistent with our policy

[223] The requirements captured in 45 CFR 156.1210 apply to all issuers who receive APTC, including issuers in State Exchanges. See part 2 of the 2022 Payment Notice, 86 FR at 24258.

[224] For example, the issuer must demonstrate the failure to identify and promptly report the data inaccuracies and discovered underpayments within the initial 90-day reporting window, under § 156.1210(a), was not unreasonable or due to the issuer's misconduct or negligence. See § 156.1210(b)(2). In addition, once identified, the issuer must notify HHS or the State Exchange (as applicable) within 15 days of identifying the inaccuracy. See § 156.1210(b)(1).

[225] As previously noted, the requirements captured in 45 CFR 156.1210 apply to all issuers who receive APTC, including issuers in State Exchanges. Also see part 2 of the 2022 Payment Notice, 86 FR at 24258.

for other risk adjustment deadlines that do not fall on a business day.[226]

We solicit comment on these proposed amendments.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order 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 comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of the agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the 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 used data from the Bureau of Labor Statistics to derive average labor costs (including a 100 percent increase for the cost of fringe benefits and overhead) for estimating the burden associated with the ICRs.[227] Table 14 in this proposed rule presents the mean 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.

TABLE 14: Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Mean Hourly Wage ($/hr.)	Fringe Benefits and Overhead ($/hr.)	Adjusted Hourly Wage ($/hr.)
Business Operations Specialist	13-1199	$38.10	$38.10	$76.20
General and Operations Manager	11-1021	$55.41	$55.41	$110.82
Management Analyst	13-1111	$48.33	$48.33	$96.66
Insurance Sales Agent	41-3021	$33.34	$33.34	$66.68
Computer and Information Systems Manager	11-3021	$78.33	$78.33	$156.66
Secretaries and Administrative Assistants, Except Legal, Medical, and Executive	43-6014	$19.75	$19.75	$39.50

B. ICRs Regarding Repeal of Risk Adjustment State Flexibility To Request a Reduction in Risk Adjustment State Transfers (§ 153.320(d))

We propose to repeal the flexibility for any State, including prior participant States, to request a reduction in risk adjustment State transfers in all State market risk pools beginning with the 2025 benefit year. As such, we propose several amendments to § 153.320(d).

The burden currently associated with this requirement is the time and effort for the State regulator to submit its request and supporting evidence and analysis to HHS. In the Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment information collection (OMB control number: 0938–1155), we estimated that submitting the request and supporting evidence and analysis would take a business operations specialist 40 hours (at a rate of $76.20 per hour) to prepare the request and 20 hours for a senior operations manager (at a rate of $110.82 per hour) to review the request and transmit it electronically to HHS. We estimated that each State seeking a reduction would incur a burden of 60 hours at a cost of approximately $5,264.40 per State to comply with this reporting requirement (40 hours for the operations specialist and 20 hours for the operations manager).

Since this proposal would eliminate the ability of the one prior participating State (Alabama) to request this flexibility beginning with benefit year 2025, we similarly propose to rescind this information collection beginning with the 2025 benefit year. The burden associated with this information collection estimated above would be removed if this proposal is finalized, since no State would have the opportunity to request this flexibility moving forward. This information collection is approved under OMB control number 0938–1155, and if this proposal is finalized, HHS would rescind the information collection under OMB control number 0938–1155 accordingly and provide the applicable comment periods once the policy is no longer in effect.

We seek comment on this proposed rescission.

C. ICRs Regarding Risk Adjustment Issuer Data Submission Requirements (§§ 153.610, 153.700, and 153.710)

We propose to require issuers to collect and make available for HHS' extraction from issuers' EDGE servers a new data element, a QSEHRA indicator. We propose to adopt the same transitional approach and schedule for the population of the QSEHRA indicator as was finalized for the ICHRA indicator in the 2023 Payment Notice. Under this proposal, for the 2023 and 2024 benefit years, issuers would be required to populate the QSEHRA indicator using

[226] See, for example, 45 CFR 153.730.

[227] See May 2021 Bureau of Labor Statistics, Occupational Employment Statistics, National Occupational Employment and Wage Estimates. Available at *https://www.bls.gov/oes/current/oes_stru.htm.*

data they already collect or have accessible regarding their enrollees. Then, beginning with the 2025 benefit year, issuers that do not have an existing source to populate this field for particular enrollees would be required to make a good faith effort to collect and submit the QSEHRA indicator for these enrollees. We propose to extract this data element beginning with the 2023 benefit year and also propose to include the QSEHRA indicator in the enrollee-level EDGE limited data sets available to qualified researchers upon request, once available.

We propose to begin collection of the QSEHRA indicator with the 2023 benefit year, and estimate that approximately 650 issuers of risk adjustment covered plans would be subject to this data collection. We propose to collect a QSEHRA indicator from issuers' ESES files and risk adjustment recalibration enrollment files. We believe the burden associated with the collection of this data would be similar to that of the collection of ICHRA indicator finalized in the 2023 Payment Notice. Much like the ICHRA indicator data, we believe that some issuers already collect or have access to the relevant information to populate the QSEHRA indicator. However, we do not believe the information to populate the QSEHRA indicator is routinely collected by all issuers at this time; therefore, we anticipate that there may be administrative burden for some issuers in developing processes for collection, validation, and submission of this new data element. In recognition of the burden that collection of this new data element potentially would pose for some issuers, we propose to adopt a transitional approach for the QSEHRA indicator that mirrors the approach finalized for the ICHRA indicator in the 2023 Payment Notice and is similar to how we have handled other new data collection requirements.[228] For successful EDGE server data submission, each issuer would need to update their file creation process to include the new data element, which would require a one-time administrative cost. After incorporating the most recently updated wage estimate data, we estimate this one-time administrative cost at $579.96 per issuer (reflecting 6 hours of work by a management analyst at an average hourly rate of $96.66 per hour). Based on this, we estimate the cumulative one-time cost to update issuers' file creation process to be $376,974 for 650 issuers (3,900 total hours for all issuers). We also estimate a cost of $96.66 in total annual labor costs for each issuer which reflects 1 hour of work by a management analyst per issuer at an average hourly rate of $96.66 per hour. Based on this, we estimate $62,829 in total annual labor costs for 650 issuers (650 total hours per year for all issuers). We believe that this proposed data collection should not pose significant additional operational burden to issuers given that the operational burden associated with populating the QSEHRA indicator should be aided by the requirement finalized in the 2023 Payment Notice mandating the collection of the ICHRA indicator in the same fashion. The proposed extraction of the new proposed QSEHRA indicator should also not pose additional burden to issuers since the creation and storage of the extract—which issuers do not receive—are mainly handled by HHS. If finalized, HHS would revise the information collection request to account for the burden associated with this policy, and would provide the applicable comment periods.[229]

We also propose to amend the applicability date for the extraction of the plan ID and rating area data elements to extend the extraction of these two data elements to the 2017, 2018, 2019 and 2020 benefit year data sets. As detailed earlier and in prior rulemakings, issuers have been required to collect and submit these two data elements as part of the required risk adjustment data since the 2014 benefit year. Therefore, HHS estimates that the proposal to extract these data elements would not pose additional operational burden to the majority of issuers, since the creation and storage of the extract—which issuers do not receive—is mainly handled by HHS. However, some issuers may not have benefit year 2017, 2018, 2019, or 2020 data readily available for extraction from their EDGE servers, and therefore, there may be some burden associated with restoring past years' data to their respective EDGE servers should this be the case. Our intention with this policy proposal is to limit the burden on issuers for us to collect and extract the plan ID and rating area data elements from additional prior benefit year data. Therefore, while we broadly solicit comment on these data collection proposals, we specifically solicit comments on this burden estimate and ways that we can further limit the burden on extracting these two data elements from the 2017, 2018, 2019 and 2020 benefit year data sets.

D. ICRs Regarding Risk Adjustment Data Validation Requirements When HHS Operates Risk Adjustment (HHS–RADV) (§ 153.630)

Under § 153.630(g)(2), issuers below a materiality threshold, as defined by HHS, are exempt from the annual HHS–RADV audit requirements in § 153.630(b). While these issuers are exempt from the annual HHS–RADV audit process, they are subject to random and targeted sampling such that they undergo HHS–RADV approximately every 3 years (barring any risk-based triggers based on experience that would warrant more frequent audits). We propose, beginning with 2022 benefit year HHS–RADV, to change the materiality threshold from $15 million in total annual premiums Statewide in the benefit year being audited to 30,000 BMM Statewide in the benefit year being audited.

We estimate that this proposal will not significantly impact issuer burden relative to previous estimates for HHS–RADV and the current materiality threshold. In particular, the proposed threshold will not significantly alter the anticipated number of issuers that would fall under the materiality threshold and be subject to random and targeted sampling rather than the annual audit requirements. We estimate that each year, on average, there are 197 issuers of risk adjustment covered plans with total annual Statewide premiums below $15 million and 201 issuers of risk adjustment covered plans below 30,000 BMM Statewide. If we assume one-third of issuers below the materiality threshold would be subject to HHS–RADV each year, we estimate that the total number of issuers selected for HHS–RADV that fall under the materiality threshold would remain fairly constant. We believe that the number of issuers participating in HHS–RADV for any given benefit year under the proposed 30,000 BMM Statewide threshold will not be significantly different than the number of issuers participating under the current $15 million total annual premium Statewide threshold and reflected in our current HHS–RADV burden estimates, and therefore, we believe that there will not be an overall increase or decrease in burden. If finalized, we would revise the information collection currently approved under OMB control number 0938–1155 to account for the changes to

[228] For example, HHS did not penalize issuers for temporarily submitting a default value for the in/out-of-network indictor for the 2018 benefit year to give issuers time to make the necessary changes to their operations and systems to comply with the new data collection requirement, but required issuers to provide full and accurate information for the in/out-of-network indicator beginning with the 2019 benefit year.

[229] Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment (OMB control number 0938–1155).

the HHS definition for the materiality threshold in § 153.630(g)(2).

E. ICRs Regarding Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210 and 155.225)

This proposal would not impose any new information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Though CMS requires Navigator grantees to track enrollment numbers on weekly, monthly, and quarterly progress reports, this is already accounted for in an existing PRA package (OMB control number 0938–1205, Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel—CAC), and they are not required to specifically track enrollments completed for door-to-door enrollments.

F. ICRs Regarding Providing Correct Information to the FFEs (§ 155.220(j))

As discussed in the preamble of this proposed rule, we are proposing amendments to § 155.220(j)(2)(ii) to require agents, brokers, and web-brokers to document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or their authorized representative prior to application submission. This proposal would require the consumer or their authorized representative to take an action that produces a record that they reviewed and confirmed the information on the eligibility application to be accurate prior to application submission. This documentation would be required to be maintained by agents, brokers, and web-brokers for a minimum of 10 years and produced upon request in response to monitoring, audit, and enforcement activities.

We estimate costs will be associated with this proposal, including those related to documenting, maintaining, and producing the documentation. Our proposal, if finalized, would not mandate any method or prescribe a template for documenting that a consumer or their authorized representative reviewed and confirmed the accuracy of their eligibility application information. It would be up to the agents, brokers, and web-brokers to determine the best way to meet these proposed regulatory requirements.

Costs related to requiring the consumer take some affirmative action to memorialize the review of application information are as follows. We estimate it would take an additional 5 minutes for an enrolling agent, broker, or web-broker to obtain documentation from a consumer or their authorized representative that they have reviewed and confirmed the accuracy of their application information. Billing at $66.68 per hour using the Insurance Sales Agent occupation code, each enrollment will have approximately $5.33 additional cost associated with it based on extra time commitment. In PY 2021, agents submitted 3,630,849 policies. This makes the yearly total cost associated with the extra time per enrollment approximately $19,352,425.17 (3,630,849 × $5.33).

Costs associated with maintaining consumer or their authorized representative's documentation would depend on the method selected by the agent, broker, or web-broker to meet the regulatory requirements. For those agents, brokers, or web-brokers currently meeting the requirements, no additional costs would be incurred. If an enrolling entity opts to use paper for documentation, they would bear the costs of paper, ink and filing cabinets to store the paperwork.

HHS would only require an agent, broker, or web-broker to produce retained records in limited circumstances related to monitoring, audit, and enforcement activities. In instances of fraud investigation, HHS typically asks for documentation associated with approximately 10 different applications, generally from the past 2 to 3 years. We estimate it would take an agent approximately 2 hours to gather consumer documentation for 10 applications. Each year, HHS generally investigates approximately 50 agents, brokers, or web-brokers. Therefore, we estimate the yearly cost of producing documentation for HHS to be approximately $6,668 (($66.68 hourly rate × 2 hours) × 50). The documentation would be able to be mailed electronically, so there would be no cost associated with printing or mailing the documentation. Agency-wide audits are not completed often by HHS but may become more widespread. In those instances, HHS would ask the agency to produce a certain number of records from the past 10 years.

We seek comment on these burden estimates.

G. ICRs Regarding Documenting Receipt of Consumer Consent (§ 155.220(j))

As discussed earlier in the preamble of this proposed rule, we are proposing amendments to § 155.220(j)(iii) to require agents, brokers, and web-brokers to document the receipt of consumer consent. This proposal would require the consumer or their authorized representative to take an action that produces a record that they provided consent. Agents, brokers, and web-brokers would be required to maintain the records for a minimum of 10 years and produce the records upon request in response to monitoring, audit, and enforcement activities.

We estimate costs will be associated with this proposal, including those related to documenting, maintaining, and producing the records of consumer consent. Our proposal, if finalized, would not mandate any method or prescribe a template for documenting receipt of consumer consent. It would be up to the agents, brokers, and web-brokers to determine the best way to meet these proposed regulatory requirements. As agents, brokers, and web-brokers are currently required to obtain consumer consent prior to assisting them, the requirement to obtain consent would not add any costs to the enrolling agent, broker, or web-broker.

Costs related to requiring that the consumer or their authorized representative take some affirmative action to memorialize that consent was provided are as follows. We estimate it would take about 5 minutes for an enrolling agent, broker or web-broker to obtain consumer, or their authorized representative, affirmation of their consent. Using the adjusted hourly wage rate of $66.68 for an Insurance Sales Agent, each enrollment will have approximately $5.33 in additional cost associated with it based on the extra time commitment from these proposed policy changes. In PY 2021, agents submitted 3,630,849 policies. Based on this number of enrollments, the total annual burden is 290,468 hours with a total annual cost of $19,352,425.17. HHS would only require an agent, broker, or web-broker to produce retained records in limited circumstances related to fraud investigation or agency audits. In instances of fraud investigation, HHS typically asks for consent records of approximately 10 different applications, generally from the past 2 to 3 years. We estimate it would take an agent approximately 2 hours to gather consent documentation for 10 applications. Each year, HHS generally investigates approximately 50 agents, brokers, or web-brokers. Therefore, we estimate the yearly cost of producing consumer consent documentation to HHS to be approximately $6,668 (($66.68 hourly rate × 2 hours) × 50). These records are able to be mailed electronically, so there would be no cost associated with printing or mailing the records. Agency-wide audits are not completed often by HHS but may become more widespread.

In those instances, HHS would ask the agency to produce a certain number of records from the past 10 years.

The estimated total annual cost of memorializing the documentation of consumer consent is $19,352,425.17, and the estimated total cost of producing the retained eligibility and consent records is $6,668.00. Combined, the total annual cost of the proposed information collection requirements is $19,359,093.17.

We seek comment on these burden estimates.

H. ICRs Regarding Failure To File and Reconcile Process (§ 155.305(f))

We are proposing to amend current regulation at § 155.305(f)(4) under which an Exchange may not find a consumer eligible for APTC where a consumer has failed to file a tax return reconciling their APTC for a previous year to provide more flexibility to Exchanges to ensure that consumers are complying with the requirement to file their Federal income tax returns and reconcile past year's APTC, while ensuring continuity of coverage in Exchange QHPs. We are proposing to provide Exchanges the option to end APTC after 1 year of a taxpayer's (or taxpayer's spouse, if married) failure to file and reconcile APTC, or only after two consecutive years of a taxpayer's failure to file and reconcile APTC.

On Exchanges on the Federal platform, FTR would otherwise be conducted in the same as manner it had previously been conducted, with minimal changes to the language of the Exchange application questions necessary to obtain relevant information; as such, we anticipate that the proposed amendment will not impact the information collection (OMB control number 0938–1191) burden for consumers.

I. ICRs Regarding Income Inconsistencies (§§ 155.315 and 155.320)

Section 155.320 requires the Exchange to generate an income DMI and proceed with the process in § 155.315(f)(1) through (4) when there is no IRS data available to verify attested projected annual household income or when such IRS data available but it is inconsistent with the projected annual household income attestation. In order to verify an applicant or enrollee's attested projected annual household income to determinate eligibility for APTC and CSRs, an applicant generally must mail or upload documentation which must then be reviewed by an HHS eligibility support staffer. We propose to amend § 155.320 to require Exchanges to accept attestation when the Exchange requests tax return data from the IRS to verify attested projected annual household income, but the IRS confirms there is no such tax return data available.

Based on historical DMI data, we estimate that HHS would conduct document verification for 1.2 million fewer households per year. Once households have submitted the required verification documents, we estimate that it takes approximately 12 minutes for an eligibility support staff person (occupation No. 43–4061), at an hourly cost of $46.70, to review and verify submitted verification documents. The proposed revisions to § 155.320 would result in a decrease in annual burden for the Federal Government of 240,000 hours at a cost of $11,208,000.

In addition to the reduced administrative burden for HHS eligibility support staff, the proposed change would reduce the time consumers spend submitting documentation to verify their income. We estimate that consumers each spend 1 hour to submit documentation and that the proposed change would decrease burden on consumers by 1.2 million hours per year.

