DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 153, 155, and 156

[CMS–9899–F]

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: Final rule.

SUMMARY: This final rule includes payment parameters and provisions related to the HHS-operated risk adjustment and risk adjustment data validation programs, as well as 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 final rule also has requirements related to updating standardized plan options and reducing plan choice overload; the automatic 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: These regulations are effective on June 18, 2023.

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I. Executive Summary

We are finalizing changes to the provisions and parameters implemented through prior rulemaking to implement the Patient Protection and Affordable Care Act (ACA).[1] These requirements are published under the authority granted to the Secretary by the ACA and the Public Health Service (PHS) Act.[2] In this final rule, we are finalizing changes related to some of the ACA provisions and parameters we previously implemented and are implementing new provisions. Our goal with these requirements is providing quality,

[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.

affordable coverage to consumers while minimizing administrative burden and ensuring program integrity. The changes finalized in this rule are also intended to help advance health equity and mitigate health disparities.

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 advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs) for QHPs sold through an Exchange.

Sections 1313 and 1321 of the 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 that 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 premium tax credit (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 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 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 data set.[5]

[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).

[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.*

• 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 Center for Consumer Information and Insurance Oversight (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 International Classification of Diseases, Tenth Revision (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. 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.

[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.*

[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.*

• 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 for the 2023 benefit year. We also finalized various policies to address certain agent, broker, and web-broker practices and conduct. We also finalized updates to the requirement that all Exchanges conduct 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 final rule will 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. We did not receive any requests from States to operate risk adjustment for the 2024 benefit year; therefore, HHS will operate risk adjustment in every

[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.*

State and the District of Columbia for the 2024 benefit year.

We will recalibrate the 2024 benefit year risk adjustment models using the 2018, 2019, and 2020 benefit year enrollee-level EDGE data, with no exceptions. For the 2024 benefit year, we will continue to apply 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). We will also continue to maintain the CSR adjustment factors finalized in the 2019, 2020, 2021, 2022, and 2023 Payment Notices.[10]

We are finalizing the repeal of the ability under § 153.320(d) for prior participant States to request reductions of State risk adjustment transfers calculated by HHS under the State payment transfer formula in all State market risk pools for the 2025 benefit year and beyond. We are approving Alabama's requests to reduce risk adjustment State transfers in its individual and small group markets by 50 percent for the 2024 benefit year.

Additionally, we are finalizing, beginning with the 2023 benefit year, the proposal 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 are finalizing our proposal to extract the plan identifier and rating area data elements from issuers' EDGE servers for certain benefit years prior to the 2021 benefit year. We are finalizing the proposed 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 are changing 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 of HHS–RADV, we are no longer exempting 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, we are applying HHS–RADV results to adjust the plan liability risk scores of all exiting and non-exiting issuers identified as outliers in the benefit year being audited.

Beginning with the 2022 benefit year of HHS–RADV, we announce that we are discontinuing the use of the lifelong permanent condition list and the use of non-EDGE claims in HHS–RADV. Additionally, beginning with the 2022 benefit year of HHS–RADV, we are finalizing the shortening of the window to confirm the findings of the second validation audit (SVA) (if applicable),[11] or file a discrepancy report to dispute the SVA findings, to within 15 calendar days of the notification by HHS.

We are amending 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) will 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 are finalizing the revision of 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 are finalizing the removal of the existing deadlines for when we provide approval, or conditional approval, on an Exchange Blueprint, and instead will require that such approval be provided at some point prior to the date on which the Exchange proposes to begin open enrollment either as a SBE or SBE–FP.

We are finalizing the proposal to address the standards applicable to Navigators and other assisters and their consumer service functions. At § 155.210(d)(8), we are finalizing the removal of the prohibition on Navigators from going door-to-door or using other unsolicited means of direct contact to provide application or enrollment assistance. This will 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 are finalizing the removal of the prohibition on certified application counselors from going door-to-door or using unsolicited means of direct contact to provide application or enrollment assistance. We believe policies as finalized will allow Navigators and other assisters in the FFEs to help more consumers.

In part 155, we are finalizing changes to address certain agent, broker, and web-broker practices. We are finalizing the proposal 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 the suspension of their Exchange agreement(s). We also are finalizing the proposal to allow HHS up to an additional 30 calendar days to review evidence submitted by agents, brokers, or web-brokers that led to the termination of their Exchange agreement(s). The amendments adopted in this final rule will 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 are finalizing the proposal 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 are finalizing the proposal that the documentation will 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 agent, broker, or web-broker will be required to maintain the documentation for a minimum of 10 years and produce it upon request in response to monitoring, audit, and enforcement activities.

We also are finalizing the proposal 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 seeking assistance or their authorized

[10] See 83 FR 16930 at 16953; 84 FR 17454 at 17478 through 17479; 85 FR 29164 at 29190; 86 FR 24140 at 24181; and 87 FR 27208 at 27235 through 27235.

[11] 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.

representative prior to providing assistance. We are finalizing the proposal that the documentation will 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; the name of the agent, broker, web-broker, or agency being granted consent; and the process by which the consumer or their authorized representative may rescind consent. Further, we are finalizing the requirement that agents, brokers, or web-brokers will be required to maintain the consent documentation for a minimum of 10 years and produce it upon request in response to monitoring, audit, and enforcement activities.