We would revise the information collection currently approved under OMB control number 0938–1207 (Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment) to account for this decreased burden. Given that this change entails a reduction in consumer burden, the 30-day notice soliciting public comment will be published in the **Federal Register** at a future date.

J. ICRs Regarding the Improper Payment Pre-Testing and Assessment (IPPTA) for State Exchanges (§§ 155.1500–155.1515)

As described in the preamble to § 155.1510, the IPPTA is proposed to replace the existing voluntary State engagement initiative with mandatory participation and related requirements. The IPPTA is designed to test processes and procedures that support HHS's review of determinations of APTC made by State Exchanges and to prepare State Exchanges for the planned measurement of improper payments.

In the preamble to § 155.1510(a)(1), we propose that State Exchanges provide to HHS: (1) the State Exchange's data dictionary including attribute name, data type, allowable values, and description; (2) an entity relationship diagram; and (3) business rules and related calculations. This data documentation is currently retained by State Exchanges in a digital format and can be electronically transmitted to HHS. We estimate that the burden associated with this data transfer would be no more than 22 hours.

In the preamble to § 155.1510(a)(2), we propose that HHS will provide State Exchanges with the pre-testing and assessment data request form. HHS proposes to review the form and its instructions with each State Exchange prior to the State Exchange completing and returning the form and required data to HHS. Both the pre-testing and assessment data request form and the requested source data are in an electronic format. The burden associated with completion and return of the pre-testing and assessment data request form and required data would be the time it would take each State Exchange to meet with HHS to review the form and its requirements, analyze and design the database queries based on the data elements identified in the form, electronically transmit the data to HHS, and meet with HHS to verify and validate the data.

We expect respondent costs will not substantially vary since the data being collected is largely in a digitized format and that each State Exchange will be providing the application data and consumer submitted documents for approximately 10 tax households. We seek comment on these assumptions.

We estimate that gathering and transmitting the data documentation as specified in § 155.1510(a)(1) and completion of the pre-testing and assessment data request form as specified in § 155.1510(a)(2) would take 530 hours per respondent at an estimated cost of $56,986.48 per respondent. To compile our estimates, we referenced our experience collecting data in our FFE pilot initiative and in working with State Exchanges in the existing voluntary State engagement initiative. We identified specific personnel and the number of hours that would be involved in collecting the data broken down by specific area (for example, eligibility verification, auto-re-enrollment, periodic data matching, enrollment reconciliation, plan management, and manual reviews including document retrieval).

Hourly wage rates vary from $92.92 for a Computer Programmer to $156.66 for a Computer and Information Systems Manager depending on occupation code and function. With a mean hourly rate of $111.07 for the respective occupation codes, the burden across the 18 State Exchanges equals 9,540 hours for a total

cost of up to $1,025,756. We seek comment on these burden estimates.

K. ICRs Regarding QHP Rate and Benefit Information (§ 156.210)

a. Age on Effective Date for SADPs

In this proposed rule, we propose to require issuers of Exchange-certified stand-alone dental plans (SADPs), whether they are sold on- or off-Exchange, to use the age on effective date methodology as the sole method to calculate an enrollee's age for rating and eligibility purposes, as a condition of QHP certification, beginning with Exchange certification for PY 2024. This rule does not propose to alter any of the information collection requirements related to age determination for rating and eligibility purposes during the QHP certification process in a way that would create any additional costs or burdens for issuers seeking QHP certification. This information collection is currently approved under OMB control number 0938–1187.

b. Guaranteed Rates for SADPs

The proposal to require issuers of Exchange-certified SADPs, whether they are sold on- or off-Exchange, to submit guaranteed rates, as a condition of Exchange certification beginning with Exchange certification for PY 2024, will not impose an additional burden on issuers. Exchange-certified SADP issuers already submit either guaranteed or estimated rates during QHP certification, and are therefore, familiar with the QHP certification rate submission process. This information collection is currently approved under OMB control number 0938–1187.

L. ICRs Regarding Establishing a Timeliness Standard for Notices of Payment Delinquency (§ 156.270)

The proposal to add a timeliness standard to the requirement for QHP issuers to send enrollees notice of payment delinquency would not impose an additional information burden on issuers. Per § 156.270(f), issuers are already required to send notices to enrollees when they become delinquent on premium payments, and this proposal would not require any additional information collection. We are merely proposing to add a requirement that issuers send these notices promptly and without undue delay. This information collection is currently approved under OMB control number 0938–1341 (CMS–10592).

M. Summary of Annual Burden Estimates for Proposed Requirements

TABLE 15: Proposed Annual Recordkeeping and Reporting Requirements

Regulation Section(s)	OMB Control Number	Number of Respondents	Number of Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting ($)	Total Cost ($)
§ 153.320(d)	0938-1155	-1	-1	-60	-60	-$5,264.40	-$5,264.40
§§ 153.610, 153.700, and 153.710	0938-1155	650	650	1	650	$62,829	$62,829
§ 155.220(j)	0938-NEW	50	50	2	100	$6,668	$6,668
§ 155.220(j)	0938-NEW	3,630,849	3,630,849	0.08	290,467.92	$19,352,425.17	$19,352,425.17
§ 155.320	0938-1207	-1,200,000	-1,200,000	-0.2	-240,000	-$11,208,000	-$11,208,000
§ 155.1510	0938-NEW	18	18	530	9,540	$1,025,756	$1,025,756
TOTAL		2,431,566	2,431,566		60,697.92	$9,234,413.77	$9,234,413.77

This proposed rule includes one proposal—repealing risk adjustment State flexibility to request a reduction in risk adjustment State transfers (§ 153.320(d))—with information collection requests which seeks to use this rulemaking as the **Federal Register** notice through which to receive comment on its proposed revisions to the associated PRA package.

The following proposals with associated information collection requests will be submitted for PRA approval outside of this rulemaking, through separate **Federal Register** notices: risk adjustment issuer data submission requirements (§§ 153.610, 153,700, and 153.710); and income inconsistencies (§ 155.320).

The HHS–RADV, Navigator, FTR, application to SADPs, and QHP rate and benefit information proposals contain information collections which are covered by the following PRA packages: Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment, OMB control number: 0938–1155; Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges, OMB control number: 0938–1215; Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid and CHIP Agencies, OMB control number: 0938–1191; Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations, OMB control number: OMB 0938–1187; and Establishment of Qualified Health Plans and American Health Benefit Exchanges, OMB control number: 0938–1156.

N. 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 access the CMS PRA website by copying and pasting the following web address into your web browser: *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing,* 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–9899–P), the ICR's CFR citation, CMS ID number, and OMB control number.

Comments must be received on/by February 13, 2023.

V. Regulatory Impact Analysis

A. Statement of Need

This rule proposes to improve risk adjustment and HHS–RADV policies to use the most recent data to recalibrate the risk adjustment models and reduce operational burden for HHS–RADV, and to update Navigator standards to permit door-to-door and other unsolicited means of direct contact. The rule also proposes to require agents, brokers, and web-brokers to provide correct consumer information and document consumer consent; and require Exchanges on the Federal platform to accept an applicant's or enrollee's attestation of projected annual household income when IRS data is not available and determine the applicant or enrollee eligible for APTC or CSRs in accordance with the applicant's or enrollee's attested projected household income. In addition, the rule proposes to implement the IPPTA, reduce 2024 user fee rates to 2.5 percent of premiums for FFE issuers and 2.0 percent of premiums for SBE–FP issuers, and make minor updates to standardized plan options and limit the number of non-standardized plan options issuers can offer. Finally, the rule proposes to require that QHP plan marketing names include correct information, without omission of material fact, and do not include content that is misleading; revise the network adequacy and ECP standards §§ 156.230 and 156.235 to state that all QHP issuers, including SADPs, must use a network of providers that complies with the standards described in those sections; expand access to care for low-income and medically underserved consumers by strengthening ECP standards for QHP certification; and add a timeliness standard to the requirement for QHP issuers to send enrollees notice of payment delinquency.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action/s and/or with economically significant effects ($100 million or more in any 1 year). Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is ''economically significant'' as measured by the $100 million threshold. Accordingly, we have prepared an RIA that to the best of our ability presents the costs and benefits of the rulemaking. Therefore, OMB has reviewed these proposed regulations, and the Departments have provided the following assessment of their impact.

C. Impact Estimates of the Payment Notice Provisions and Accounting Table

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf*), we have prepared an accounting statement in Table 16 showing the classification of the impact associated with the provisions of this proposed rule.

This proposed rule proposes standards for programs that will 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 an Exchange. We are unable to quantify all benefits and costs of this proposed rule. The effects in Table 16 reflect qualitative assessment of impacts and estimated direct monetary costs and transfers resulting from the provisions of this proposed rule for health insurance issuers and consumers. The annual monetized transfers described in Table 16 include changes to costs associated with the risk adjustment user fee paid to HHS by issuers.

We are proposing the risk adjustment user fee of $0.21 PMPM for the 2024 benefit year to operate the risk adjustment program on behalf of States,[230] which we estimate to cost approximately $60 million in benefit year 2024. This estimated total cost remains stable with the approximately $60 million estimated for the 2023 benefit year.

Additionally, for 2024, we are proposing an FFE and SBE–FP user fee rate of 2.5 and 2.0 percent of premiums, respectively. These user fee rates are lower than the 2023 FFE and SBE–FP user fee rates of 2.75 and 2.25 percent of premiums, respectively.

For our proposed implementation of the IPPTA program, we estimate record keeping costs for data submission to be approximately $1,025,756 beginning in PY 2024.

BILLING CODE 4120–01–P

[230] As noted previously in this proposed rule, no State has elected to operate the risk adjustment program for the 2024 benefit year; therefore, HHS will operate the risk adjustment program for all 50 States and the District of Columbia.

TABLE 16: Accounting Table

Benefits:	Estimate	Year Dollar	Discount Rate	Period Covered	
Annualized Monetized ($/year)	$79.52 Million		2022	7 percent	2023-2027
	$81.16 Million		2022	3 percent	2023-2027

Quantitative:

- Reduction of $5,264.40 in reporting costs associated with repealing the ability of prior participant States to request a reduction in risk adjustment State transfers starting with the 2025 benefit year.
- Annual cost savings of approximately $66 million to the Federal Government and $37 million to State Exchanges as a result of the proposed revisions to income DMIs beginning in 2024.

Qualitative:

- Improved review of rebuttal evidence and reconsideration requests based on the proposal to increase the review period for agent, broker, or web-broker suspensions or terminations to 60 days.
- Requiring a consent recordation will reduce the number of unauthorized enrollments and help resolve disputes between enrolling entities and consumers, as well as between enrolling entities.
- Requiring enrolling entities to confirm information prior to submitting an application will help reduce the number of incorrect DMIs.
- Improved consumer experience by amending the hierarchy for re-enrollment to facilitate enrollment into lower cost, higher generosity plans.
- Improved continuity of care by including provider networks in re-enrollment determinations when the enrollee's current plan is no longer available.
- Improved consumer experience as a result of reduced choice overload due to the proposal to limit the number of non-standardized plan offerings.
- Increased access to continuous health insurance coverage for individuals who qualify for a special enrollment period due to attesting to a future loss of MEC, associated with the proposal to allow earlier effective dates for individuals qualifying for such special enrollment periods.
- Increased access to continuous health insurance coverage for individuals losing Medicaid or CHIP who qualify for a special enrollment period with 60 days before or 90 days after to report such loss of MEC to an Exchange.
- Potential direct benefit of reducing improper payments, with secondary effects including a boost of issuer confidence in State Exchanges, through implementation of the proposed IPPTA.
- Reduced burden on consumers and assisters due to the proposal to require QHP plan marketing names to include correct information without omission of material fact and to not include misleading content.
- Potential increased access to coverage associated with the proposal to add a timeliness standard for payment delinquency notices for enrollees who become delinquent on premium payments by ensuring they are properly informed of their delinquency in time to avoid losing coverage.
- Increased access to more comprehensive provider networks due to the network adequacy and ECP proposals, which would better ensure that individuals have reasonable, timely access to an adequate number, type, and distribution of providers and facilities to manage their health care needs.

Costs:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	$710.84 Million	2022	7 percent	2023-2027
	$721.71 Million	2022	3 percent	2023-2027

Quantitative:

- Cumulative additional cost estimate for the collection of one new data element for risk adjustment estimated to be approximately $62,829 annually for 650 issuers beginning in 2024, plus a one-time cost of $376,974 in 2024 to update their data collection processes to begin collecting this new data element.
- Increased APTC expenditures of $373 million per coverage year beginning in benefit year 2024 due to FTR proposal to not determine an enrollee ineligible for APTC until after two consecutive years.
- One-time costs of approximately $6.6 million in benefit year 2024 to five State Exchanges that have not fully implemented the infrastructure to run FTR operations, with annual costs to maintain FTR operations of approximately $10 million beginning in 2024.
- Recordkeeping costs incurred by State Exchanges related to IPPTA, estimated to be a total, one-time cost of approximately $1.025 million across all 18 State Exchanges during calendar years 2024 and 2025.

- One-time cost of $500,000 in 2023 for HHS to implement a 60-day extension for households with income DMIs for Exchanges on the Federal platform and $9 million for State Exchanges to implement 60-day extension.
- One-time cost of $500,000 in 2023 for HHS to accept attestation for households without IRS data for Exchanges on the Federal platform and $9 million for State Exchanges to implement accepting attestation for households without IRS data.
- Increased costs of $175 million per year starting in 2024 associated with increased APTC expenditures due to the income DMI proposals.
- Increased costs of $161 million per coverage year beginning in 2023 associated with increased APTC expenditures due to the proposal to modify current coverage effective date rules for qualifying individuals who qualify for a special enrollment period due to a future loss of MEC for Exchanges on the Federal platform.
- Increased costs of $98 million per coverage year beginning in 2024 associated with increased APTC expenditures due to the proposal to add a new special rule permitting Exchanges on the Federal platform to allow consumers up to 60 days before and up to 90 days after to report a loss of Medicaid or CHIP.
- Increased costs of $48 million per year beginning in 2024 with increased APTC spending due to the proposal to amend the re-enrollment hierarchy to allow Exchanges to direct re-enrollment for enrollees who are eligible for CSR in accordance with § 155.305(g) from a bronze QHP to a silver QHP with a lower or equivalent premium after APTC provided certain conditions are met.

Qualitative:

- Under the proposed limits to the number of non-standardized plan options that issuers of QHPs can offer through the FFEs and SBE-FPs, we estimate that approximately 60,949 of a total of 106,037 non-standardized plan option plan-county combinations (57 percent) would be discontinued in PY 2024. Relatedly, we estimate that approximately 2.72 million of the 10.21 million total enrollees on the FFEs and SBE-FPs (26.6 percent of total enrollees) would be affected by these discontinuations.
- Increase in administrative burden to State Exchanges that choose to adopt the proposal to prohibit issuers from terminating coverage for policy dependent enrollees because they reached the maximum allowable age mid-plan year.
- Potential administrative burden on issuers to comply with new plan marketing name standards and on SBE-FPs to support and enforce these new standards.
- Increased burden for plans that do not currently use a provider network and wish to remain in the Exchanges to comply with the proposal to require all QHPs and SADPs to use a network and comply with the network adequacy standards at § 156.235 beginning with plan year 2024.
- Increased burden to consumers, agent/brokers, and assisters to change enrollment to another plan if a consumer's current plan does not use a provider network and exits the Exchanges due to the proposal that all QHPs and SADPs use provider networks beginning with plan year 2024.

Transfers:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	-$142.09 Million	2022	7 percent	2023-2027
	-$147.35 Million	2022	3 percent	2023-2027

Quantitative:

- Reduction in FFE and SBE-FP user fee transfers from issuers to the Federal Government of $74 million for benefit year 2024 compared to the prior benefit year. We estimate additional reductions in FFE and SBE-FP user fee transfers from issuers to the Federal Government of $147 million in 2025, $317 million in 2026, and $219 million in 2027 if this user fee level were maintained in subsequent years.
-

This RIA expands upon the impact analyses of previous rules and utilizes the Congressional Budget Office's (CBO) analysis of the ACA's impact on Federal

BILLING CODE 4120–01–C

spending, revenue collections, and insurance enrollment. Table 17 summarizes the effects of the risk adjustment program on the Federal budget from fiscal years 2024 through 2028, with the additional, societal effects of this proposed rule discussed in this RIA. We do not expect the provisions of this proposed rule to significantly alter CBO's estimates of the budget impact of the premium stabilization programs that are described in Table 17.[231]

TABLE 17: Estimated Federal Government Outlays and Receipts for the Risk Adjustment and Reinsurance Programs from Fiscal Year 2024-2028, in billions of dollars[231]

Year	2024	2025	2026	2027	2028	2024-2028
Risk Adjustment and Reinsurance Program Payments	6	7	7	8	8	36
Risk Adjustment and Reinsurance Program Collections	6	7	7	8	8	36

Note: Risk adjustment program payments and receipts lag by one quarter. Receipt will fully offset payments over time. Source: Congressional Budget Office. Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2022 to 2032. Table A-2. June 30, 2022. https://www.cbo.gov/system/files/2022-06/57962-health-insurance-subsidies.pdf.

1. Data for Risk Adjustment Model Recalibration for 2024 Benefit Year

We propose to use the 2018, 2019, and 2020 benefit year enrollee-level EDGE data to recalibrate the 2024 benefit year risk adjustment models with an exception for the use of the 2020 benefit year to recalibrate the age-sex coefficients for the adult models. Specifically, we propose to use only 2018 and 2019 benefit year enrollee-level EDGE data to recalibrate the age-sex coefficients in the adult models to account for the observed anomalous decreases in the unconstrained coefficients for the 2020 benefit year enrollee-level EDGE data for older adult enrollees, especially older female adult enrollees. Consistent with the approach outlined in the 2020 Payment Notice to no longer rely upon MarketScan® data for recalibrating the risk adjustment models, under this proposal, we would continue to recalibrate the risk adjustment models for the 2024 benefit year using only enrollee-level EDGE data, and would continue to use blended, or averaged, coefficients from the 3 years of separately solved models for the 2024 benefit year model recalibration, with the noted exception for recalibration of the adult models' age-sex factors. This approach seeks to maintain stability in the markets, and therefore, we anticipate that this proposal would have minimal impact on risk scores and transfers for issuers in the individual and small group (including merged) markets.

2. Repeal of Risk Adjustment State Flexibility To Request a Reduction in Risk Adjustment State Transfers (§ 153.320(d))

We propose to eliminate the flexibility for any State, including prior participant States, to request reductions of risk adjustment State transfers calculated by HHS under the State payment transfer formula beginning with the 2025 benefit year. We anticipate that this change would have a minimal impact as only one State, Alabama, is considered a prior participant and would no longer be able to request reductions in risk adjustment transfers if this policy is finalized.

3. Risk Adjustment Issuer Data Requirements (§§ 153.610, 153.700, and 153.710)

We are also proposing the collection and extraction of a new data element, the QSEHRA indicator, as part of the required risk adjustment data submissions issuers make accessible to HHS through their respective EDGE servers. For the 2023 and 2024 benefit years, similar to the transitional approach finalized for the ICHRA indicator, issuers would be required to populate the field for the QSEHRA indicator using only data they already collect or have accessible regarding their enrollees. Then, beginning with the 2025 benefit year, the transitional approach would end, and issuers would be required to populate the field using available sources (for example, information from Exchanges, and requesting information directly from enrollees) and, in the absence of an existing source for particular enrollees, to make a good faith effort to ensure collection and submission of the QSEHRA indicator for these enrollees. HHS would provide additional details on what constitutes a good faith effort to ensure collection and submission of the QSEHRA indicator beginning with 2025 benefit year data submissions in the future. An updated burden estimate associated with this policy may be found in section IV of this proposed rule, in the *ICRs Regarding Risk Adjustment Issuer Data Submission Requirements (§§ 153.610, 153.700, and 153.710)* section earlier in this rule.

In addition, we propose to extract the plan ID and rating area data elements from issuers' EDGE servers that issuers already make accessible to HHS as part of the required risk adjustment data for additional prior benefit years of data. Specifically, we propose to amend the applicability date for the extraction of these two data elements from issuers' enrollee-level EDGE data as finalized in the 2023 Payment Notice to also allow extraction of these data elements from the 2017, 2018, 2019 and 2020 benefit year data.

4. Risk Adjustment User Fee for 2024 Benefit Year (§ 153.610(f))

For the 2024 benefit year, HHS will operate a risk adjustment program 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 on behalf of States is funded through a risk adjustment user fee. For the 2024 benefit year, we propose to use the same methodology to estimate our

[231] Reinsurance collections ended in FY 2018 and outlays in subsequent years reflect remaining payments, refunds, and allowable activities.

administrative expenses to operate the risk adjustment program as was used in the 2023 Payment Notice. Risk adjustment user fee costs for the 2024 benefit year are expected to remain stable from the prior 2023 benefit year estimates. However, we project higher enrollment than our prior estimates in the individual and small group (including merged) markets in the 2023 and 2024 benefit years due to the enactment of the ARP,[232] and section 12001 of the IRA, which extended the enhanced PTC subsidies in section 9661 of ARP through the 2025 benefit year. We estimate that the total cost for HHS to operate the risk adjustment program on behalf of States and the District of Columbia for 2024 will be approximately $60 million, and therefore, the proposed risk adjustment user fee would be $0.21 PMPM. Because enrollment projections have increased for the 2023 and 2024 benefit year due to the IRA and the proposed 2024 risk adjustment user fee is $0.01 PMPM lower than the 2023 user fee, we expect the proposed risk adjustment user fee for the 2024 benefit year to reduce the transfer amounts collected or paid by issuers of risk adjustment covered plans.

5. Risk Adjustment Data Validation Requirements When HHS Operates Risk Adjustment (HHS–RADV) (§ 153.630)

We propose, beginning with 2022 benefit year HHS–RADV, to change the HHS definition for the materiality threshold for the HHS–RADV exemption under § 153.630(g)(2) from $15 million total annual premiums Statewide to 30,000 BMM Statewide in the benefit year being audited. The purpose of this policy is to address the estimated increase in costs to complete the IVA over the years and to ensure the materiality threshold is not eroded as costs increase. We quantify this increase in IVA cost in the Standards Related to Reinsurance, Risk Corridors, Risk Adjustment, and Payment Appeal of the PRA (OMB Control Number 0938–1155), which was updated in 2022.[233] We believe that the number of issuers exempt from HHS–RADV for any given benefit year under the proposed 30,000 BMM threshold will not be significantly different than the number of issuers exempt under the current $15 million total annual premium Statewide threshold, and therefore, we believe that there will not be an overall reduction in burden. However, those issuers that are exempted from HHS–RADV will have less burden and administrative costs than an issuer subject to these requirements.

We propose, beginning with 2021 benefit year HHS–RADV, to remove the policy to only make adjustments to reflect exiting outlier issuers HHS–RADV results when the issuer is a positive error rate outlier in the applicable benefit year's HHS–RADV. Under the proposal to remove this policy, exiting and non-exiting outlier issuers would be treated the same, and HHS would apply HHS–RADV adjustments to risk scores and risk adjustment State transfers for both positive and negative error rate outlier exiting and non-exiting issuers. Based on our experience, we estimate that the number of negative error rate outlier exiting issuers in any given benefit year would be very small, and therefore, we believe that changing this policy would not significantly increase burden.

We also propose to change the attestation and discrepancy reporting window to file a discrepancy report or confirm SVA findings from 30 calendar days to within 15 calendar days of the notification by HHS, beginning with the 2022 benefit year HHS–RADV. Shortening this attestation and discrepancy reporting window would improve HHS' ability to finalize SVA findings results prior to release of the HHS Risk Adjustment Data Validation (RADV) Results Memo and the Summary Report of Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers for the applicable benefit year in a timely fashion, which would support timely reporting of information on HHS–RADV adjustments to risk adjustment State transfers in issuers' MLR reports.

Based on our experience operating HHS–RADV, few issuers have insufficient pairwise agreement and receive SVA findings, and the 15-calendar-day attestation and discrepancy reporting window is consistent with the IVA sample and EDGE discrepancy reporting windows under §§ 153.630(d)(1) and 153.710(d)(1). Further, HHS believes that this shortened reporting window would not be overly burdensome to the few impacted issuers, and that any disadvantages of this shortened reporting window would be outweighed by the benefits of timely resolution of any discrepancies before the release of the applicable benefit year HHS Risk Adjustment Data Validation (RADV) Results Memo and the Summary Report of Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers for the applicable benefit year.

6. EDGE Discrepancy Materiality Threshold (§ 153.710)

We propose to amend the materiality threshold for EDGE discrepancies at § 153.710(e) to align with the materiality threshold as described in the preamble of part 2 of the 2022 Payment Notice final rule (86 FR 24194 through 24195) to reflect that the amount in dispute must equal to or exceeds $100,000 or 1 percent of the total estimated transfer amount in the applicable State market risk pool, whichever is less. HHS generally only takes action on reported material EDGE discrepancies when an issuer's submission of incorrect EDGE server premium data has the effect of increasing or decreasing the magnitude of the risk adjustment transfers to other issuers in the market (83 FR 16970 through 16971). We do not believe that the proposal related to the materiality threshold for EDGE discrepancies would impose additional administrative burden on issuers beyond the effort already required to submit data to HHS for the purposes of operating State market risk pool transfers, as previously estimated in part 2 of the 2022 Payment Notice (86 FR 24273 through 24274).

7. Exchange Blueprint Approval Timelines (§ 155.106)

As discussed in the preamble of this proposed rule, the proposed regulatory amendments would not eliminate the requirement for States seeking to transition to a different Exchange operational model (FFE to SBE–FP or SBE, or SBE–FP to SBE) to submit an Exchange Blueprint or for HHS to approve, or conditionally approve, a State's Exchange Blueprint. It would only impact the timeline, by providing additional time, for HHS to provide approval, or conditional approval.

We do not estimate any burden associated with this proposal as States are currently required to submit an Exchange Blueprint to HHS for approval, or conditional approval, and HHS is currently required to approve, or conditionally approve, a State's Exchange Blueprint.

We seek comment on this estimate.

8. Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210 and 155.225)

As discussed in the preamble, this new language would permit enrollment assistance on initial door-to-door outreach. Currently, Assisters are permitted to go door-to-door to engage in outreach and education activities, just not enrollment assistance. Therefore, this proposed change would

[232] Public Law 117–2.

[233] Available at *https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202207-0938-001.*

not impose any new or additional opportunity costs on Navigators, non-Navigator assistance personnel, or CACs, and we do not anticipate any estimated burden associated with this proposal. The benefits of this proposal would be eliminating barriers to coverage access by maximizing pathways to enrollment. We believe it is important to be able to increase access to coverage for those whose ability to travel is impeded due to mobility, sensory or other disabilities, who are immunocompromised, and who are limited by a lack of transportation. We anticipate that this proposal would be a positive step toward enabling Assisters to reach a broader consumer base in a timely manner—helping to reduce uninsured rates and health disparities by removing underlying barriers to accessing health coverage.

We seek comment on these assumptions, specifically about any reduction in costs, benefits, or burdens on Navigators, non-Navigator assistance personnel, CACs, and consumers as related to this proposal.

9. Extension of Time To Review Suspension Rebuttal Evidence and Termination Reconsideration Requests (§§ 155.220(g) and 155.220(h))

As discussed in the preamble of this proposed rule, the proposed regulatory amendments would provide HHS with up to an additional 15 calendar days to review evidence submitted by agents, brokers, or web-brokers to rebut allegations that led to the suspension of their Exchange agreement(s) and up to an additional 30 calendar days to review evidence submitted by agents, brokers, or web-brokers to request reconsideration of termination of their Exchange agreement(s).

We do not estimate much burden associated with this proposal, as there is no requirement for HHS to utilize the additional 15 or 30 calendar days and this will only impact a very small percentage of enrolling agents, brokers, or web-brokers. Only those agents, brokers, or web-brokers that are reasonably suspected to have engaged in fraud or abusive conduct, or those with a specific finding of non-compliance against them or who have exhibited a pattern of non-compliance or abuse that may pose imminent consumer harm would be impacted.

As discussed in the preamble, this proposal would not impose any new requirements on agents, brokers, or web-brokers. At present, agents, brokers, or web-brokers whose Exchange agreement(s) are suspended or terminated may submit rebuttal evidence or reconsideration requests for HHS to consider. During this review, the submitting agent, broker, or web-broker remains unable to enroll consumers on the FFEs. This process would not change. While we would be increasing the amount of potential time the review process would take, which could lead to slightly longer periods during which agents, brokers, or web-brokers cannot enroll consumers through the FFEs and SBE–FPs, we would not be mandating HHS utilize the additional 15 or 30 calendars days for its reviews. For this reason, we do not expect any impact on agents, brokers, or web-brokers based on this proposal. We seek comment on this assumption.

10. Providing Correct Information to the FFEs and Documenting Receipt of Consumer Consent (§ 155.220(j))

As discussed in the preamble of this proposed rule, the proposed regulatory amendments would require agents, brokers, and web-brokers assisting with and facilitating enrollment through FFEs and SBE–FPs or assisting an individual with applying for APTC and CSRs for QHPs to document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or their authorized representative prior to application submission. The proposal would require the consumer or their authorized representative taking an action that produces a record showing the consumer or their authorized representative reviewed and confirmed the accuracy of their application information that must be maintained by the assisting agent, broker, or web-broker and produced to confirm the submitted eligibility application information was reviewed and confirmed to be accurate by the consumer or their authorized representative.

Also discussed in the preamble of this proposed rule, the proposed regulatory amendments would require agents, brokers, and web-brokers assisting with and facilitating enrollment through FFEs and SBE–FPs or assisting an individual with applying for APTC and CSRs for QHPs to document the receipt of consent from the consumer or their authorized representative, designated in compliance with § 155.227, qualified employers, or qualified employees they are assisting. The proposal would require the consumer or their authorized representative taking an action that produces a record of consent that must be maintained by the assisting agent, broker, or web-broker and produced to confirm the consumer or their authorized representative's consent was provided. As these two documentation processes would likely be occurring as part of the same consumer interaction,[234] the two proposals are discussed below together.

A potential cost to consider is the additional time it would take to process and submit each consumer's application. It currently takes approximately 30 minutes for an assisting agent, broker, or web-broker to submit a consumer's application. These proposed requirements may add approximately five minutes additional time, per proposal, to each application, making each application submission take 40 minutes under the new proposed policies. This means that for every six policies submitted under the proposed regulatory requirements, there would have been two additional applications that could have been submitted under the former regulatory requirements (10 extra minutes per application × 3 applications = 30 minutes, which is the estimated completion time for applications at present). If we assume agents, brokers, and web-brokers work traditional 8-hour days, they would have been able to enroll approximately 4 more consumers per day (1 application per 30 minutes = 16 per day; 1 application per 40 minutes = 12 per day). An approximation of commission for each submitted policy is $16.67.[235] Therefore, the proposed regulatory text may result in $66.68 lost per day per agent, broker, or web-broker. ($16.67 × 4 less applications submitted).

However, there would only be a potential loss of income if an agent, broker, or web-broker were constantly enrolling consumers and running out of time during the workday. It is unlikely agents, brokers, and web-brokers are constantly enrolling consumers non-stop throughout an 8-hour workday. During PY 2021, agents submitted 3,630,849 policies. The top 1 percent of agents[236] submitted 1,159,608 policies during PY 2021, which equals approximately 7 submitted policies per day.[237] As it was determined under the

[234] We note that obtaining documentation of consumer consent must occur before an application is completed. In contrast, obtaining documentation that a consumer has reviewed and confirmed the accuracy of their application information must necessarily take place during or after the application is completed. However, we expect generally that application completion, including the documentation we are proposing to require before and after the completion of the application, would occur as part of a single interaction in most cases.

[235] This was derived using the Insurance Sales Agent mean hourly wage from the above wage estimate table of $33.34 and dividing in-half.

[236] The current number of agents registered with the Exchange is 66,893. We looked at data from the 668 top-selling agents.

[237] This assumed an agent worked 250 days per year (50 weeks at 5 days per week).

new proposed policies that an agent could submit approximately 12 applications per day, there is no clear impact associated with this proposal as far as the number of applications being submitted. However, this could be different during Open Enrollment Period (OEP) as that generally has more activity than regular business days. During PY 2022 Open Enrollment, agents submitted 2,572,341 applications, which translates to 38 per agent. The top selling 1 percent of agents submitted 689,146 applications during Open Enrollment, which is approximately 18 applications per day.[238] Under the proposed regulatory amendments, a top-selling agent could lose approximately 6 applications per day due to time constraints. OEP runs from November 1 through January 15, which is 76 days. Under the assumption an agent is working 5 days per work for eight hours per day, an agent would submit 330 fewer applications during OEP (55 days working × 6 fewer applications per day). Using the above reference of $16.67 commission gained per submitted policy, a top-selling agent may lose $5,501.10 in commissions during OEP (330 applications × $16.67). It is likely these agents are working more hours than we accounted for, meaning the 330 fewer applications is an estimate such that the actual loss of commission would be less than we estimated. We seek comment on these burden estimates.

11. Failure To File and Reconcile Process (§ 155.305)

We propose to require that Exchanges instead determine an enrollee as ineligible for APTC if their taxpayer did not file a Federal income tax return and reconcile their APTC for two consecutive tax years, rather than one tax year as currently outlined at § 155.305(f)(4). We believe this proposal would benefit both Exchanges and consumers as it provides Exchanges with additional flexibility with their FTR operations and procedures, while ensuring continuity of coverage for consumers, that would otherwise go uninsured after losing ATPC to help pay for their Exchange QHPs.

We anticipate that this proposal would increase APTC expenditures by promoting continuous enrollment of consumers with APTC, who, absent this proposal, would likely choose to terminate their coverage altogether after losing their APTC eligibility due to having an FTR status. Based on HHS' own analysis, for Open Enrollment 2020, about 116,000 enrollees with an FTR status were automatically re-enrolled into an Exchange QHP without APTC; by March 2020, approximately 14,000 (12 percent) of those enrollees were still enrolled in an Exchange QHP. With the new 2-year FTR proposal, if those enrollees that ended their QHP coverage after losing APTC were given another year of APTC eligibility to come into compliance with the requirement to file and reconcile, we estimate that about 102,000 enrollees would have retained coverage with APTC for another coverage year; however, based on HHS' experience running FTR since 2015, we anticipate that about 20,400 (20 percent) of these enrollees are likely to receive a second FTR flag. Therefore, we estimate that this 2-year FTR proposal is likely to increase APTC expenditures by approximately $373 million per year beginning in benefit year 2024.

HHS is also aware of five States that have only recently transitioned to operating their own State Exchange and have not yet fully implemented the infrastructure to run FTR operations for plan years through 2023 due to the flexibility the Exchanges were given to temporarily pause FTR operations between 2021 and 2023 due to the COVID–19 public health emergency. We estimate the one-time costs for these five States to fully implement the functionality and infrastructure to conduct FTR operations to be approximately $6.6 million and estimate that the annual costs to maintain FTR operations to be approximately $10 million.