We are finalizing the revisions to the failure to file and reconcile (FTR) process at § 155.305(f)(4). First, we are finalizing the proposal to amend the FTR process described in § 155.305(f)(4) so 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 (specifically, years for which tax data will be utilized for verification of household income and family size). In the proposed rule (87 FR 78256), we proposed that this policy would be effective January 1, 2024, with the intent that the proposed rule would apply to eligibility determinations made in 2024 for PY 2025 (and beyond). We are clarifying in the final rule that this will become effective on the general effective date of the final rule. Second, we are finalizing the proposal to continue to pause FTR operations until HHS and the Internal Revenue Service (IRS) will be able to implement the new FTR policy.

We are finalizing revisions to § 155.320, which will require Exchanges to accept an applicant's attestation of projected annual household income when the Exchanges request 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 are finalizing revisions to § 155.315, which will require that an enrollee with a household income inconsistency receive a 60-day extension to present satisfactory documentary evidence to resolve a data matching issue (DMI) in addition to the 90 days currently provided in § 155.315(f)(2)(ii). These changes will ensure consumers are treated equitably, ensure continuous coverage, and strengthen the risk pool.

We are finalizing amendments and additions to § 155.335(j), including the clarification that when an enrollee is determined upon annual redetermination eligible for income-based CSRs, is currently enrolled in a bronze level QHP, and would be re-enrolled in a bronze level QHP, then to the extent permitted by applicable State law, unless the enrollee terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430, at the option of the Exchange, the Exchange may re-enroll such enrollee in a silver level QHP within the same product, with the same provider network, and with a lower or equivalent premium after the application of APTC as the bronze level QHP into which the Exchange would otherwise re-enroll the enrollee. We are also finalizing modifications to the proposed policy to specify that Exchanges implementing this policy may auto re-enroll enrollees from a bronze QHP to a silver QHP provided that the net monthly silver plan premium for the future year is not more than the net monthly bronze plan premiums for the future year, as opposed to comparing net monthly bronze plan premiums for the current year with future year silver plan premiums. Lastly, for enrollees whose current QHP or product will no longer be available in the coming year, we are finalizing the policy to require Exchanges to incorporate network similarity into auto re-enrollment criteria.

We are finalizing the proposed changes related to SEPs at § 155.420. First, we are finalizing 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 revisions will clarify that only one person in a household applying for coverage or financial assistance through the Exchange must qualify for a SEP in order for the entire household to qualify for the SEP. Second, we are finalizing the change to the current coverage effective date requirements at § 155.420(b)(2)(iv) to permit Exchanges to offer earlier coverage effective dates for consumers attesting to a future loss of MEC. This change will 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 finalizing the proposed new rule at § 155.420(c)(6) with a modification that will give Exchanges the option to allow consumers who are eligible for a SEP under § 155.420(d)(1)(i) due to loss of Medicaid or Children's Health Insurance Program (CHIP) coverage up to 90 days after their loss of Medicaid or CHIP coverage to select a plan and enroll in coverage through the Exchange. The modification will grant an Exchange the option to provide more than 90 days to select a plan and enroll in coverage through the Exchange up to the length of the applicable Medicaid or CHIP redetermination period if the State Medicaid Agency allows or provides for a Medicaid or CHIP reconsideration period greater than 90 days. Fourth, we are finalizing § 155.420(d)(12) to align the policy of the Exchanges on the Federal platform for granting SEPs to consumers who enrolled in a plan influenced by a material plan display error with current plan display error SEP operations. The proposal will 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 are finalizing § 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 will clarify to issuers participating in Exchanges on the Federal platform their obligation to maintain coverage for dependent children, as well as to enrollees regarding their ability to maintain coverage for dependent children. This change is optional for State Exchanges.

We are finalizing § 155.505(g), which acknowledges the ability of the CMS Administrator to review Exchange eligibility appeals decisions prior to judicial review. This change will 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.

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

3. 45 CFR part 156

In part 156, after revising our projections based on newly available data that impacted enrollment projections, we are finalizing for the 2024 benefit year a user fee rate for all issuers offering QHPs through an FFE of 2.2 percent of the monthly premium charged by issuers for each policy under plans where enrollment is through an FFE, and a user fee rate for all issuers offering QHPs through an SBE–FP of 1.8 percent of the monthly premium charged by issuers for each policy under plans offered through an SBE–FP.

We are also finalizing the proposal to maintain a large degree of continuity with our approach to standardized plan options finalized in the 2023 Payment Notice, making only minor updates to each set of plan designs. In particular, for PY 2024 and subsequent PYs, we are finalizing two sets of plan designs that, in contrast to the policy finalized in the 2023 Payment Notice (87 FR 28278 through 28279), 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 are finalizing revisions to § 156.201 to require issuers to offer standardized plan options for the following metal levels throughout every service area that they also offer non-standardized plan options: 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 also will 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 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 (Classic DE) and Enhanced Direct Enrollment (EDE) Pathways.

To mitigate the risk of plan choice overload, we are finalizing § 156.202, which limits the number of non-standardized plan options that QHP issuers may offer through the Exchanges using the Federal platform to four non-standardized plan options per product network type, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage, in any service area for PY 2024, and to two non-standardized plan options per product network type, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage, in any service area for PY 2025 and subsequent PYs.

We are finalizing new § 156.210(d)(1) to require stand-alone dental plan (SADP) issuers 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, as a condition of QHP certification, beginning with Exchange certification for PY 2024. We believe 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, will reduce consumer confusion and promote operational efficiency. This policy will apply to Exchange-certified SADPs, whether they are sold on- or off-Exchange.