We invite comments from interested parties on this proposal, including regarding additional costs, burdens, and benefits to issuers, consumers, and Exchanges as a result of this proposal.

12. Income Inconsistencies (§§ 155.315 and 155.320)

We anticipate that proposed revision to § 155.315 would impose a minimal regulatory and cost burden on Exchanges using the Federal platform and State Exchanges in order to grant the 60-day extension for income DMIs. We estimate that the proposed change to grant a 60-day extension to applicants with income DMIs would result in a $500,000 one-time cost to Exchanges on the Federal platform and to each of the State Exchanges using their own platform. Therefore, we estimate that the total cost for State Exchanges would be $9 million to comply with the requirement to grant the 60-day extension, and the total cost to the Federal Government would be $500,000.

We anticipate that the proposed revisions to § 155.320 would impose a minimal regulatory burden and a one-time cost burden on the Exchanges using the Federal platform and State Exchanges using their own platform. We estimate that the proposed change to accept the income attestation for households for which the Exchange requests tax return data from the IRS to verify attested projected annual household income but for whom the IRS confirms there is no such tax return data available would result in a $500,000 one-time cost to the Federal Government and a one-time cost of $500,000 to each of the State Exchanges using their own platform. We also anticipate $175 million in increased APTC costs annually as a result of this proposal, due to applicants remaining enrolled through the end of the plan year instead of losing eligibility for APTC due to not providing sufficient documentation to verify their projected household income.

However, we do anticipate that the proposed revisions to § 155.320 would also result in some decreases in ongoing administrative costs for the Exchanges using the Federal platform and State Exchanges. The proposed change would eliminate the requirement to generate income DMIs when the Exchange requests tax return data from the IRS for an applicant or enrollee and the IRS confirms no such data is available. For Exchanges on the Federal platform, we anticipate that this will result in 1.2 million fewer households receiving an income DMI, which would result in $66 million in annual cost savings to the Federal Government. Additionally, State Exchanges using their own platform would also experience annual cost savings of $37 million due to this proposed change.

We do not anticipate that these proposed changes would impose a cost or regulatory burden on issuers. However, the proposed changes would have a financial impact on issuers via the continued enrollment of consumers who otherwise would have experienced APTC adjustment and are thus likely to disenroll.

13. Annual Eligibility Redetermination (§ 155.335(j))

We propose revising § 155.335(j) to allow the Exchange, beginning in PY 2024, to direct re-enrollment for enrollees who are eligible for CSR in accordance with § 155.305(g) from a bronze QHP to a silver QHP with a lower or equivalent premium after APTC within the same product and QHP issuer, regardless of whether their current plan is available or not. We also

[238] This assumed an agent worked 5 days per week at 8 hours per day, which is likely a low estimate.

propose to amend the Exchange re-enrollment hierarchy to allow all Exchanges (Exchanges on the Federal platform and SBEs) to ensure enrollees whose QHPs are no longer available to them and enrollees who would be re-enrolled into a silver-level QHP in order to receive income-based CSRs are re-enrolled into plans with the most similar network to the plan they had in the previous year, provided that certain conditions are met.

We propose revising paragraph (j)(2)(i) to state that if the enrollee is not CSR eligible, the Exchange will re-enroll the enrollee in a QHP at the same metal level as and with the most similar network compared to the enrollee's current QHP. We propose amending and redesignating paragraphs (j)(2)(ii) and (iii) as paragraphs (j)(2)(iv) and (v), respectively, to specify that the enrollee's provider network must also be considered in re-enrollment determinations. We also propose adding a new paragraph (j)(2)(ii) to establish that if the enrollee is CSR-eligible, in accordance with § 155.305(g), and the enrollee's current QHP is a bronze level plan, the Exchange will re-enroll the enrollee either in a bronze level QHP, or, at the option of the Exchange, in a silver level QHP that has a lower or equivalent premium after APTC and has the most similar network compared to the enrollee's current QHP in the product offered by the same issuer through the Exchange that is most similar to the enrollee's current product. Lastly, we propose to add a new paragraph (j)(2)(iii) to establish that if the enrollee is CSR-eligible, in accordance with § 155.305(g), and the enrollee's current QHP is not a bronze level plan, the enrollee will be re-enrolled in a QHP at the same metal level that has the most similar network compared to the enrollee's current QHP in the product offered by the same issuer that is the most similar to the enrollee's current product.

We anticipate that the inclusion of additional criteria in the Federal hierarchy for re-enrollment would increase costs and burden for issuer and Exchanges, although we are unable to quantify this increase. However, we believe initially limiting the scope to only CSR-eligible enrollees who are currently in a bronze QHP and have a lower cost silver CSR QHP available would allow issuers and Exchanges to incrementally update their processes, as opposed to incorporating both premium (after APTC) and out-of-pocket cost (OOPC) throughout the hierarchy in PY 2024. Additionally, we believe that allowing the Exchange to direct re-enrollment for CSR-eligible enrollees from bronze plans to silver CSR plans with lower or equivalent premium after APTC would facilitate enrollment into silver CSR plans and help reduce CSR forfeiture. We believe these proposed changes to the re-enrollment process, in combination with improved consumer notification, would further streamline the consumer shopping experience, enhance consumer understanding of plan options, and help move enrollment into more affordable, higher generosity plans, especially in cases where market conditions have substantially increased the old plan's cost. By amending the current Federal hierarchy for re-enrollment to incorporate provider networks and facilitate enrollment into lower cost, higher generosity plans, we believe we would be promoting consumer access to affordable, high-quality coverage.

We seek comment on the estimated costs and benefits described in this section, as well as any additional impacts on consumers, issuers, and Exchanges as a result of this proposal.

14. Coverage Effective Dates for Qualified Individuals Losing Other Minimum Essential Coverage (§ 155.420(b))

We propose to add paragraph (b)(2)(iv) to § 155.420(b) to provide earlier SEP coverage effective dates for qualifying individuals who attest to a future loss of MEC, such as coverage offered through an employer, Medicaid, CHIP, or Medicare., within 60 days before such loss of MEC s. Currently, the earliest start date for Exchange coverage when a qualifying individual attests to a future loss of MEC is the first day of the month following the date of loss of MEC, which may result in coverage gaps when consumers lose forms of MEC (other than Exchange coverage) mid-month. We believe that this proposed change is necessary to ensure that qualifying individuals are able to seamlessly transition from other non-Exchange MEC to Exchange coverage as quickly as possible with minimal coverage gaps. As discussed earlier in preamble, ensuring smooth and quick transitions into Exchange coverage will be especially critical once the COVID–19 PHE comes to an end and higher numbers of consumers lose their Medicaid or CHIP coverage and transition to Exchange coverage, as applicable.

Based on HHS' own analysis, for plan years 2019 through 2021, approximately 214,000 households seeking coverage on Exchanges using the Federal platform reported a future mid-month loss of MEC date and ultimately did not enroll in a QHP. In PY 2021, about 45,000 households attested to a future mid-month loss of coverage MEC date and did not enroll in QHP coverage. If these consumers had been given the opportunity for Exchange coverage to begin the first of the month in which their prior mid-month loss of MEC coverage end date occurred, rather than having to wait weeks for their coverage to start, these consumers could have avoided a gap in coverage and could have received an additional month of APTC, given our interpretation of IRS' definition of a coverage month, which we plan to codify in the final rule. Therefore, for consumers who report a future loss of MEC, especially those who reside in States that allow mid-month terminations for Medicaid or CHIP, we estimate that this proposed change could increase APTC expenditures by approximately $161 million dollars per coverage year by allowing Exchange coverage to start the first of the month in which the mid-month loss of MEC or COBRA occurs and assuming that similar volume of consumers would choose enroll in an Exchange QHP, however, this number could be slightly lower but we are unable to estimate what proportion of consumers would still elect to not enroll in an Exchange QHP. We also anticipate additional costs to certain consumers as some consumers would be required to pay for an additional month of Exchange coverage for which they would not have previously been eligible while also still possibly paying for one last month of their prior MEC coverage. However, in order to mitigate adverse selection concerns, we are not proposing that Exchanges permit consumers to select a different, prospective coverage start date, such as the first of the month following plan selection. We also seek comment from issuers regarding any additional or remaining risk regarding mid-month coverage effective dates.

We seek comment on this proposal, specifically about any additional costs, benefits, or burdens on State Exchanges, issuers, and consumers as related to this proposal.

15. Special Rule for Loss of Medicaid or CHIP Coverage (§ 155.420(c))

We propose to add paragraph (c)(6) to § 155.420(c) to provide qualifying individuals losing Medicaid or CHIP that is considered MEC in accordance with § 155.420(d)(1)(i), and who qualify for a special enrollment period, with up to 60 days before and up to 90 days after their loss of coverage to enroll in QHP coverage. We believe that this proposed change is necessary to ensure that qualifying individuals are able to seamlessly transition from Medicaid or

CHIP into Exchange coverage as quickly as possible with little to no coverage gaps. As discussed earlier in preamble, ensuring smooth and quick transitions into Exchange coverage will be especially critical once the COVID–19 PHE comes to an end and higher numbers of consumers lose their Medicaid or CHIP coverage and transition to Exchange coverage, as applicable.

Based on HHS's own analysis, in plan year 2019, about 60,000 consumers seeking coverage on Exchanges using the Federal platform attested to a Medicaid/CHIP loss or denial between 60 to 90 days prior on their *HealthCare.gov* application. We estimate that this proposed change to permit Exchanges to use a special rule to provide consumers losing Medicaid or CHIP with 90 days after their loss of Medicaid or CHIP to enroll in QHP coverage would increase APTC expenditures by approximately $98 million per year.

We seek comment on this proposal, specifically about any additional costs, benefits, or burdens on States, issuers, and consumers as related to this proposal.

16. Plan Display Error Special Enrollment Periods (§ 155.420(d))

We anticipate that revisions to § 155.420(d)(12) would maintain current regulatory burden and cost on issuers. As discussed earlier in preamble, our proposal to make necessary changes to the text of § 155.420(d)(12) is to align the policy for granting SEPs to persons who are adversely affected by a plan display error with current plan display error SEP operations. Our proposal would have minimal operational impact, as interested parties such as issuers, States, and the Exchanges on the Federal platform currently have the infrastructure to demonstrate that a material plan display error influenced a qualified individual's, enrollee's, or their dependents' enrollment and, or decision to purchase a QHP through the Exchange. This does not impose additional regulatory burden or costs because the revisions do not require the consumers, HHS, or issuers to conduct new or additional processes to existing data change requirements.

17. Termination of Exchange Enrollment or Coverage (§ 155.430)

We anticipate that the proposal to expressly prohibit issuers from terminating coverage for policy dependent children because they reached the maximum allowable age mid-plan year would benefit affected enrollees by providing clarity regarding their ability to maintain coverage. Because this prohibition has already been in place on the Exchanges on the Federal platform, we do not anticipate a financial impact to issuers or HHS. There may be some minor costs for State Exchanges that choose to implement this prohibition and have not previously done so, but we do not have adequate data to estimate these costs. We seek comment on these benefit and burden assumptions.

18. Improper Payment Pre-Testing and Assessment for State Exchanges (§ 155.1500)

This proposal would prepare 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 PIIA 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 improper payment rates as mandated by statute.

This proposal tests State Exchanges' readiness to provide the information necessary to measure the rate of improper payments. Even slight decreases in this rate would accrue large taxpayer savings. The IPPTA incurs approximately $57,000 in costs per respondent. Nevertheless, HHS believes that the potential benefits of this regulatory action justify the present costs.

This proposal would prepare HHS to implement the statutory requirement for measurement of improper payments for programs susceptible to significant improper payments. We have quantified the costs for this proposal. Neither this IPPTA nor any follow-on program should affect transfers between parties.

19. FFE and SBE–FP User Fee Rates for the 2024 Benefit Year (§ 156.50)

We are proposing an FFE user fee rate of 2.5 percent of monthly premiums for the 2024 benefit year, which is a decrease from the 2.75 percent FFE user fee rate finalized in the 2023 Payment Notice (87 FR 27289). We also propose an SBE–FP user fee rate of 2.0 percent for the 2024 benefit year, which is a decrease from the 2.25 percent SBE–FP user fee rate finalized in the 2023 Payment Notice. Based on our estimated costs, enrollment (including anticipated transitions of States from the FFE and SBE–FP models to either the SBE–FP or State Exchange model), premiums for the 2024 benefit year, and proposed user fee rates, we are estimating that FFE and SBE–FP user fee transfers from issuers to the Federal Government would be $170 million lower compared to those estimated for the prior benefit year. We also anticipate that the lower user fee rates may exert downward pressure on premiums.

20. Standardized Plans

a. Standardized Plan Options (§ 156.201)

At § 156.201, we propose minor updates to our approach to standardized plan options for PY 2024 and subsequent PYs. In particular, in contrast to the policy finalized in the 2023 Payment Notice, HHS proposes, for PY 2024 and subsequent PYs, to no longer include a standardized plan option for the non-expanded bronze metal level. Accordingly, HHS proposes at new § 156.201(b) that for PY 2024 and subsequent PYs, FFE and SBE–FP issuers offering QHPs through the Exchanges must offer standardized QHP options designed by HHS at every product network type (as described in the definition of ''product'' at § 144.103), at every metal level except the non-expanded bronze level, and throughout every service area that they offer non-standardized QHP options.

HHS believes that maintaining the highest degree of continuity possible in the approach to standardized plan options minimizes the risk of disruption for a range of interested parties, including issuers, agents, brokers, States, and enrollees. HHS believes that making major departures from the approach to standardized plan options in the 2023 Payment Notice could result in drastic changes in these plan designs that could potentially cause undue burden for these interested parties. Furthermore, if the standardized plan options HHS creates vary significantly from year to year, those enrolled in these plans could experience unexpected financial harm if the cost-sharing for services they rely upon differs substantially from the previous year. Ultimately, HHS believes consistency in standardized plan options is important to allow both issuers and enrollees to become accustomed to these plan designs.

Thus, similar to the approach taken in the 2023 Payment Notice, HHS proposes to create standardized plan options that would continue to resemble the most popular QHP offerings that millions of consumers are already enrolled in. As such, these proposed standardized plan options are based on refreshed PY 2022

cost-sharing and enrollment data to ensure that these plans continue to reflect the most popular offerings in the Exchanges.

With HHS proposing to maintain a similar approach to standardized plan options to that taken in the 2023 Payment Notice, issuers would continue to be able to utilize many existing benefit packages, networks, and formularies, including those paired with standardized plan options for PY 2023. Furthermore, since HHS is proposing to require QHP issuers to offer standardized plan options at every product network type, at every metal level except the non-expanded bronze metal level, and throughout every service area they also offer non-standardized plan options (but not for different product network types, metal levels, and service areas where they do not also offer non-standardized plan options), issuers would continue to not be required to extend plan offerings beyond their existing service areas.

Furthermore, as discussed earlier in the preamble, HHS noted that it would continue to differentially display standardized plan options on *HealthCare.gov* per the existing authority at § 155.205(b)(1). Since HHS would continue to assume the burden for differentially displaying standardized plan options on *HealthCare.gov,* FFE and SBE–FP issuers would continue to not be subject to this burden.

In addition, as noted in the preamble, HHS would continue enforcement of the standardized plan option display requirements for approved web-brokers and QHP issuers using a direct enrollment pathway to facilitate enrollment through an FFE or SBE–FP—including both the Classic DE and EDE Pathways—at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv), respectively. HHS believes that continuing the enforcement of these differential display requirements would not require significant modification of these entities' platforms and non-Exchange websites, especially since the majority of this burden already occurred when the standardized plan option differential display requirements were first finalized in the 2018 Payment Notice [239] or when enforcement of these requirements resumed beginning with the PY 2023 open enrollment period.

Finally, since HHS would continue to allow these entities to submit requests to deviate from the manner in which standardized plan options are differentially displayed on *HealthCare.gov,* the burden for these entities would continue to be minimized. HHS intends to continue providing access to information on standardized plan options to web-brokers through the Health Insurance Marketplace Public Use Files (PUFs) and QHP Landscape file to further minimize burden. Specific burden estimates for these requirements can be found in the corresponding ICR sections for §§ 155.220 and 156.265 of the 2023 Payment Notice (87 FR 698 and 699 and 87 FR 27360 and 27361).

b. Non-Standardized Plan Option Limits (§ 156.202)

At § 156.202, we propose to limit the number of non-standardized plan options that issuers of individual market medical QHPs can offer through the FFEs and SBE–FPs to two per product network type, metal level, and service area. If such a limit were adopted in PY 2024, it is estimated that the weighted average number of non-standardized plan options (which does not take into consideration standardized plan options) available to each consumer would be reduced from approximately 107.8 in PY 2022 to 37.2 in PY 2024. Furthermore, it is estimated that approximately 60,949 of a total 106,037 non-standardized plan option plan-county combinations (amounting to 57.5 percent of non-standardized plan option plan-county combinations) would be discontinued.[240] Finally, it is estimated that approximately 2.72 million of the approximate 10.21 million enrollees on the FFEs and SBE–FPs (amounting to 26.6 percent of enrollees) would be affected by these discontinuations.[241]

The total number of QHPs that would have to undergo QHP certification each year would be reduced as a result of limiting the number of non-standardized plan options. Relatedly, although issuers would be required to select another QHP to which to crosswalk affected enrollees from discontinued non-standardized plan options, the existing discontinuation notices and process as well as the current re-enrollment hierarchy and corresponding crosswalk process outlined at § 155.335(j) could accommodate crosswalking these affected enrollees, and no additional modification to these processes or to this re-enrollment hierarchy would be required. Finally, no additional action would be required from consumers to complete this crosswalking process.

We do not have sufficient data to estimate the costs associated with these proposed changes, so we seek comment from interested parties regarding cost estimates and data sources.

21. QHP Rate and Benefit Information (§ 156.210)

a. Age on Effective Date for SADPs

This rule proposes standards related to the rate submission process for Exchange-certified SADPs during QHP certification. This rule proposes to modify the rate submission process to require issuers of Exchange-certified SADPs, whether they are sold on- or off-Exchange, to use age on effective date as the sole method to calculate an enrollee's age for rating and eligibility purposes beginning with Exchange certification in PY 2024. Requiring these issuers to use the age on effective date methodology for calculating an enrollee's age, and consequently removing the less common and more complex age calculation methods, will reduce potential consumer confusion and the burden placed on Exchange interested parties (including issuers, as well as DE and EDE partners) by promoting operational efficiency.

This proposed policy change reduces the risk of consumer harm and confusion since the age on effective date method allows consumers to more easily understand the rate they are charged. This proposed policy also helps reduce enrollment blockers, which will improve the efficiency of the enrollment process and reduce the burden placed on Exchange interested parties (including issuers, as well as DE and EDE partners). Therefore, this proposed policy helps facilitate more informed enrollment decisions and enrollment satisfaction.

We also do not anticipate any negative financial impact as a result of this proposed policy, given that it would be a small operational change. If anything, this proposed policy has the potential to reduce financial burden on issuers and CMS, as removing the other age rating methods would reduce the added expense and slower development times that must account for test cases in

[239] These differential display requirements were first effective and enforced beginning with PY 2018. See 81 FR 94117 through 94118, 94148.

[240] Plan-county combinations are the count of unique plan ID and FIPS code combinations. This measure is 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 service area, for example.

[241] These calculations assume that the non-standardized plan options removed due to the proposed limit would be those with the fewest enrollees based on PY 2022 data, which includes individual market medical QHPs for Exchanges using the *HealthCare.gov* eligibility and enrollment platform, including SBE–FPs.

the rating engine for the less commonly used and more complex methods.

Additionally, this proposed policy change would not create any additional information submission burden, as it would apply to information that Exchange issuers already submit as part of the QHP certification process.

b. Guaranteed Rates for SADPs

This rule proposes standards related to the rate submission process for Exchange-certified SADPs during QHP certification. This rule proposes to modify the rate submission process to require issuers of Exchange-certified SADPs, whether they are sold on- or off-Exchange, to submit guaranteed rates beginning with Exchange certification in PY 2024. Requiring guaranteed rates would reduce potential consumer harm and burden associated with incorrect APTC calculation for the pediatric dental EHB portion of premiums, and the need for consumers to contact issuers who post estimated rates for final rates.

Requiring guaranteed rates would reduce the risk of consumer harm by reducing the risk of incorrect APTC calculation for the pediatric dental EHB portion of premiums. Therefore, we believe that this proposed policy change would support health equity by helping to ensure that low-income enrollees who qualify for APTC are charged the correct premium amount. Beyond reducing the potential for consumer financial harm, this proposed policy would also reduce the burden placed on consumers because it would allow them to rely on the information they see on the issuer's website and not have to contact issuers for final rates after the QHP certification process.

22. Plan and Plan Variation Marketing Name Requirements for QHPs (§ 156.225)

We propose at § 156.225 to require that QHP plan and plan variation marketing names include correct information, without omission of material fact, and do not include content that is misleading. CMS, States, and QHP issuers work together to ensure that consumers can make informed decisions when selecting a health insurance plan based on factors such as QHP benefit design, cost-sharing requirements, and available financial assistance. In PY 2022, Exchanges on the Federal platform saw a significant increase in the number of plan and plan variation marketing names using cost-sharing information and other benefit details. Following Open Enrollment for PY 2022, CMS received complaints from consumers in multiple States who misunderstood cost-sharing information in their QHP's marketing name. We believe that clear policy can result in plan and plan variation marketing names that reduce consumer confusion.

By providing standards that help ensure plan and plan variation marketing names are clear and accurate, we anticipate the proposed policy will reduce burden on consumers and on those who help consumers to enroll in Exchange coverage because it will allow them to rely on information they see during the plan selection process. In addition, we believe that the proposed standards for plan and plan variation marketing names would have an overall positive impact on other Exchange interested parties as well, by ensuring that the consumer education that plans use to compete in the individual health insurance market is clear and accurate.

This proposed policy may require additional effort during the QHP certification process on the part of Exchange issuers to comply with new plan marketing name standards. However, we would work to streamline this process by incorporating education about plan and plan variation marketing name standards into the annual QHP certification process, and proactively addressing issuer and State questions through existing outreach and education vehicles including webinars, email blasts, and regularly scheduled meetings on individual health insurance market policy and operations.

The proposed policy would not create any new information submission burden, because it would apply to information that Exchange issuers already submit as part of the QHP certification process. Additionally, while requiring increased effort initially, we believe this proposed policy would ultimately decrease issuer and State effort following QHP certification, and during and after the annual Open Enrollment Period, by reducing the number of plan and plan variation marketing name-related consumer complaints to triage and, in some cases, special enrollment periods to be provided.

We seek comment on the burden that this proposed policy would impose, and on the burden reduction it could provide. We also seek comment on how CMS can further alleviate any burden associated with this proposed policy, such as through technical assistance to Exchange interested parties, including issuers and enrollment assisters.

Finally, we also believe that the proposed policy would promote health equity by reducing the likelihood of QHP benefit misunderstanding and confusion that leads to less informed enrollment decisions, especially for consumers with low health literacy, which is disproportionately experienced among underserved communities and other vulnerable populations. For example, a 2022 study found higher self-reported low health literacy among people who are Hispanic, non-U.S. citizens, unemployed, or who have less than a high school education.[242] A 2019 study that tested participants' knowledge of health insurance terminology found statistically significant disparities based on race, ethnicity, and language preference.[243] We seek comment on this proposal and on whether this proposal would promote health equity, and on additional ways that CMS can support health insurance literacy through plan marketing guidance and technical assistance.

23. Network Adequacy (§ 156.230)

Regarding HHS's proposal to require all QHP issuers, including SADP issuers, to utilize a contracted network of providers and comply with network adequacy standards at § 156.230 and ECP standards at § 156.235, we acknowledge that SADP issuers that only offer plans that do not use a provider network and that want to be certified may initially face increased costs associated with developing contractual relationships with providers or leveraging pre-existing networks associated with their other plans. However, studies have found that provider networks allow for insurer-negotiated prices and controlled (that is, reduced) costs in the form of reduced patient cost-sharing, premiums, and service price, as compared with such services obtained out of network.[244] [245] We expect any initial increased issuer costs to differ from the costs experienced once such provider

[242] 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. PMID: 31768496; PMCID: PMC6831506.

[243] Villagra VG, Bhuva B, Coman E, Smith DO, Fifield J. Health insurance literacy: disparities by race, ethnicity, and language preference. Am J Manag Care. 2019 Mar 1;25(3):e71–e75. PMID: 30875174.

[244] Benson NM, Song Z. Prices And Cost Sharing For Psychotherapy In Network Versus Out Of Network In The United States. Health Aff (Millwood). 2020 Jul;39(7):1210–1218. *https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01468.*

[245] Song, Z., Johnson, W., Kennedy, K., Biniek, J. F., & Wallace, J. Out-of-network spending mostly declined in privately insured populations with a few notable exceptions from 2008 to 2016. Health Aff. 2020;39(6), 1032–1041. *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01776.*

contractual relationships have been established or pre-existing networks associated with their other plans have been leveraged. We request comment on whether and how to extrapolate from literature on voluntary network formation for purposes of assessing impacts of this regulatory provision.

For SADPs that do not use a provider network, this proposal would require these issuers to contract with providers in accordance with our existing network adequacy requirements or withdraw from the Exchange. The latter may create a burden for enrollees and QHP plans in the service area if no SADPs remain. However, we expect this burden to only affect a small number of consumers, given the overall small number of Exchange-certified SADPs that do not use a provider network on the FFEs. As discussed further in Table 12 in the preamble for part 156, over the last few years, fewer than 100 counties have had SADPs without provider networks, and most of these counties had SADPs with provider network options available. For PY 2022, there were only 8 Exchange-certified SADPs without provider networks in the FFEs. Similarly, the number of States with these types of plans has decreased over time. At its highest, in 2014, 9 FFE States had Exchange-certified SADPs without provider networks. Since PY 2020, this number has dropped to 4 or fewer FFE States, with only 2 FFE States having this plan type in PYs 2022 and 2023. Additionally, Exchange-certified SADPs with provider networks are becoming more available in counties that previously only had no-network SADP options: for PYs 2022 and 2023, only 2 FFE States (Alaska and Montana) offer Exchange-certified SADPs without provider networks. For Montana, all counties offering this plan type also offer Exchange-certified SADPs with provider networks. For Alaska in PYs 2022 and 2023, 90 percent of counties with Exchange-certified SADPs without provider networks have no Exchange-certified SADPs with provider networks.

We anticipate approximately 2,200 enrollees will be affected by this proposal. Enrollees in SADPs that choose not to comply with this requirement would need to select a different plan for coverage, which may cause hardship if the enrollee cannot access assistance, requires culturally and linguistically appropriate support, and/or does not have an understanding of health insurance design and benefits. In the event service areas are left without SADPs due to the provider network requirement, health plans will have to amend their benefits to include the pediatric dental benefit EHB. This change may require costs for issuers to build the benefit and contract with providers.

These impacts may be mitigated if we finalize a limited exception to allow SADPs to not use a provider network in areas where it is prohibitively difficult for the SADP issuer to establish a network of dental providers that complies with §§ 156.230 and 156.235.

Finally, we do not anticipate any impact as a result of this proposal on health plans that do not use a network, given our understanding that no such plan is currently certified as a QHP by an Exchange, but solicit comment to inform that understanding.

24. Essential Community Providers (§§ 156.235(a)(2)(i) and 156.235(a)(2)(ii)(B))

Regarding HHS's proposal to strengthen the ECP standards under § 156.235(a)(2)(i) by requiring QHPs to contract with at least 35 percent of available FQHCs that qualify as ECPs in the plan's service area and at least 35 percent of available Family Planning Providers that qualify as ECPs in the plan's service area, we acknowledge that issuers whose provider networks do not currently include such a percentage of these provider types that qualify as ECPs may face increased costs associated with complying with the proposed policies. However, we do not expect this increase to be prohibitive. Based on data from PY 2023, it is likely that a majority of issuers would be able to meet or exceed the threshold requirements for FQHCs and Family Planning Providers without needing to contract with additional providers in these categories.

To illustrate, if these requirements had been in place for PY 2023, out of 137 QHP issuers on the FFEs, 76 percent would have been able to meet or exceed the 35 percent FQHC threshold, while 61 percent would have been able to meet or exceed the 35 percent Family Planning Provider threshold without contracting with additional providers. For SADP issuers, 84 percent would have been able to meet the 35 percent threshold requirement for FQHCs offering dental services without contracting with additional providers. In PY 2023, for medical QHPs, the mean and median ECP percentages for the FQHC category were 74 and 83 percent, respectively. For the Family Planning Providers category, the mean and median ECP percentages were 66 and 71 percent, respectively. For SADPs, the mean and median ECP percentages for the FQHC category were 61 and 64 percent, respectively.

Regarding HHS's proposal to strengthen the ECP standards under § 156.235(a)(2)(ii)(B) by establishing two additional stand-alone ECP categories to include SUD Treatment Centers and Mental Health Facilities, we acknowledge challenges associated with a general shortage and uneven distribution of SUD Treatment Centers and mental health providers. However, the ACA requires that a QHP's network include ECPs where available. As such, the proposal to require QHPs to offer a contract to at least one available SUD Treatment Center and one available Mental Health Facility in every county in the plan's service area does not unduly penalize issuers facing a lack of certain types of ECPs within a service area, meaning that if there are no provider types that map to a specified ECP category available within the respective county, the issuer is not penalized. Further, as outlined in prior Letters to Issuers, HHS prepares the applicable PY HHS ECP list that potential QHPs use to identify eligible ECP facilities. The HHS ECP list reflects the total supply of eligible providers (that is, the denominator) from which an issuer may select for contracting to count toward satisfying the ECP standard. As a result, issuers are not disadvantaged if their service areas contain fewer ECPs. HHS anticipates that any QHP issuers falling short of the 35 percent threshold for PY 2024 could satisfy the standard by using ECP write-ins and justifications. As in previous years, if an issuer's application does not satisfy the ECP standard, the issuer would be required to include as part of its application for QHP certification a satisfactory justification.

25. Termination of Coverage or Enrollment for Qualified Individuals (§ 156.270)

We propose to amend § 156.270(f) by adding a timeliness standard to the requirement for QHP issuers to send enrollees notice of payment delinquency. Specifically, we propose to revise § 156.270(f) to require issuers to send notice of payment delinquency promptly and without undue delay. We anticipate that this proposal would be beneficial to enrollees who become delinquent on premium payments by ensuring they are properly informed of their delinquency in time to avoid losing coverage. It may be especially beneficial to enrollees who are low income, who would be especially negatively impacted by disruptions in coverage. We expect some minimal costs to issuers associated with updating their internal processes to ensure compliance with the finalized

timeliness standard, but do not have adequate data to estimate these costs. We seek comment on the benefit and cost assumptions of this proposal.

26. Final Deadline for Reporting Enrollment and Payment Inaccuracies Discovered After the Initial 90-Day Reporting Window (§ 156.1210(c))

We propose to amend § 156.1210(c) to remove the alternate deadline at § 156.1210(c)(2), which requires an issuer to describe all data inaccuracies identified in a payment and collection report by the date HHS notifies issuers that the HHS audit process with respect to the plan year to which such inaccuracy relates has been completed, in order for these data inaccuracies to be eligible for resolution. Under this proposal, we would retain only the deadline at § 156.1210(c)(1), which requires that issuers describe all inaccuracies identified in a payment and collections report within 3 years of the end of the applicable plan year to which the inaccuracy relates to be eligible to receive an adjustment to correct an underpayment. Under this proposal, beginning with the 2020 plan year coverage, HHS would not pay additional APTC payments or reimburse user fee payments for FFE, SBE–FP, and SBE issuers for data inaccuracies reported after the 3-year deadline. Further, we propose that HHS would not accept or take action that results in an outgoing payment on data inaccuracies or payment errors for the 2015 through 2019 plan year coverage that are reported after December 31, 2023. We anticipate that this proposed change would result in a less operationally burdensome process for the identification and resolution of these data inaccuracies for issuers, State Exchanges, and HHS, and a slight reduction in associated burdens, such as resolution of data inaccuracies for discovered underpayments. However, we anticipate the impact would be minimal, if any, and result in no significant financial impact.

27. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed or final rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on last year's proposed rule (465) will be the number of reviewers 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 number of past commenters 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 will 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 rule is $115.22 per hour, including overhead and fringe benefits.[246] Assuming an average reading speed, we estimate that it would take approximately 1 hour for the staff to review half of this proposed or final rule. For each entity that reviews the rule, the estimated cost is $115.22 (1-hour × $115.22). Therefore, we estimate that the total cost of reviewing this regulation is $53,577.30 ($115.22 × 465).

D. Regulatory Alternatives Considered

With respect to the inclusion or exclusion of the 2020 benefit year enrollee-level EDGE data in the recalibration of 2024 benefit year risk adjustment models, we considered a variety of alternative options to our proposal to use 2018, 2019, and 2020 enrollee-level EDGE data with an exception to exclude 2020 benefit year data from recalibration of the age-sex coefficients for the adult models, which is the fourth option outlined above. The first option considered was to maintain current policy, recalibrating the risk adjustment models using 2018, 2019, and 2020 enrollee-level EDGE data (without any adjustment). The second option involved using 2018, 2019, and 2020 enrollee-level EDGE data, but assigning a lower weight to the 2020 data. The third option we considered would utilize 4 years of enrollee-level EDGE data, instead of three, to recalibrate the risk adjustment models using 2017, 2018, 2019, and 2020 data. The fifth option would exclude the 2020 enrollee-level EDGE data and use the 2017, 2018, and 2019 enrollee-level EDGE data in recalibration for the 2024 benefit year or to use the final 2023 models as the 2024 risk adjustment models. The sixth and final option we considered would use 2 years of enrollee-level EDGE data for 2024 benefit year recalibration—only 2018 and 2019 data.

Our analyses found that the 2019 and 2020 benefit year enrollee-level EDGE recalibration data were largely comparable, however, there were observed anomalous decreases in the unconstrained coefficients for the 2020 benefit year enrollee-level EDGE recalibration data for older adult enrollees, especially older female enrollees. Option 1 therefore would not address the identified anomalous trend that is not expected to continue in future benefit years.

The second option would represent a compromise between those who wish to include 2020 data in model recalibration and those who wish to exclude 2020 data, by capturing the utilization and spending patterns underlying the 2020 data while dampening its effects in the model. However, we were concerned this approach would require finding an appropriate weighting methodology, and we are further concerned that broadly dampening the effect of the 2020 benefit year data in the models defeats the purpose of adding the next available benefit year of data as part of model recalibration because doing so would prevent the models from reflecting changes in utilization and cost of care that are unrelated to the impact of the COVID–19 PHE. There are similar concerns with option 3 and the inclusion of an additional prior benefit year (that is, 2017) to recalibrate the 2024 benefit year models to dampen the impact of the 2020 benefit year data. We do not believe that such a broad dampening is necessary because the anomalous coefficient changes identified from the 2020 benefit year data were largely limited to the adult model age-sex coefficients, and incorporating an additional prior benefit year of data would dampen the impact of the 2020 benefit year data on other factors and would prevent the models from reflecting changes in utilization and cost of care that are unrelated to the impact of the COVID–19 PHE.