In addition, we are finalizing new § 156.210(d)(2) to require SADP issuers to submit guaranteed rates as a condition of QHP certification, beginning with Exchange certification for PY 2024. We believe this change will help reduce the risk of incorrect APTC calculation for the pediatric dental EHB portion of premiums, thereby reducing the risk of consumer harm. This policy will apply to Exchange-certified SADPs, whether they are sold on- or off-Exchange.

We are finalizing a new rule at § 156.225(c) to require that plan and plan variation marketing names for QHPs include correct information, without omission of material fact, and not include content that is misleading. We will review plan and plan variation marketing names during the annual QHP certification process in close collaboration with State regulators in States with Exchanges on the Federal platform.

We are finalizing revisions to the network adequacy and ECP standards at §§ 156.230 and 156.235 to provide that all individual market QHPs, including individual market SADPs, and all Small Business Health Options Program (SHOP) QHPs, including SHOP SADPs, 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. However, we are finalizing a limited exception at § 156.230(a)(4) for certain SADP issuers that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers. Specifically, under this exception, an area is considered ''prohibitively difficult'' for the SADP issuer to establish a network of dental providers based on attestations from State departments of insurance in States with at least 80 percent of their counties classified as Counties with Extreme Access Considerations (CEAC) that at least one of the following factors exists in the area of concern: a significant shortage of dental providers, a significant number of dental providers unwilling to contract with Exchange issuers, or significant geographic limitations impacting consumer access to dental providers.

To expand access to care for low-income and medically underserved consumers, we are finalizing our proposal 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, and adding rural emergency hospitals (REHs) as a provider type in the Other ECP Providers category. In addition, we are finalizing our proposed revisions to § 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, we will require that QHPs contract with at least 35 percent of available Federally Qualified Health Centers (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 for PY 2024 and subsequent PYs. Furthermore, we are finalizing revisions to § 156.235(a)(2)(i) to clarify that these threshold requirements will be in addition to the existing provision that QHPs must satisfy the overall 35 percent ECP threshold requirement in the plan's service area. In addition, we revised § 156.235(b)(2)(i) to reflect that these policies would also affect issuers subject to the Alternate ECP Standard under § 156.235(b).

We are finalizing revisions to § 156.270(f) to require QHP issuers in Exchanges operating on the Federal platform to send enrollees a notice of payment delinquency promptly and without undue delay. Specifically, we will require QHP issuers in Exchanges operating on the Federal platform to send such notices within 10 business days of the date the issuer should have

discovered the delinquency. This requirement 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 are finalizing the proposal 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 will 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 of APTC to the issuer and user fee overpayments to HHS. Under this policy, beginning with the 2015 PY coverage, we will 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, for PYs 2015 through 2019, to be eligible for resolution, an issuer must describe before January 1, 2024, all inaccuracies identified in a payment and collections report for these PYs that relate to discovered underpayments to the issuer of APTC or user fee overpayments to HHS, thus allowing issuers additional time to submit and seek resolution of such inaccuracies for the 2015 through 2019 PY coverage. These policies will better align with the existing limitation under the Code on amending a Federal income tax return and reduce administrative and operational burden on issuers, State Exchanges, and HHS when handling payment and enrollment disputes.

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.[12] We did not receive any requests from States to operate a risk adjustment program for the 2024 benefit year. Therefore, we 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.[13] 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,[14] 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 will be sequestered in future fiscal years, and any sequestered funding will become available in the fiscal year following that in which it was sequestered.

Additionally, we note that the Infrastructure Investment and Jobs Act[15] 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.[16] [17]

We received no comments on the fiscal year 2023 sequestration rate for risk adjustment.

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,[18] and prescription drug categories (RXCs) beginning with the 2018 benefit year.[19] Starting with the 2023 benefit year, we added interacted HCC count factors to the adult and child models applicable to certain severity and transplant HCCs.

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,[20] 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

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

[13] 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.*

[14] Public Law 99–177 (1985).

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

[16] 2 U.S.C. 901a.

[17] 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).

[18] 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.

[19] 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.

[20] 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 benefit year (BY). See, for example, 81 FR 94080.

Standards of Practice for risk classification.

a. Data for Risk Adjustment Model Recalibration for 2024 Benefit Year

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78214), we proposed 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. However, after consideration of comments, we are not finalizing the 2024 benefit year model recalibration approach as proposed. Instead, based on our analysis and in response to comments, we are finalizing the use of 2018, 2019 and 2020 benefit year enrollee-level EDGE data for recalibration of the 2024 benefit year risk adjustment models for all model coefficients, including the adult age-sex coefficients, with no exceptions.

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 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 proposed 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 proposed 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 [21] 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, we 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: (1) comments received in response to the 2023 Payment Notice proposed rule (87 FR 598); (2) 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 which 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; and (3) our experience that every year of data can be unique and therefore some level of deviation from year to year is expected.[22] All of these general considerations weigh in favor of including the 2020 benefit year data in the recalibration of the risk adjustment models.

However, we recognized 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 [23] of a situation that requires this additional consideration. Thus, to help further inform our decision on whether it is appropriate to use 2020 enrollee-level EDGE data to calibrate the risk adjustment coefficients, we analyzed the 2020 benefit year enrollee-level EDGE recalibration data to assess how it compares to 2019 benefit year enrollee-level EDGE recalibration data. For more information on our analysis of the 2020 benefit year enrollee-level EDGE recalibration data see the proposed rule (87 FR 78215 through 78218). Based on this analysis, we determined that on many key dimensions, the 2019 benefit year and 2020 benefit year enrollee-level EDGE data recalibration were largely comparable. However, there were some observed anomalous decreases in the unconstrained age-sex coefficients in the 2020 benefit year data for older adult enrollees, especially older female enrollees.

With this analysis in mind, and based on the comments received in response to the 2023 Payment Notice proposed rule,[24] we outlined six different options the Department considered 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 involved the use of 2020 benefit year enrollee-level EDGE recalibration data in the risk adjustment

[21] 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.*

[22] 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.

[23] In the 10 years since the start of model calibration for the HHS-operated risk adjustment program, which began with 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 potential impact.

[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] See 87 FR 78214 through 78218.

model recalibration, and two involved the exclusion of the 2020 benefit year data. These six options were 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.
- *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.
- *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 have determined 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 blending of the adult models' age-sex coefficients. Instead, only 2018 and 2019 benefit year enrollee-level EDGE recalibration data would be used in blending the adult risk adjustment models age-sex coefficients.
- *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.

As noted above, we proposed to use the 3 most recent available consecutive benefit year data sets (the 2018, 2019, and 2020 benefit year enrollee-level EDGE recalibration data), with a narrowly tailored exception to exclude the 2020 benefit year data from the blending of the age-sex coefficients for the adult models (Option 4).

After reviewing the public comments, we are finalizing the use of 2018, 2019, and 2020 enrollee-level EDGE data with no exceptions or modifications for recalibration of the risk adjustment models for the 2024 benefit year (Option 1). Consistent with prior benefit model recalibrations and the proposed adoption of Option 4 to recalibrate the HHS risk adjustment models for the 2024 benefit year, this will involve the use of the 3 most recent consecutive years of enrollee-level EDGE data that were available 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. The coefficients listed in Tables 1 through 6 of this final rule reflect the use of 2018, 2019, and 2020 benefit year enrollee-level EDGE recalibration data for all coefficients, including adult age-sex coefficients, as well as the pricing adjustment for Hepatitis C drugs finalized in this final rule.[26] [27] We summarize and respond to public comments received on the proposed approach to recalibration of the HHS risk adjustment models for the 2024 benefit year below.

Comment: Several commenters supported our proposal to recalibrate the 2024 risk adjustment models with 2018, 2019, and 2020 enrollee-level EDGE data, except for the age-sex coefficients, which would be calculated by blending the age-sex coefficients from the 2018 and 2019 enrollee-level EDGE data only. One of these commenters stated that, of the options presented by HHS, Option 4 struck the best balance between maintaining HHS's established practice of recalibrating the models based on the 3 most recent years of available EDGE data while also accounting for the anomalous decreases in the age-sex coefficients observed in the 2020 benefit year enrollee-level EDGE recalibration data. Another commenter stated that using 2017, 2018, and 2019 enrollee-level EDGE data for recalibration (Option 5), or using only 2018 and 2019 enrollee-level EDGE data (Option 6) would also be reasonable approaches. One commenter supported the proposal to adopt Option 4, but generally objected to the use of age-sex factors in the HHS-operated risk adjustment program due to concerns about discrimination.

However, several commenters opposed the finalization of Option 4, objecting to the use of different data years to recalibrate different coefficients for the same benefit year of the HHS-operated risk adjustment program (that is, blending benefit year 2024 adult age-sex coefficients using 2018 and 2019 enrollee-level EDGE data, and blending all other benefit year 2024 coefficients using 2018, 2019, and 2020 enrollee-level EDGE data) on the grounds that model coefficients are interrelated, so the 2020 enrollee-level EDGE data adult age-sex coefficients that were excluded from blending had an influence during initial model fitting on 2020 enrollee-level EDGE data adult model coefficients that were used in blending. One commenter urged HHS to include 2020 enrollee-level EDGE data, but to weight that data year less than other data years (Option 2).

Several other commenters supported using the 2017, 2018, and 2019 enrollee-level EDGE data for the 2024 benefit year model recalibration (Option 5). One commenter suggested that HHS might identify fixable anomalies in the 2020 enrollee-level EDGE recalibration data prior to model fitting and then refit the models as an alternative option to use 2018, 2019 and 2020 data for all coefficients across all models.

Response: In light of our analysis and further consideration of the previously identified model recalibration options along with the benefit of interested party comments on the six options, we are finalizing the use of 2018, 2019, and 2020 enrollee-level EDGE data to recalibrate the 2024 risk adjustment models for all model coefficients, with no exceptions (Option 1). As stated in the proposed rule, although our analyses found that the 2019 and 2020 benefit year enrollee-level EDGE data were largely comparable, there were observed anomalous decreases in the unconstrained age-sex coefficients for the 2020 benefit year enrollee-level

[26] Similar to recalibration of the 2023 risk adjustment adult models and consistent with the policies adopted in the 2023 Payment Notice, the 2024 benefit year 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 x HCC056 or 057 and 048 or 041; RXC 09 x HCC056; RXC 09 x HCC 057; RXC 09 x 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 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 27231 through 27232.

[27] 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. We did not propose changes to the high-cost risk pool parameters for the 2024 benefit year. See 87 FR 78237. Therefore, as detailed below, we are maintaining the $1 million threshold and 60 percent coinsurance rate.