We are similarly concerned about options 5 and 6, which would involve the complete exclusion of 2020 benefit year data, because both of these options would result in reliance on data that may not be the most reflective data set of the utilization and spending trends. Furthermore, there are questions about whether there is a sufficient justification to completely exclude 2020 benefit year

[246] *https://www.bls.gov/oes/current/oes_nat.htm.*

enrollee-level EDGE recalibration data in the recalibration of the risk adjustment models. The sixth option has the same limitations and would also have the additional drawback of decreasing the stabilizing effect of using multiple years of data in model recalibration. More specifically, because this option would reduce the number of years of data used, a change in a coefficient occurring in just 1 year of the data that is actually included in recalibration (that is, the 2018 or 2019 benefit years of enrollee-level EDGE recalibration data) would have a greater impact on the risk adjustment model coefficients due to the increase in the reliance of the blended coefficients on the remaining 2 years of data.

We solicit comment on all of these alternatives for the use of the 2020 enrollee-level EDGE data in the 2024 benefit year risk adjustment model recalibration.

In developing the updated materiality threshold for HHS–RADV proposed in this rule, we sought to ensure the materiality threshold would ease the burden of annual audit requirements for smaller issuers of risk adjustment covered plans that do not materially impact risk. To do this, we considered the costs associated with hiring an initial validation auditor and submitting IVA results and the relative growth of issuers' total annual premiums Statewide and total BMM. We also evaluated the benefits of shifting to a threshold based on BMM rather than annual premiums, and we are proposing changing the materiality threshold from $15 million in total annual premiums Statewide to 30,000 BMM Statewide. As an alternative option, we considered increasing the threshold to $17 million in total annual premiums Statewide and maintaining a cutoff based on premium dollars (instead of BMMs). However, we were concerned that a premium threshold would fail to capture small issuers overtime as PMPM premiums grow and would require more regular updates to the materiality threshold to maintain the current balance. The use of a BMM threshold avoids this issue. We invite comment on our proposed materiality threshold and on the potential alternative option to update the threshold to $17 million annual premiums Statewide for the benefit year being audited, and we also invite comment on the applicability date for when the new materiality threshold should begin to apply.

Regarding our proposal to require Exchanges to determine an enrollee as ineligible for APTC after having failed to file and reconcile for two consecutive tax years rather than after one tax year, we considered multiple alternatives. One alternative we considered was extending the current pause on FTR operations through plan year 2024, while HHS continued to examine the current FTR process, and explore ways in which the FTR process could promote continuity of coverage, while maintaining its critical program integrity function to ensure that only enrollees eligible for APTC continue to do so. Another alternative we considered was repealing the requirement under 45 CFR 155.305(f)(4) that a taxpayer(s) must file a Federal income tax return and reconcile their APTC for any tax year in which they or their tax household received APTC in order to continue their eligibility for APTC. However, we wanted to maintain the program integrity benefits of the FTR process, and believe there is still value in ensuring that only people who are filing and reconciling remain eligible to receive APTC. Because of this, we have amended our proposal and are instead proposing requiring that Exchanges end APTC only after two consecutive years of FTR status rather than ending APTC after a single year.

We considered two alternatives to accepting attestation to determine household income for households for which IRS does not return any data and expanding the amount of time to resolve income DMIs to meet the goal of increased consumer service and advancing health equity. We considered establishing a threshold when adjusting APTC following an income inconsistency period. Under this alternative, HHS would continue current operations but would not eliminate APTC eligibility completely if consumers are unable to provide sufficient documentation. While this alternative would require fewer changes to implement, our current proposal would create better outcomes for more consumers and decrease administrative burden. Additionally, we considered eliminating income DMIs for all consumers, including those for whom the Exchanges have IRS data, due to the large burden the income verification process places on consumers, but we found that the verification process was required for consumers with IRS data, and that consumers with other IRS data would have their household income adjusted based on that data as opposed to those without IRS data who would instead lose all of their APTC.

In developing the proposal for re-enrollment hierarchy, we considered a variety of alternatives, including making no modifications. We also considered revising the policy, beginning in PY 2024, such that the Exchange could direct re-enrollment for income-based CSR-eligible enrollees from a bronze QHP to a silver QHP with a $0 net premium within the same product and QHP issuer, regardless if the enrollee's current plan is available. Under this alternative we considered revising the policy to allow the Exchange to ensure the enrollee's coverage retained a similar provider network throughout the Federal hierarchy for re-enrollment. While we believe this may slightly reduce operational complexity, we believe income-based CSR-eligible enrollees who have a de minimis or non-zero-dollar premium would still greatly benefit from having their coverage renewed into a silver CSR QHP with a lower or equivalent net premium and OOPC, by saving thousands in care costs.

We also considered revising the policy, beginning in PY 2024, such that the Exchange could: (1) direct re-enrollment, for income-based CSR-eligible enrollees, from a bronze QHP to a silver QHP with a lower or equivalent net premium and total OOPC within the same product and QHP issuer regardless if their current plan is available; (2) if their current plan is available and the enrollee is not income-based CSR eligible, re-enroll the enrollee's coverage in the enrollee's same plan; (3) if their current plan is not available and the enrollee is not income-based CSR eligible, direct re-enrollment to a plan at the same metal level that has a lower or equivalent net premium and total out-of-pocket cost compared to the enrollee's current QHP within the same product and QHP issuer; and (4) if a plan at the same metal level as their current QHP is not available and the enrollee is not income-based CSR eligible, direct re-enrollment to a QHP that is one metal level higher or lower than the enrollee's current QHP and has a lower or equivalent net premium and total OOPC compared to the enrollee's current QHP within the same product and issuer. Under this alternative, we considered revising the policy to allow the Exchange to ensure the enrollee's coverage retained a similar provider network throughout the Federal hierarchy for re-enrollment. While we believe this alternative would be beneficial for all enrollees, we understand this would pose a substantial operational burden and complexities for issuers and Exchanges to shift from the current policy to this revised alternative. We believe an incremental change would help issuers and Exchanges diligently and appropriately adjust their re-enrollment operations. We solicit comment on all

aspects of the re-enrollment proposal at § 155.335(j).

HHS considered taking no action related to the two technical corrections to the regulatory text at § 155.420(a)(4)(ii)(A) and (B). However, HHS felt these changes were necessary to make it explicitly clear that when a qualified individual or enrollee, or his or her dependent, experiences the special enrollment period triggering event, all members of a household may enroll in or change plans together in response to the event experienced by one member of the household. These proposed technical corrections should eliminate any confusion surrounding special enrollment period triggering events and may help Exchanges and other interested parties more effectively communicate and message rules that determine eligibility for special enrollment periods and how plan category limitations may apply for certain special enrollment periods as outlined under § 155.420(a).

We considered taking no action related to our proposal to revise paragraph § 155.420(b)(2)(iv), to provide Exchanges with more flexibility by allowing Exchanges the option to provide consumers with earlier coverage effective dates so that consumers are able to seamlessly transition from one form of coverage to Exchange coverage as quickly as possible with no coverage gaps. However, we believe that many consumers would benefit from this proposed change, especially those consumers whose States allow for mid-month terminations for Medicaid/CHIP or those consumers whose COBRA coverage ends mid-month and who report their coverage loss to the Exchange before it happens. We also considered allowing consumers the option to request a prospective coverage start date rather than the day following loss of MEC or COBRA coverage but we determined that this could introduce adverse selection as consumers could choose to delay enrolling in Exchange coverage and paying premiums until coverage was necessary. Finally, we also considered for consumers attesting to a past loss of MEC and who also report a mid-month coverage loss that Exchange coverage would be effective retroactively back to the first day after the prior coverage loss date. For example, if a consumer lost coverage on July 15, coverage would be effective retroactively back to July 16. We decided against this option as it would require a statutory change to allow for mid-month PTC for consumers losing MEC mid-month, in addition to being too operationally complex for both Exchanges and issuers to implement.

We considered taking no action related to our proposal to add new paragraph § 155.420(c)(6), to ensure that qualifying individuals losing Medicaid or CHIP coverage are able to seamlessly transition to Exchange coverage as quickly as possible with little to no coverage gaps. However, we believe that many consumers will benefit from this proposed change, especially during the PHE unwinding period, where many consumers will need to seamlessly transition off Medicaid or CHIP and into Exchange coverage. We also considered whether this proposed change should be broadened to include consumers in other disadvantaged groups such as those impacted by natural disasters or other exceptional circumstances, consumers losing Medicaid or CHIP that is not considered MEC, and consumers who are denied Medicaid or CHIP coverage. We decided not to include other groups, such as those residing in a Federal Emergency Management Agency (FEMA) declared disaster area, as current CMS guidance requires that an SEP be made available for an additional 60 days after the end of a FEMA declaration.[247] Additionally, for other exceptional circumstances, there is flexibility under § 155.420(d)(9) that CMS may offer impacted consumers more time to enroll under an SEP depending on the type of exceptional circumstance, like a national PHE such as COVID–19. Finally, regarding the population that is denied Medicaid or CHIP coverage, we also considered whether to extend the SEP window length from 60 days to 90 days for the population that is denied Medicaid or CHIP, however, we chose not to extend the SEP window length for this population as there is no 90 day reconsideration period that needs alignment for consumers denied Medicaid or CHIP as there is for consumers who have lost eligibility for Medicaid or CHIP as described earlier in preamble.

We considered taking no action regarding our proposal to modify § 155.430(b) to expressly prohibit issuers from terminating coverage for policy dependent enrollees because they reached the maximum allowable age mid-Plan Year. However, we believe it is important to provide clarity to issuers and consumers regarding this policy so that coverage is not prematurely disrupted.

In developing the IPPTA policies contained in this proposed rule (§ 155.1500), we requested to meet individually with each State Exchange currently participating in the voluntary State engagement initiative in order to gather State-specific information regarding options for data collection that would impose the least burden on State Exchanges. Based on information provided by those State Exchanges that were able to participate in the meetings, we considered several data collection options but chose the option that provides State Exchanges with the greatest amount of control in aligning their source data to the requested data elements. In addition, the proposed data collection option requests that the State Exchange provide no fewer than 10 sampled tax households that we propose the State Exchange would identify based upon fulfilling the scenarios described in the preamble. An alternative option consisted of allowing the State Exchange to provide to HHS all of the source data in an unstructured format for the respective, sampled tax households. HHS using its own resources would then map the State Exchange source data to the required data elements that are necessary for performing the pre-testing and assessment. The mapping process would require consultative sessions with each State Exchange and a validation process to ensure the accurate mapping of the data. While the proposed pre-testing and assessment data request form also entails a process to validate the data with the State Exchanges, the consultative process associated with this alternative data collection mechanism would entail more frequency and a higher level of intensity.

We invite comment on this proposed data collection option and invite comment on potential alternative data collection options.

With respect to standardized plan options, we considered a range of options for the proposed policy approach at § 156.201, such as modifying the methodology used to create the standardized plan options for PY 2024 and subsequent PYs. Specifically, we considered including more than four tiers of prescription drug cost-sharing in the standardized plan option formularies. We also considered lowering the deductibles in these plan designs and offsetting this increase in plan generosity by increasing cost-sharing amounts for several benefit categories. We also considered simultaneously maintaining the current cost-sharing structures and decreasing the deductibles for these plan designs, which would have increased the AVs of these plans to be at the ceiling of each AV de minimis range. Ultimately, we

[247] *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/8-9-natural-disaster-SEP.pdf.*

decided to maintain the AVs of these plans near the floor of each de minimis range by largely maintaining the cost-sharing structures and deductible values from the standardized plan options from PY 2023, as well as by increasing the MOOP values for these plan designs. We believe this proposed approach would strike the greatest balance in providing enhanced pre-deductible coverage while ensuring competitive premiums for these standardized plan options.

We invite comment on this proposed approach.

With respect to non-standardized plan option limits, we considered a range of options for the proposed policy approach at § 156.202. Specifically, we considered limiting the number of non-standardized plan options to three, two, or one per issuer, product network type, metal level, and service area combination. We also considered no longer permitting non-standardized plan options to be offered through the Exchanges.

We also considered redeploying the meaningful difference standard, which was previously codified at § 156.298, either in place of or in conjunction with imposing limits on the number of non-standardized plan options that issuers can offer through the Exchanges. In this scenario, we considered selecting from among several combinations of the criteria in the original version of the meaningful difference standard to determine whether plans are ''meaningfully different'' from one another.[248] Specifically, we considered using only a difference in deductible type (that is, integrated or separate medical and drug deductible), as well as a $1,000 difference in deductible to determine whether plans are ''meaningfully different'' from one another.

We believe the proposed approach of limiting the number of non-standardized plan options to two per issuer, product network type, service area, and metal level would most significantly reduce the risk of plan choice overload, streamlining the plan selection process and enhancing choice architecture for consumers on the Exchanges.

We invite comment on this proposed approach.

With respect to plan and plan variation marketing names, we considered issuing sub-regulatory guidance in lieu of proposed rulemaking to require that marketing names include correct information, without omission of material fact, and not include content that is misleading. However, given the important role that plan and plan variation marketing names play in facilitating plan competition through consumer education on Exchanges, we are proposing this requirement in regulation to allow interested parties the opportunity to comment.

We considered leaving the ECP provider participation threshold and major ECP categories unchanged from PY 2023, but elected to propose these changes to ECP policy in an effort to increase access to care, particularly mental health care and SUD treatment, for low-income and medically underserved consumers. We invite comment on these proposals.

We considered not introducing a proposal to require all QHP issuers, including stand-alone dental plans, to utilize a contracted network of providers, but elected to propose this change to network adequacy policy in an effort to ensure that consumers have access to insurer-negotiated prices and reduced costs in the form of reduced cost-sharing, premiums, and service price, as compared with cost-sharing, premiums, and service prices obtained from plans with no network of contracted providers. We invite comment on this proposal.

We considered not proposing an amendment to § 156.270(f) to add a timeliness standard to the requirement for QHP issuers to send enrollees notices of payment delinquency. However, because there is currently no timeliness standard for delinquency notices, we are concerned that there is a risk that enrollees may not receive sufficient notice of their delinquency in order to avoid termination of coverage. We also considered proposing requirements on how much advance notice issuers must provide on premium bills after coverage is effectuated, but have declined to propose regulation here, determining that our focus on delinquency notice timeliness will have the desired impact without creating potential conflicts with the existing pattern of State rules and issuer practices that have long applied in the individual market.

E. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that small businesses, nonprofit organizations, and small governmental jurisdictions are small entities as that term is used in the RFA. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $8.0 million to $41.5 million in any 1 year). Individuals and States are not included in the definition of a small entity.

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). According to SBA size standards, entities with average annual receipts of $41.5 million or less would be considered small entities for these NAICS codes. Issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be $35 million or less.[249] 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 2020 MLR reporting year, approximately 78 out of 480 issuers of health insurance coverage nationwide had total premium revenue of $41.5 million or less.[250] This estimate may overstate the actual number of small health insurance issuers that may be affected, since over 76 percent of these small issuers belong to larger holding groups, and many, if not all, of these small companies are likely to have non-health lines of business that will result in their revenues exceeding $41.5 million.

In this proposed rule, we propose standards for the risk adjustment and HHS–RADV programs, which are intended to stabilize premiums and reduce incentives for issuers to avoid higher-risk enrollees. Because we believe that insurance firms offering comprehensive health insurance policies generally exceed the size thresholds for ''small entities'' established by the SBA, we do not

[248] Under the original meaningful difference standard, a plan was considered to be ''meaningfully different'' from other plans in the same product network type, metal level, and service area combination if the plan had at least one of the following characteristics: difference in network ID, difference in formulary ID, difference in MOOP type, difference in deductible, multiple in-network provider tiers rather than only one, a difference of $500 or more in MOOP, a difference of $250 or more in deductible, or any difference in covered benefits.

[249] *https://www.sba.gov/document/support--table-size-standards.*

[250] Available at *https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.*

believe that an initial regulatory flexibility analysis is required for such firms. Furthermore, the proposals related to IPPTA at §§ 155.1500–155.1515 will affect only State Exchanges. As State governments do not constitute small entities under the statutory definition, and as all State Exchanges have revenues exceeding $5 million, an impact analysis for these provisions is not required under the RFA.

As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent. We do not believe that this threshold will be reached by the requirements in this proposed rule. Therefore, the Secretary has certified that this proposed rule will not have a significant economic impact on a substantial number of small entities.

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 rule is not subject to section 1102 of the Act, we have determined that this proposed rule would not affect small rural hospitals. Therefore, the Secretary has certified that this proposed rule will 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 2022, that threshold is approximately $165 million. Although we have not been able to quantify all costs, we expect the combined impact on State, local, or Tribal governments and the private sector does not meet the UMRA definition of unfunded mandate.

G. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates 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 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 will 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 would 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 that is offered in the individual and small group markets. For example, the repeal of the risk adjustment State flexibility policy may have Federalism implications, but they are mitigated because States have the option to operate their own Exchange and risk adjustment program if they believe the HHS risk adjustment methodology does not account for State-specific factors unique to the State's markets.

As previously noted, the proposals in this rule related to IPPTA would impose a minimal unfunded mandate on State Exchanges to supply data for the improper payment calculation. Accordingly, E.O. 13132 does not apply to this section of the proposed rule. In addition, statute requires HHS to determine the amount and rate of improper payments. Finally, States have the option to choose an FFE or SBE–FP, each of which place different Federal burdens on the State. As the IPPTA section of the proposed rule should not conflict with State law, HHS does not anticipate any preemption of State law. We invite State Exchanges to submit comments on this section of the proposed rule if they believe it would conflict with State law.