EDGE data for older adult enrollees, especially older female enrollees. Therefore, our proposed adoption of Option 4 included an exception narrowly tailored to account for the observed anomalous decreases in the unconstrained coefficients for the 2020 benefit year enrollee-level EDGE data. At the same time, as explained in the proposed rule (87 FR 78215 through 78216), our analysis generally found that the 2020 enrollee-level EDGE data were anomalous primarily in the volume and frequencies of certain types of claims, but that the relative costs of specific services, at least those associated with payment HCCs in the HHS risk adjustment models, were largely unaffected. Because the risk adjustment models predict relative costs of care for specific conditions on an enrollee-level basis and tend not to rely on overall patterns of utilization, the minimal impacts to relative costs of care for payment HCCs likewise resulted in minimal impacts on the coefficients fitted by the 2020 enrollee-level EDGE recalibration data.

Although we found anomalous trends in the adult age-sex factors, they were limited to the direction of coefficient changes. Specifically, age and sex in the adult models seemed to be predictive of whether an age-sex coefficient would go up or down with older female enrollees more likely to see a decrease in their age-sex coefficient fit to 2020 enrollee-level EDGE data relative to their age-sex coefficient fit to 2019 enrollee-level EDGE data, and younger male enrollees more likely to see an increase in the coefficient fit to 2020 data relative to the coefficient fit with 2019 data. To put these directional changes into perspective, the magnitudes of these changes were small and did not appear as anomalous when further compared to previous benefit years. Specifically, as part of our consideration of comments we further investigated these anomalies and found that:

- For the risk adjustment model coefficients from the 2016 through the 2023 benefit years, the adult age-sex factors varied in magnitude from their prior benefit year by a historic median value of 16.1 percent.
- Using only 2018 and 2019 data to blend the adult age-sex factors (as in our proposed approach, Option 4,[28]) across metal levels, the median change in magnitude between the 2023 final adult age-sex coefficients [29] and the 2024 proposed adult age-sex coefficients was 2.0 percent and the maximum change in magnitude was 12.0 percent.
- Using all 3 years of enrollee-level EDGE data (2018, 2019, and 2020), the median change in magnitude between the 2023 final adult age-sex coefficients and the 2024 adult age-sex coefficients was 3.6 percent and the maximum change in magnitude was 13.2 percent.
- The median magnitude of the differences between the proposed age-sex coefficients, and blended age-sex coefficients using 2018, 2019, and 2020 enrollee-level EDGE data [30] was 2.7 percent.

These values show that although the pattern of the direction of the changes in adult age-sex coefficients might appear to be anomalous, with older female enrollees showing more decreases than expected, the coefficients were actually more consistent between the 2023 final risk adjustment models and those proposed or explored as alternatives for the 2024 benefit year than we have seen in previous benefit years. As noted in the proposed rule (78 FR 78217), 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. Although the adult age-sex trends may have displayed a systematic effect such that older female enrollees were more likely to see lower coefficients, the magnitude of this effect appears very small and does not rise above what we have seen in prior year-to-year variation.

Moreover, the intent of the established policy to use the 3 most recent consecutive years of enrollee-level EDGE data for recalibration of the risk adjustment models is to provide stability within the HHS-operated risk adjustment program and minimize volatility in changes to risk scores between benefit years due to differences in the data set's underlying populations, while reflecting the most recent years' claims experience available.[31] Given that the magnitude of differences in the coefficients between separately solved models from the 2019 and 2020 enrollee-level EDGE data sets are similar in magnitude to the normal variation we see between data years, despite the initially observed anomalous trends, after review of comments and further consideration and analysis of the options presented, we now believe that the blending of 3 years of data for all coefficients, including the adult model age-sex coefficients, is the better approach for recalibration of the 2024 benefit year risk adjustment models, because we continued to find that there may not be a sufficient justification to exclude 2020 benefit year enrollee-level EDGE data in the recalibration of the risk adjustment models. Additionally, this approach will continue to serve the purpose of providing stability in risk scores by maintaining the policy to use the 3 most recent consecutive years of enrollee-level data available at the time we incorporated the data in the draft recalibrated coefficients published in the proposed rule and will update the models to reflect the most recent year's claims experience available.

Additionally, we agree with commenters and recognize there are disadvantages with Option 4 and the use of different benefit years to recalibrate the adult model age-sex coefficients because model coefficients are interdependent. For example, if the 2020 data differed from the 2019 data in that some risk had shifted from an HCC to an age-sex category for which that HCC was common, the removal of the age-sex category from blending would result in that HCC being slightly underpredicted relative to its predicted value if all three benefit years of data were used because the shifted risk would not be captured in the blended age-sex coefficient with that benefit year of data being included. Another example may include vaccinations. Costs associated with vaccinations have an impact on age-sex coefficients because they are not associated with a diagnosis that would be captured by an HCC. As such, if there were changes in the relative costs of common vaccinations between the 2019 and 2020 years of enrollee-level EDGE data, removing the 2020 enrollee-level EDGE data age-sex coefficients from blending would prevent the models from capturing these changes.

We also continue to believe that the COVID–19 PHE is an example of the type of situation that requires a close examination of the potential impact on utilization and costs to identify whether there are sufficiently anomalous trends relative to expected future patterns of care or significant changes that differentially impact certain conditions or populations relative to others that could impact the use of that benefit year in the annual recalibration of the HHS risk adjustment models. HHS intends to similarly examine 2021 enrollee-level EDGE data, which will be available for use in recalibration of the 2025 benefit

[28] See the 2024 Payment Notice proposed rule, Table 2 at 87 FR 78220.