In addition, we believe this proposed regulation does have Federalism implications due to our proposal that Exchanges offer earlier effective dates for consumers attesting to future mid-month loss of MEC or COBRA coverage. However, the Federalism implications are mitigated as Exchanges would have the flexibility to continue offering the current coverage effective dates as described at § 155.420(b)(2)(iv) or the new proposed earlier effective dates for consumers attesting to a future loss of MEC as described earlier in preamble. In addition, through the cross-references in § 147.104(b)(5), the new proposed earlier coverage effective dates for consumers attesting to a future loss of MEC would be applicable market-wide at the option of the applicable State authority.

Additionally, we believe this proposed regulation does have Federalism implications due to our proposal that Exchanges provide consumers losing Medicaid or CHIP with a 90-day special enrollment period window to enroll in an Exchange QHP rather than the current 60-day window. However, the Federalism implications are mitigated as Exchanges will have the flexibility to decide whether to continue providing 60 days before or 60 days after for consumers losing Medicaid or CHIP to enroll in a QHP plan as described at § 155.420(c)(1) or to implement the proposed new special rule providing consumers with 60 days before or 90 days after their loss of Medicaid or CHIP to enroll in QHP coverage.

List of Subjects

45 CFR Part 153

Administrative practice and procedure, Health care, Health insurance, Health records, Intergovernmental relations, Organization and functions (Government agencies), Reporting and recordkeeping requirements.

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers,

Conflict of interests, Consumer protection, 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, under the authority at 5 U.S.C. 301, the Department of Health and Human Services proposes to amend 45 CFR subtitle A, subchapter B, as set forth below.

PART 153—STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT

■ 1. The authority citation for part 153 continues to read as follows:

Authority: 42 U.S.C. 18031, 18041, and 18061 through 18063.

■ 2. Amend § 153.320 by revising paragraphs (d) introductory text, (d)(1)(iv), and (d)(4)(i)(B) to read as follows:

§ 153.320 Federally certified risk adjustment methodology

* * * * *

(d) *State flexibility to request reductions to transfers.* For the 2020 through 2023 benefit years, States can request to reduce risk adjustment transfers in the State's individual catastrophic, individual non-catastrophic, small group, or merged market risk pool by up to 50 percent in States where HHS operates the risk adjustment program. For the 2024 benefit year, only prior participants, as defined in paragraph (d)(5) of this section, may request to reduce risk adjustment transfers in the State's individual catastrophic, individual non-catastrophic, small group, or merged market risk pool by up to 50 percent in States where HHS operates the risk adjustment program.

(1) * * *

(i) * * *

(iv) For the 2024 benefit year only, a justification for the requested reduction demonstrating the requested reduction would have *de minimis* impact on the necessary premium increase to cover the transfers for issuers that would receive reduced transfer payments.

* * * * *

(4) * * *

(B) For the 2024 benefit year only, that the requested reduction would have *de minimis* impact on the necessary premium increase to cover the transfers for issuers that would receive reduced transfer payments.

* * * * *

■ 3. Section 153.630 is amended by—

■ a. Revising paragraph (d)(2);

■ b. Redesignating paragraph (d)(3) as paragraph (d)(4); and

■ c. Adding new paragraph (d)(3).

The revision and addition read as follows:

§ 153.630 Data validation requirements when HHS operates risk adjustment.

* * * * *

(d) * * *

(2) Within 15 calendar days of the notification of the findings of a second validation audit (if applicable) by HHS, in the manner set forth by HHS, an issuer must confirm the findings of the second validation audit (if applicable), or file a discrepancy report to dispute the findings of a second validation audit (if applicable).

(3) Within 30 calendar days of the notification by HHS of the calculation of a risk score error rate, in the manner set forth by HHS, an issuer must confirm the calculation of the risk score error rate as a result of risk adjustment data validation, or file a discrepancy report to dispute the calculation of a risk score error rate as a result of risk adjustment data validation.

* * * * *

■ 4. Section 153.710 is amended by revising paragraphs (e) and (h)(1) introductory text to read as follows:

§ 153.710 Data requirements.

* * * * *

(e) *Materiality threshold.* HHS will consider a discrepancy reported under paragraph (d)(2) of this section to be material if the amount in dispute is equal to or exceeds $100,000 or 1 percent of the total estimated transfer amount in the applicable State market risk pool, whichever is less.

* * * * *

(h) * * *

(1) Notwithstanding any discrepancy report made under paragraph (d)(2) of this section, any discrepancy filed under § 153.630(d)(2) or (3), or any request for reconsideration under § 156.1220(a) of this subchapter with respect to any risk adjustment payment or charge, including an assessment of risk adjustment user fees and risk adjustment data validation adjustments; reinsurance payment; cost-sharing reduction payment or charge; or risk corridors payment or charge, unless the dispute has been resolved, an issuer must report, for purposes of the risk corridors and MLR programs:

* * * * *

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 155.106 is amended by revising paragraphs (a)(3) and (c)(3) to read as follows:

§ 155.106 Election to operate an Exchange after 2014.

(a) * * *

(3) Have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment prior to the date on which the Exchange would begin open enrollment as a State Exchange;

* * * * *

(c) * * *

(3) Have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment prior to the date on which the Exchange proposes to begin open enrollment as an SBE–FP, in accordance with HHS rules, as a State Exchange utilizing the Federal platform;

* * * * *

§ 155.210 [Amended]

■ 7. Section 155.210 is amended by removing and reserving paragraph (d)(8).

■ 8. Section 155.220 is amended by—

■ a. Revising paragraphs (g)(5)(i)(B), (h)(3), and (j)(2)(ii) introductory text;

■ b. Redesignating paragraphs (j)(2)(ii)(A) through (D) as paragraphs (j)(2)(ii)(B), through (E), respectively;

■ c. Adding new paragraph ((j)(2)(ii)(A); and

■ d. Revising paragraph (j)(2)(iii).

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 QHPs.

* * * * *

(g) * * *

(5) * * *

(i) * * *

(B) The agent, broker, or web-broker may submit evidence in a form and manner to be specified by HHS, to rebut the allegation during this 90-day period. If the agent, broker, or web-broker submits such evidence during the suspension period, HHS will review the evidence and make a determination whether to lift the suspension within 45 calendar days of receipt of such evidence. If the rebuttal evidence does not persuade HHS to lift the suspension, or if the agent, broker, or web-broker fails to submit rebuttal evidence during the suspension period, HHS may terminate the agent's, broker's, or web-broker's agreements required under paragraph (d) of this section and under § 155.260(b) for cause under paragraph (g)(5)(ii) of this section.

* * * * *

(h) * * *

(3) *Notice of reconsideration decision.* The HHS reconsideration entity will provide the agent, broker, or web-broker with a written notice of the reconsideration decision within 60 calendar days of the date it receives the request for reconsideration. This decision will constitute HHS' final determination.

* * * * *

(j) * * *

(2) * * *

(ii) Provide the Federally-facilitated Exchanges with correct information, and document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer, or the consumer's authorized representative designated in compliance with § 155.227, prior to the submission of information under section 1411(b) of the Affordable Care Act, including but not limited to:

(A) Documenting that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or the consumer's authorized representative must require the consumer or their authorized representative to take an action that produces a record that can be maintained by the individual or entity described in paragraph (j)(1) of this section and produced to confirm the consumer or their authorized representative has reviewed and confirmed the accuracy of the eligibility application information. Non-exhaustive examples of acceptable documentation include obtaining the signature of the consumer or their authorized representative (electronically or otherwise), verbal confirmation by the consumer or their authorized representative that is captured in an audio recording, a written response (electronic or otherwise) from the consumer or their authorized representative to a communication sent by the agent, broker, or web-broker, or other similar means or methods specified by HHS in guidance.

(*1*) The documentation required under paragraph (j)(2)(ii)(A) of this section must include the date the information was reviewed, the name of the consumer or their authorized representative, an explanation of the attestations at the end of the eligibility application, and the name of the assisting agent, broker, or web-broker.

(*2*) An individual or entity described in paragraph (j)(1) of this section must maintain the documentation described in paragraph (j)(2)(ii)(A) of this section for a minimum of ten years, and produce the documentation upon request in response to monitoring, audit, and enforcement activities conducted consistent with paragraphs (c)(5), (g), (h), and (k) of this section.

* * * * *

(iii) Obtain and document the receipt of consent of the consumer or their authorized representative designated in compliance with § 155.227, employer, or employee prior to assisting with or facilitating enrollment through a Federally-facilitated Exchange or assisting the individual in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs;

(A) Obtaining and documenting the receipt of consent must require the consumer, or the consumer's authorized representative designated in compliance with § 155.227, to take an action that produces a record that can be maintained and produced by an individual or entity described in paragraph (j)(1) of this section to confirm the consumer's or their authorized representative's consent has been provided. Non-exhaustive examples of acceptable documentation of consent include obtaining the signature of the consumer or their authorized representative (electronically or otherwise), verbal confirmation by the consumer or their authorized representative that is captured in an audio recording, a response from the consumer or their authorized representative to an electronic or other communication sent by the agent, broker, or web-broker.

(B) The documentation required under paragraph (j)(2)(iii)(A) of this section must include a description of the scope, purpose, and duration of the consent provided by the consumer or their authorized representative designated in compliance with § 155.227, the date consent was given, name of the consumer or their authorized representative, and the name of the agent, broker, web-broker, or agency being granted consent, as well as a process through which the consumer or their authorized representative may rescind the consent.

(C) An individual or entity described in paragraph (j)(1) of this section must maintain the documentation described in paragraph (j)(2)(iii)(A) of this section for a minimum of 10 years, and produce the documentation upon request in response to monitoring, audit, and enforcement activities conducted consistent with paragraphs (c)(5), (g), (h), and (k) of this section.

* * * * *

§ 155.225 [Amended]

■ 9. Section 155.225 is amended by removing and reserving paragraph (g)(5).

■ 10. Section 155.305 is amended by revising paragraph (f)(4) to read as follows.

§ 155.305 Eligibility standards.

* * * * *

(f) * * *

(4) *Compliance with filing requirement.* Beginning January 1, 2024, the Exchange may not determine a tax filer eligible for APTC if the IRS notifies HHS and HHS notifies the Exchange as part of the process described in § 155.320(c)(3) that APTC payments were made on behalf of the tax filer or either spouse if the tax filer is a married couple for two consecutive years for which tax data would be utilized for verification of household income and family size in accordance with § 155.320(c)(1)(i), and the tax filer or his or her spouse did not comply with the requirement to file an income tax return for that year and for the previous year as required by 26 U.S.C. 6011, 6012, and their implementing regulations and reconcile APTC for that period.

* * * * *

■ 11. Section 155.315 is amended by adding paragraph (f)(7) to read as follows:

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

* * * * *

(f) * * *

(7) Must extend the period described in paragraph (f)(2)(ii) of this section by a period of 60 days for an applicant if the applicant is required to present satisfactory documentary evidence to verify household income.

* * * * *

■ 12. Section 155.320 is amended by adding paragraph (c)(5) to read as follows:

§ 155.320 Verification process related to eligibility for insurance affordability programs.

* * * * *

(c) * * *

(5) Notwithstanding any other requirement described in this paragraph (c) to the contrary, when the Exchange requests tax return data and family size from the Secretary of Treasury as described in § 155.320(c)(1)(i)(A) but no such data is returned for an applicant, the Exchange will accept that applicant's attestation of income and family size without further verification.

* * * * *

■ 13. Section 155.335 is amended by revising paragraphs (j)(1)(i), (j)(1)(ii), (j)(1)(iii)(A) and (B), (j)(1)(iv), (j)(2)(i) through (iii) and adding paragraphs (j)(2)(iv) and (v) to read as follows:

§ 155.335 Annual eligibility redetermination.

* * * * *

(j) * * *

(1) * * *

(i) If the enrollee's current QHP is available through the Exchange and –

(A) The enrollee is not CSR-eligible, in accordance with § 155.305(g), the Exchange will re-enroll the enrollee in the same plan as the enrollee's current QHP.

(B) The enrollee is CSR-eligible, in accordance with § 155.305(g), and the enrollee's current QHP is a bronze level plan, the Exchange will re-enroll the enrollee either in the same plan as the enrollee's current QHP, or, at the option of the Exchange, in a silver level QHP within the same product that has a lower or equivalent premium after APTC and that has the most similar network compared to the enrollee's current QHP;

(C) The enrollee is CSR-eligible, in accordance with § 155.305(g), and the enrollee's current QHP is not a bronze level plan, the Exchange will re-enroll the enrollee in the same plan as the enrollee's current QHP.

(ii) If the enrollee's current QHP is not available through the Exchange and –

(A) The enrollee is not CSR-eligible, in accordance with § 155.305(g), the Exchange will re-enroll the enrollee in a QHP within the same product, at the same metal level and that has the most similar network compared to the enrollee's current QHP.

(B) The enrollee is CSR-eligible, in accordance with § 155.305(g), and the enrollee's current QHP is a bronze level plan, the Exchange will re-enroll the enrollee either in a bronze level QHP within the same product, or, at the option of Exchange, in a silver level QHP within the same product that has a lower or equivalent premium after APTC and that has the most similar network compared to the enrollee's current QHP;

(C) The enrollee is CSR-eligible, in accordance with § 155.305(g), and the enrollee's current QHP is not a bronze level plan, the Exchange will re-enroll the enrollee in a QHP within the same product at the same metal level and that has the most similar network compared to the enrollee's current QHP;

(iii) * * *

(A) The enrollee's current QHP is a silver level plan, the Exchange will re-enroll the enrollee in a silver level QHP under a different product offered by the same QHP issuer that is most similar to and that has the most similar network compared to the enrollee's current product. If no such silver level QHP is available for enrollment through the Exchange, the Exchange will re-enroll the enrollee in a QHP under the same product that is one metal level higher or lower than the enrollee's current QHP and that has the most similar network compared to the enrollee's current QHP;

(B) The enrollee's current QHP is not a silver level plan, the Exchange will re-enroll the enrollee under the same product that is one metal level higher or lower than the enrollee's current QHP and that has the most similar network compared to the enrollee's current QHP and ; or

(iv) If the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP that is at the same metal level as, or one metal level higher or lower than the enrollee's current QHP, the Exchange will re-enroll the enrollee in any other QHP offered under the product in which the enrollee's current QHP is offered in which the enrollee is eligible to enroll that has the most similar network compared to the enrollee's current QHP.

(2) * * *

(i) If the enrollee is not CSR eligible, the Exchange will re-enroll the enrollee in a QHP in the product offered by the same issuer that is the most similar to the enrollee's current product at the same metal level as and with the most similar network compared to the enrollee's current QHP;

(ii) If the enrollee is CSR-eligible, in accordance with § 155.305(g), and the enrollee's current QHP is a bronze level plan, the Exchange will re-enroll the enrollee either in a bronze level QHP, or, at the option of the Exchange, in a silver level QHP that has a lower or equivalent premium after APTC and that has the most similar network compared to the enrollee's current QHP in the product offered by the same issuer through the Exchange that is most similar to the enrollee's current product;

(iii) If the enrollee is CSR-eligible, in accordance with § 155.305(g), and the enrollee's current QHP is not a bronze level plan, the Exchange will re-enroll the enrollee in a QHP at the same metal level that has the most similar network compared to the enrollee's current QHP in the product offered by the same issuer that is the most similar to the enrollee's current product;

(iv) If the issuer does not offer another QHP at the same metal level as the enrollee's current QHP, the Exchange will re-enroll the enrollee in a QHP that is one metal level higher or lower than the enrollee's current QHP and that has the most similar network compared to the enrollee's current QHP in the product offered by the same issuer through the Exchange that is the most similar to the enrollee's current product; or

(v) If the issuer does not offer another QHP through the Exchange at the same metal level as, or one metal level higher or lower than the enrollee's current QHP, the Exchange will re-enroll the enrollee in any other QHP offered by the same issuer in which the enrollee is eligible to enroll in the product that is most similar to the enrollee's current product and in a QHP within that product that has the most similar network to the enrollee's current QHP.

* * * * *

■ 14. Section 155.420 is amended by—

■ a. Revising paragraphs (a)(4)(ii)(A) and (B), (b)(2)(iv), and (c)(2);

■ b. Adding paragraph (c)(6); and

■ c. Revising paragraph (d)(12).

The revisions and addition read as follows:

§ 155.420 Special enrollment periods.

(a) * * *

(4) * * *

(ii) * * *

(A) If an enrollee or his or her dependents become newly eligible for cost-sharing reductions in accordance with paragraph (d)(6)(i) or (ii) of this section and the enrollee or his or her

dependents are not enrolled in a silver-level QHP, the Exchange must allow the enrollee and his or her dependents to change to a silver-level QHP if they elect to change their QHP enrollment; or

(B) Beginning January 2022, if an enrollee or his or her dependents become newly ineligible for cost-sharing reductions in accordance with paragraph (d)(6)(i) or (ii) of this section and the enrollee or his or her dependents are enrolled in a silver-level QHP, the Exchange must allow the enrollee and his or her dependents to change to a QHP one metal level higher or lower if they elect to change their QHP enrollment;

* * * * *

(b) * * *

(2) * * *

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

* * * * *

(c) * * *

(2) *Advanced availability.* A qualified individual or his or her dependent who is described in paragraph (d)(1), (d)(6)(iii), or (d)(15) of this section has 60 days before and, unless the Exchange exercises the option in paragraph (c)(6) of this section, 60 days after the triggering event to select a QHP. At the option of the Exchange, a qualified individual or his or her dependent who is described in paragraph (d)(7) of this section; who is described in paragraph (d)(6)(iv) of this section becomes newly eligible for advance payments of the premium tax credit as a result of a permanent move to a new State; or who is described in paragraph (d)(3) of this section and becomes newly eligible for enrollment in a QHP through the Exchange because he or she newly satisfies the requirements under § 155.305(a)(2), has 60 days before or after the triggering event to select a QHP.