[29] See the 2023 Benefit Year Final HHS Risk Adjustment Model Coefficients, Table 1, available at *https://www.cms.gov/files/document/2023-benefit-year-final-hhs-risk-adjustment-model-coefficients.pdf.*

[30] See the 2024 Payment Notice proposed rule, Table 1 at 87 FR 78218.

[31] For a discussion of the established policy governing the data used for the annual risk adjustment model recalibration, see 86 FR 24151 through 24155.

year HHS risk adjustment models,[32] and would propose any changes to current policies for recalibration of the models in future benefit years through notice-and-comment rulemaking.

We recognize that some commenters preferred alternative options that would use 2017, 2018, and 2019 enrollee-level EDGE data (Option 5) or only 2018 and 2019 enrollee-level EDGE data (Option 6). We remain concerned about these options, which would completely exclude 2020 enrollee-level EDGE data, because these options would result in the HHS risk adjustment models reflecting older costs and utilization trends than would be desirable. As previously stated, our analyses of the 2020 benefit year enrollee-level EDGE recalibration data found that it was largely comparable to 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. This raises the question about whether there is a sufficient justification to completely exclude 2020 benefit year enrollee-level EDGE data in the recalibration of the HHS risk adjustment models. Beyond the concern about using older data and the question about the justification to completely exclude 2020 benefit year data, Option 6 has the additional drawback of decreasing the stabilizing effect of using multiple years of data. As our goal in using the 3 most recent consecutive years of data that are available at the time we incorporate data to recalibrate the models and determine draft coefficients based on a blend of equally-weighted, separately solved coefficients from each year 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 under this approach, 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 HHS 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.

Option 2, which was supported by one commenter and would have weighted 2020 enrollee-level EDGE data less than the other two benefit years (2018 and 2019 enrollee-level EDGE data) used in recalibration while continuing to include it in the blended coefficients, would represent a middle ground between Option 1 and Option 6. However, we continue to be concerned that this approach would require identifying an appropriate weighting methodology other than the equal weighting that we generally use to blend coefficients 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, although Option 2 would not completely eliminate 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), this option would dampen the effect of 2020 benefit year data, raising similar concerns as Options 5 and 6 in that Option 2 would also, to some extent, prevent the models from reflecting changes in utilization and cost of care that are unrelated to the impact of the COVID–19 PHE.

Regarding the recommendation to identify and address fixable anomalies in the underlying data and then refit the models using the modified data, we do not believe this recommendation is feasible or prudent. Although it may be possible to identify an increase or a decrease in the frequency of particular diagnosis or service codes, these checks and procedures do not presently allow HHS to identify whether a diagnosis or service code on a given enrollee's record was directly attributable to the COVID–19 PHE. We are also presently unable to determine whether an enrollee had care deferred due to office closures or other logistical issues or what care would have been provided in the absence of the PHE. We generally consider this sort of enrollee-level adjustment to be out of scope for model calibration unless there is a clear data error. As such, we generally[33] use the data as is, with only some basic trending assumptions[34] to ensure the costs are measured for the year in which the coefficients will be used. Furthermore, as previously stated, the HHS risk adjustment models rely more on relative cost of care for a given diagnosis than they do on how many such diagnoses are present in the underlying data.

Regarding the general concerns about use of age-sex factors in the HHS risk adjustment models, HHS takes very seriously our obligation to protect individuals from discrimination and generally disagrees that the use of these factors in risk adjustment is inappropriate. Consistent with section 1343 of the ACA, the HHS-operated risk adjustment program reduces the incentives for issuers to avoid higher-than-average risk enrollees, such as those with chronic conditions, by using charges collected from issuers that attract lower-than-average risk enrollees to provide payments to health insurance issuers that attract higher-than-average risk enrollees. The ACA also prohibits issuers from establishing or charging premiums on the basis of sex,[35] and limits issuers ability to do so on the basis of age.[36] However, the cost of care for and actuarial risk of enrollees is, in part, predicted by their age and sex. As such, without the inclusion of age-sex factors in the HHS risk adjustment models, some issuers would be incentivized to design plans that are less attractive to potential enrollees whose age-sex category is predicted to create a higher liability for the issuer. The age-sex factors in the HHS risk adjustment models help alleviate this incentive by ensuring issuers whose enrollees' actuarial risk is greater than the average actuarial risk of all enrollees in the State market risk pool, such as issuers that enroll a higher-than-average proportion of enrollees who fall into a high-cost age-sex category, are appropriately compensated. The use of age and sex factors in the HHS risk adjustment models is therefore necessary, appropriate, and helps reduce the likelihood that discrimination based on age or sex will occur with respect to health insurance coverage issued or renewed in the individual and small group (including merged) markets.

After review of comments and further consideration of the options presented, for the reasons outlined above, we are finalizing adoption of Option 1 for recalibrating the HHS risk adjustment models for the 2024 benefit year. The

[32] Consistent with the policies finalized in the 2022 Payment Notice, use of the 3 most recent consecutive years of enrollee-level EDGE data would result in the use of 2019, 2020, and 2021 enrollee-level EDGE data for recalibration of the 2024 benefit year models; the use of 2020, 2021, and 2022 enrollee-level EDGE data for recalibration of the 2025 benefit year models; and the use of 2021, 2022, and 2023 enrollee-level EDGE data for recalibration of the 2026 benefit year models. See 86 FR 24151 through 24155.

[33] As previously stated in the March 2016 Risk Adjustment Methodology White Paper (March 24, 2016; available at *https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf*), we exclude enrollees with capitated claims from the recalibration sample due to concerns that methods for computing and reporting derived amounts from capitated claims would not result in reliable data for recalibration or analysis. See also 87 FR 27227.

[34] These trending assumptions include the pricing adjustment for Hepatitis C drugs. See 84 FR 17463 through 17466. See also 87 FR 78218.

[35] See section 2701 of the Public Health Service Act (42 U.S.C. 300gg) as amended by section 1201 of the ACA.

[36] Ibid. See also the Market Rules and Rate Review final rule (78 FR 13411 through 13413).

model coefficients for the 2024 benefit year listed in Tables 1 through 6 of this final rule are based on a blend of equally-weighted, separately solved coefficients from the 2018, 2019, and 2020 benefit years of enrollee-level EDGE data for all coefficients.[37] [38] [39]

Comment: Several commenters were concerned about some of the proposed RXC adult model coefficients, in particular RXCs 1 (Anti-HIV Agents), 8 (Multiple Sclerosis Agents), and 9 (immune suppressants and immunomodulators), for which the majority of filled prescriptions fall into the category of specialty drugs. As a result, many of these commenters supported Option 5, described above, for addressing 2020 enrollee-level EDGE data in model recalibration and recommended that the 2017, 2018 and 2019 enrollee-level EDGE data not be trended forward to the 2024 benefit year (that is, that HHS should use the 2023 final model coefficients for the 2024 benefit year). These commenters also requested that HHS publish additional information on these coefficients, including the separately solved model coefficients from each data year, the trending methodology, and how these trend factors were applied as part of the 2024 benefit year risk adjustment model recalibration. Some of these commenters questioned whether the changes for these coefficients were due to anomalies in the 2020 enrollee-level EDGE data or, as others suggested, if the changes may be due to the trending methodology applied. One of these commenters suggested different trend factors may need to be applied differently for different RXCs, noting that market patterns for non-RXC specialty drugs may not align with market patterns for specialty drugs included in the affected RXCs.

Response: We are finalizing the RXC coefficients as proposed because we believe the 2024 risk adjustment models' RXCs are accurately predicting the costs of RXCs in the market for the applicable benefit year. Although there are RXC coefficients changes between the 2023 and 2024 benefit year models, these changes are not due to anomalies in the 2020 enrollee-level EDGE data and are of a similar magnitude to RXC changes found in previous benefit years. The change in these RXC coefficients relative to the previous benefit year are due to decisions HHS made in trending costs for traditional and specialty drugs, as suggested by some commenters.

To explain, we analyzed separately solved model coefficients from each data year used in the proposed 2024 risk adjustment model recalibration and found that all 3 data years used for 2024 model recalibration exhibited similar changes in these RXC coefficients. This indicates that the 2020 enrollee-level EDGE data (or any potential anomalies related to that data year) were not driving the decrease. Although we understand the importance of transparency, we do not believe it is necessary to release the separately solved model coefficients from each data year.

However, we appreciate it is important to share more information about the RXC coefficients identified by commenters and generally note that, between benefit years, the RXC coefficients are typically less stable than HCC coefficients in the HHS risk adjustment models due to smaller sample sizes than their corresponding HCC coefficients, and multicollinearity with HCC coefficients and HCC–RXC interaction factors. In addition, as part of our consideration of these comments and to investigate whether the 2020 enrollee-level EDGE data coefficients for these three RXCs were substantially different from the 2018 and 2019 years of enrollee-level EDGE data coefficients, we engaged in a further analysis of the differences between coefficients solved from each year of enrollee-level EDGE data (2018, 2019, and 2020 enrollee-level EDGE data) for these three RXCs and found:

- In the HHS risk adjustment adult model coefficients from the 2018 through the 2023 benefit years, across the five metal levels, the distance between RXC coefficient values from the 2 most dissimilar data years used in the annual model recalibration for RXC 1 have ranged between 9.2 percent and 40.7 percent. Across the five metal levels, the median distance between RXC 1 coefficients from the 2 most dissimilar data years for the 2024 benefit year risk adjustment adult models is 30.9 percent.
- For RXC 8, the distance between values from the 2 most dissimilar data years used in the annual model recalibration for this adult model coefficient across the 2018 through 2023 benefit years ranged from between 5.1 percent and 28.4 percent, with the median value for the 2024 benefit year risk adjustment adult models at 7.0 percent across metal levels.
- For RXC 9, the range of distance between values from the 2 most dissimilar data years used in the annual model recalibration for this adult model coefficient across the 2018 through 2023 benefit years has fallen between 1.6 percent and 60.1 percent, with the median value for the proposed and final 2024 risk adjustment adult models at 4.7 percent across the five metal levels.

Although coefficients for these three RXCs decreased between the 2023 and 2024 benefit year risk adjustment adult models, the similarity of the coefficients among the 3 data years used to fit the 2024 benefit year risk adjustment models and the consistency of the dispersion between data years with the range of dispersion observed for previous benefit years' HHS risk adjustment models demonstrates that these decreases are not due to any anomalous patterns in the 2020 enrollee-level EDGE data. As noted above, in past benefit years, we have attributed the lower level of stability among RXC and RXC–HCC interaction factors to the high level of collinearity between these variables. Due to their close association with one another, the models may fit coefficients that divide risk between an interaction factor and its related RXC and HCC(s) differently for different years of enrollee-level EDGE data.