* * * * *

(6) *Special rule for individuals losing Medicaid or CHIP.* Beginning January 1, 2024, at the option of the Exchange, a qualified individual or his or her dependent(s) who is described in paragraph (d)(1)(i) of this section and whose loss of coverage is a loss of Medicaid or CHIP coverage shall have 90 days after the triggering event to select a QHP.

* * * * *

(d) * * *

(12) The enrollment in a QHP through the Exchange was influenced by a material error related to plan benefits, service area, cost-sharing, or premium. A material error is one that is likely to have influenced a qualified individual's, enrollee's, or their dependent's enrollment in a QHP.

* * * * *

■ 15. Section 155.430 is amended by adding paragraph (b)(3) to read as follows:

§ 155.430 Termination of Exchange enrollment or coverage.

* * * * *

(b) * * *

(3) *Prohibition of issuer-initiated terminations due to aging-off.* Exchanges on the Federal platform must, and State Exchanges using their own platform may, prohibit QHP issuers from terminating dependent coverage of a child before the end of the plan year in which the child attains age 26, or before the end of the plan year in which the child attains the maximum age a QHP issuer is required to make available dependent coverage of children under applicable State law, on the basis of the child's age, unless otherwise permitted.

* * * * *

■ 16. Section 155.505 is amended by revising paragraph (g) to read as follows:

§ 155.505 General eligibility appeals requirements.

* * * * *

(g) *Review of Exchange Eligibility Appeal Decisions.* An appellant may seek review of Exchange eligibility appeal decisions issued under paragraph (b) of this section as follows:

(1) *Administrative Review.* The Administrator may review an Exchange eligibility appeal decision as follows:

(i) *Request by a party to the appeal.* (A) Within 14 calendar days of the date of the Exchange eligibility appeal decision issued by an impartial official as described in § 155.535(c)(4), a party to the appeal may request review of the Exchange eligibility appeal decision by the CMS Administrator. Such a request may be made even if the CMS Administrator has already at their initiative declined review as described in paragraph (g)(1)(ii)(B) of this section. If the CMS Administrator accepts that party's request for a review after having declined review, then the CMS Administrator's initial declination to review the eligibility appeal decision is void.

(B) Within 30 days of the date of the party's request for administrative review, the CMS Administrator may:

(1) Decline to review the Exchange eligibility appeal decision;

(2) Render a final decision as described in § 155.545 (a)(1) based on their review of the eligibility appeal decision; or

(3) Choose to take no action on the request for review.

(C) The Exchange eligibility appeal decision of the impartial official as described in § 155.535(c)(4) is final as of the date of the Exchange eligibility appeal decision if the CMS Administrator declines the party's request for review or if the CMS Administrator does not take any action on the party's request for review by the end of the 30-day period described in paragraph (a)(ii).

(ii) *Review at the discretion of the CMS Administrator.* (A) Within 14 calendar days of the date of the Exchange eligibility appeal decision issued by an impartial official as described in § 155.535(c)(4), the CMS Administrator may initiate a review of an eligibility appeal decision at their discretion.

(B) Within 30 days of the date the CMS Administrator initiates a review, the CMS Administrator may:

(1) Decline to review the Exchange eligibility appeal decision;

(2) Render a final decision as described in § 155.545 (a)(1) based on their review of the eligibility appeal decision; or

(3) Choose to take no action on the Exchange eligibility appeal decision.

(C) The eligibility Exchange appeal decision of the impartial official as described in § 155.535(c)(4) is final as of the date of the Exchange eligibility appeal decision if the CMS Administrator declines to review the eligibility appeal decision or chooses to take no action by the end of the 30-day period described in paragraph (g)(1)(i)(B) of this section.

(iii) *Effective dates.* If a party requests a review of an Exchange eligibility appeal decision by the CMS Administrator or the CMS Administrator initiates a review of an Exchange eligibility appeal decision at their own discretion, the eligibility appeal decision is effective as follows:

(A) If an Exchange eligibility appeal decision is final pursuant to paragraphs (g)(1)(ii)(B) of this section and (g)(1)(ii)(C) in this section, the Exchange eligibility appeal decision of the impartial official as described in § 155.535(c)(4) is effective as of the date of the official's decision.

(B) If the CMS Administrator renders a final decision after reviewing an Exchange eligibility appeal decision as described in paragraphs (g)(1)(i)(B)(*2*) and (1)(ii)(B)(*2*) of this section, the CMS Administrator may choose to change the effective date of the Exchange eligibility appeal decision as described in § 155.545 (a)(5).

(iv) Informal resolution decisions as described in § 155.535(a)(4) are not subject to administrative review by the CMS Administrator.

(2) *Judicial Review.* To the extent it is available by law, an appellant may seek judicial review of a final Exchange eligibility appeal decision.

* * * * *

■ 17. Add subpart P to read as follows:

Subpart P—Improper Payment Pre-Testing and Assessment (IPPTA) for State Exchanges

Sec.
155.1500 Purpose and scope.
155.1505 Definitions.
155.1510 Data submission.
155.1515 Pre-testing and assessment procedures.

Subpart P—Improper Payment Pre-Testing and Assessment (IPPTA) for State Exchanges

§ 155.1500 Purpose and scope.

(a) This subpart sets forth the requirements of the IPPTA. The IPPTA is an initiative between HHS and the State Exchanges. These requirements are intended to:

(1) Prepare State Exchanges for the planned measurement of improper payments.

(2) Test processes and procedures that support HHS's review of determinations of APTC made by State Exchanges.

(3) Provide a mechanism for HHS and State Exchanges to share information that will aid in developing an efficient measurement process.

(b) [Reserved]

§ 155.1505 Definitions.

As used in this subpart—

Business rules means the State Exchange's internal directives defining, guiding, or constraining the State Exchange's actions when making eligibility determinations and related APTC calculations.

Entity relationship diagram means a graphical representation illustrating the organization and relationship of the data elements that are pertinent to applications for QHP and associated APTC payments.

Pre-testing and assessment means the process that uses the procedures specified in § 155.1515 to prepare State Exchanges for the planned measurement of improper payments of APTC.

Pre-testing and assessment checklist means the document that contains criteria that HHS will use to review a State Exchange's ability to accomplish the requirements of the IPPTA.

Pre-testing and assessment data request form means the document that specifies the structure for the data elements that HHS will require each State Exchange to submit.

Pre-testing and assessment period means the one calendar year timespan during which HHS will engage in pre-testing and assessment procedures with a State Exchange.

Pre-testing and assessment plan means the template developed by HHS in collaboration with each State Exchange enumerating the procedures, sequence, and schedule to accomplish pre-testing and assessment.

Pre-testing and assessment report means the summary report provided by HHS to each State Exchange at the end of the State Exchange's pre-testing and assessment period that will include, but not be limited to, the State Exchange's status regarding completion of each of the pre-testing and assessment procedures specified in § 155.1515, as well as observations and recommendations that result from processing and reviewing the data submitted by the State Exchange to HHS.

§ 155.1510 Data submission.

(a) *Requirements.* For purposes of the IPPTA, a State Exchange must submit the following information in a form and manner specified by HHS:

(1) *Data documentation.* The State Exchange must provide to HHS the following data documentation:

(i) The State Exchange's data dictionary including attribute name, data type, allowable values, and description;

(ii) An entity relationship diagram, which shall include the structure of the data tables and the residing data elements that identify the relationships between the data tables; and

(iii) Business rules and related calculations.

(2) *Data for processing and testing.* The State Exchange must use the pre-testing and assessment data request form, or other method as specified by HHS, to submit to HHS the application data associated with no fewer than 10 tax household identification numbers and the associated policy identification numbers that address scenarios specified by HHS to allow HHS to test all of the pre-testing and assessment processes and procedures.

(b) *Timing.* The State Exchange must submit the information specified in paragraph (a) of this section within the timelines in the pre-testing and assessment plan specified in § 155.1515.

§ 155.1515 Pre-testing and assessment procedures.

(a) *General requirement.* The State Exchanges are required to participate in the IPPTA for a period of one calendar year. The State Exchange and HHS will execute the pre-testing and assessment procedures in this section within the timelines in the pre-testing and assessment plan.

(b) *Orientation and planning processes.* (1) As a part of the orientation process, HHS will provide State Exchanges with an overview of the pre-testing and assessment procedures and identify documentation that a State Exchange must provide to HHS for pre-testing and assessment.

(2) As a part of the planning process, HHS, in collaboration with each State Exchange, will develop a pre-testing and assessment plan that takes into consideration relevant activities, if any, that were completed during a prior,

voluntary State engagement. The pre-testing and assessment plan will include the pre-testing and assessment checklist.

(3) At the conclusion of the pre-testing and assessment planning process, HHS will issue the pre-testing and assessment plan specific to that State Exchange. The pre-testing and assessment plan will be for HHS and State Exchange internal use only and will not be made available to the public by HHS unless otherwise required by law.

(c) *Notifications and updates.* (1) *Notifications.* As needed throughout the pre-testing and assessment period, HHS will issue notifications to State Exchanges concerning information related to the pre-testing and assessment processes and procedures.

(2) *Updates regarding changes.* Throughout the pre-testing and assessment period, the State Exchange must provide HHS with information regarding any operational, policy, business rules, information technology, or other changes that may impact the ability of the State Exchange to satisfy the requirements of the pre-testing and assessment.

(d) *Submission of required data and data documentation.* As specified in § 155.1510, HHS will inform State Exchanges about the form and manner for State Exchanges to submit required data and data documentation to HHS in accordance with the pre-testing and assessment plan.

(e) *Data processing.* (1) HHS will coordinate with each State Exchange to track and manage the data and data documentation submitted by a State Exchange as specified in § 155.1510(a)(1) and (2).

(2) HHS will coordinate with each State Exchange to provide assistance in aligning the data specified in § 155.1510(a)(2) from the State Exchange's existing data structure to the standardized set of data elements.

(3) HHS will coordinate with each State Exchange to interpret and validate the data specified in § 155.1510(a)(2).

(4) HHS will use the data and data documentation submitted by the State Exchange to execute the pre-testing and assessment procedures.

(f) *Pre-testing and assessment checklist.* HHS will issue the pre-testing and assessment checklist as part of the pre-testing and assessment plan. The pre-testing and assessment checklist criteria will include but are not limited to:

(1) A State Exchange's submission of the data documentation as specified in § 155.1510(a)(1).

(2) A State Exchange's submission of the data for processing and testing as specified in § 155.1510(a)(2); and

(3) A State Exchange's completion of the pre-testing and assessment processes and procedures related to the IPPTA program.

(g) *Pre-testing and assessment report.* Subsequent to the completion of a State Exchange's pre-testing and assessment period, HHS will issue a pre-testing and assessment report specific to that State Exchange. The pre-testing and assessment report will be for HHS and State Exchange internal use only and will not be made available to the public by HHS unless otherwise required by law.

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

■ 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.

■ 18. Section 156.201 is revised to read as follows:

§ 156.201 Standardized plan options.

A QHP issuer in a Federally-facilitated Exchange or a State-based Exchange on the Federal platform, other than an issuer that is already required to offer standardized plan options under State action taking place on or before January 1, 2020, must:

(a) For the plan year 2023, offer in the individual market at least one standardized QHP option, defined at § 155.20 of this subchapter, at every product network type, as the term is described in the definition of ''product'' at § 144.103 of this subchapter, at every metal level, and throughout every service area that it also offers non-standardized QHP options, including, for silver plans, for the income-based cost-sharing reduction plan variations, as provided for at § 156.420(a); and

(b) For plan year 2024 and subsequent plan years, offer in the individual market at least one standardized QHP option, defined at § 155.20 of this subchapter, at every product network type, as the term is described in the definition of ''product'' at § 144.103 of this subchapter, at every metal level except the non-expanded bronze metal level, and throughout every service area that it also offers non-standardized QHP options, including, for silver plans, for the income-based cost-sharing reduction plan variations, as provided for at § 156.420(a)

(c) With respect to covered drugs:

(1) Place all covered generic drugs in the standardized plan options' generic drug cost-sharing tier, or the specialty drug tier if there is an appropriate and non-discriminatory basis in accordance with § 156.125 for doing so; and

(2) Place all covered brand drugs in either the standardized plan options' preferred brand or non-preferred brand drug cost-sharing tier, or the specialty drug cost-sharing tier if there is an appropriate and non-discriminatory basis in accordance with § 156.125 for doing so.

■ 19. Section 156.202 is added to read as follows:

§ 156.202 Non-standardized plan option limits.

For the plan year 2024 and subsequent plan years, a QHP issuer in a Federally-facilitated Exchange or a State-based Exchange on the Federal platform is limited to offering two non-standardized plan options per product network type, as the term is described in the definition of ''product'' at § 144.103 of this subchapter, and metal level (excluding catastrophic plans), in any service area.

■ 20. Section 156.210 is amended by adding paragraph (d) to read as follows:

The addition reads as follows:

§ 156.210 QHP rate and benefit information.

(d) *Rate requirements* for *stand-alone dental plans.* For benefit and plan years beginning on or after January 1, 2024:

(1) *Age on effective date.* The premium rate charged by an issuer of stand-alone dental plans may vary with respect to the particular plan or coverage involved by determining the enrollee's age. Any age calculation for rating and eligibility purposes must be based on the age as of the time of policy issuance or renewal.

(2) *Guaranteed rates.* An issuer of stand-alone dental plans must set guaranteed rates.

■ 21. Section 156.225 is amended by —

■ a. In paragraph (a) removing ''and'' from the end of the paragraph; and

■ b. In paragraph (b) removing ''.'' from the end of the paragraph and replacing it with ''; and''; and

■ c. By adding paragraph (c).

The addition reads as follows:

§ 156.225 Marketing and Benefit Design of QHPs.

* * * * *

(c) *Plan marketing names.* Offer plans and plan variations with marketing names that include correct information, without omission of material fact, and

do not include content that is misleading.

* * * * *

■ 22. Section 156.230 is amended by—

■ a. Revising paragraphs (a)(1) introductory text and (e) introductory text; and

■ b. Removing and reserving paragraph (f).

The revisions read as follows:

§ 156.230 Network adequacy standards.

(a) *General requirement.* (1) Each QHP issuer must use a provider network and ensure that the provider network consisting of in-network providers, as available to all enrollees, meets the following standards:

* * * * *

(e) *Out-of-network cost-sharing.* Beginning for the 2018 and later benefit years, for a network to be deemed adequate, each QHP must:

* * * * *

■ 23. Section 156.235 is amended by revising paragraphs (a)(1), (a)(2)(i) and (a)(2)(ii)(B) to read as follows:

§ 156.235 Essential community providers.

(a) * * *

(1) A QHP issuer must include in its provider network 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) * * *

(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 plan's service area collectively across all ECP categories defined under paragraph (ii)(B) of this section, and at least a minimum percentage of available ECPs in each 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 plan's service area and the issuer's satisfaction of the ECP participation standard. For 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 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 will be counted towards ECP standards.; and

(ii) * * *

(B) At least one ECP in each of the eight (8) ECP categories in each county in the service area, where an ECP in that category is available and provides medical or dental services that are covered by the issuer plan type. The ECP categories are: Federally Qualified Health Centers, Ryan White Program Providers, Family Planning Providers, Indian Health Care Providers, Inpatient Hospitals, Mental Health Facilities, Substance Use Disorder Treatment Centers, and Other ECP Providers. The Other ECP Providers category includes the following types of providers: Rural Health Clinics, Black Lung Clinics, Hemophilia Treatment Centers, Sexually Transmitted Disease Clinics, Tuberculosis Clinics, and Rural Emergency Hospitals

* * * * *

■ 24. Section 156.270 is amended by revising paragraph (f) to read as follows:

§ 156.270 Termination of coverage or enrollment for qualified individuals

* * * * *

(f) *Notice of non-payment of premiums.* If an enrollee is delinquent on premium payment, the QHP issuer must provide the enrollee with notice of such payment delinquency promptly and without undue delay.

* * * * *

■ 25. Section 156.1210 is amended by revising paragraph (c) to read as follows:

§ 156.1210 Dispute submission.

* * * * *

(c) *Deadline for describing inaccuracies.* To be eligible for resolution under paragraph (b) of this section, an issuer must describe all inaccuracies identified in a payment and collections report before the end of the 3-year period beginning at the end of the plan year to which the inaccuracy relates. For plan years 2015 through 2019, to be eligible for resolution under paragraph (b) of this section, an issuer must describe all inaccuracies identified in a payment and collections report before January 1, 2024. If a payment error is discovered after the timeframe set forth in this paragraph, the issuer must notify HHS, the State Exchange, or SBE–FP (as applicable) and repay any overpayments to HHS.

■ 26. Section 156.1220 is amended by revising paragraphs (a)(4)(ii) and (b)(1) to read as follows:

§ 156.1220 Administrative appeals.

(a) * * *

(4) * * *

(ii) Notwithstanding paragraph (a)(1) of this section, a reconsideration with respect to a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error may be requested only if, to the extent the issue could have been previously identified, the issuer notified HHS of the dispute through the applicable process for reporting a discrepancy set forth in §§ 153.630(d)(2) and (3), 153.710(d)(2), and 156.430(h)(1) of this subchapter, it was so identified and remains unresolved.

* * * * *

(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)(5) 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.

* * * * *

Dated: December 12, 2022.

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2022–27206 Filed 12–14–22; 4:15 pm]

BILLING CODE 4120–01–P