However, the change in these RXC coefficients relative to the previous benefit year are due to decisions we made in trending costs for traditional and specialty drugs, as suggested by some commenters, which have been trended separately from medical expenditures since the 2017 benefit year.[40] More specifically, in our annual assessment of the trending factors for the 2024 HHS risk adjustment models, we determined that the trend factors used for specialty drugs was higher than the market data supported. Therefore,

[37] The coefficients listed in Tables 1 through 6 of this final rule also reflect the pricing adjustment for Hepatitis C drugs finalized in this rule. In addition, the 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 x HCC056 or 057 and 048 or 041; RXC 09 x HCC056; RXC 09 x HCC 057; RXC 09 x 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 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 27231 through 27232.

[38] The adult, child and infant models have also been truncated to account for the high-cost risk pool payment parameters by removing 60 percent of costs above the $1 million threshold.

[39] Starting with the 2024 risk adjustment adult models, HHS will group HCC 18 Pancreas Transplant Status and CC 83 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.

[40] See 81 FR 12218.

for the 2024 benefit year, we used trend factors for specialty drugs that aligned with the market data rather than continuing the historical, higher trend factors. In determining these trend factors, we consulted our actuarial experts, reviewed relevant Unified Rate Review Template (URRT) submission data, analyzed multiple years of enrollee-level EDGE data, and consulted National Health Expenditure Accounts (NHEA) data as well as external reports and documents [41] published by third parties. In this process, we also ensured that the trends we use reflect changes in cost of care rather than gross growth in expenditures. As such, we believe the trend factors we used for specialty drugs are appropriate for the most recent trends we have seen in the market and the proposed RXC coefficient values that we finalize in this rule reflect the appropriate amount of growth between the data years used to fit the model and the 2024 benefit year. As part of our annual model recalibration activities, we intend to continue to reassess the trend factors used to update the HHS risk adjustment models in future benefit years. Consistent with § 153.320(b)(1), we will also continue to include and solicit comments on the draft model factors to be employed in the HHS risk adjustment models for a given benefit year, including but not limited to the proposed coefficients, as part of the applicable benefit year's Payment Notice proposed rule.

b. Pricing Adjustment for the Hepatitis C Drugs

In the HHS Notice of Benefits and Payment Parameters for 2024 proposed rule (87 FR 78206, 78218), for the 2024 benefit year, we proposed to continue applying a market pricing adjustment to the plan liability associated with Hepatitis C drugs in the risk adjustment models.[42]

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.[43] 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.[44]

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 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 will be used for the 2024 benefit year recalibration [45] 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 proposed to use 2018 benefit year EDGE data in the 2024 benefit year model recalibration.[46] 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. As noted in the proposed rule, we intend to continue to assess this pricing adjustment in future benefit year recalibrations using additional years of enrollee-level EDGE data.

We sought comment on this proposal. After reviewing the public comments, we are finalizing this proposal to continue applying a market pricing adjustment to the plan liability associated with Hepatitis C drugs in the 2024 benefit year HHS risk adjustment models as proposed. We summarize and respond to public comments received on the proposed pricing adjustment for Hepatitis C drugs below.

Comment: Most commenters supported the continued use of the pricing adjustment for Hepatitis C drugs with one commenter stating that the proposed Hepatitis C pricing adjustment seems reasonably well calibrated to reduce the incentives for issuers to create discriminatory plans that would drive away enrollees with Hepatitis C.

Some commenters expressed concern about the Hepatitis C pricing adjustment. These commenters cautioned against reducing the Hepatitis C RXC coefficient more than the expected decrease in cost as that may incentivize issuers to reduce the availability of treatment. These commenters were also concerned about undercompensating issuers for enrollees with serious chronic conditions, which they stated would incentivize issuers to avoid these enrollees. One commenter asserted that the professional independence and ethical standards of providers would prevent providers from prescribing drugs that they did not believe were medically necessary and appropriate, reducing the potential for issuers to game the program.

Response: We believe that continuing to apply the Hepatitis C pricing adjustment in the 2024 benefit year HHS risk adjustment models is appropriate at this time. This pricing adjustment will help avoid perverse incentives and will

[41] See for example, ''How much is health spending expected to grow?'' by the Peterson-Kaiser Family Foundation, available at *https://www.healthsystemtracker.org/chart-collection/how-much-is-health-spending-expected-to-grow/.* See also ''Medical cost trend: Behind the numbers 2022'' by PwC Health Research Institute, available at *https://www.pwc.com/us/en/industries/health-industries/library/assets/pwc-hri-behind-the-numbers-2022.pdf.* See also, ''MBB health trends'' by MercerMarsh Benefits, available at *https://www.mercer.com/content/dam/mercer/attachments/private/gl-2022-mmb-health-trends-report.pdf.*

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

[43] 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.

[44] 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.*

[45] As detailed above, we are finalizing that we will use 2018, 2019 and 2020 enrollee-level EDGE data for recalibration of the 2024 benefit year HHS risk adjustment models, with no exceptions. However, for the proposed rule, we also assessed 2017 enrollee-level EDGE data in the event one of the alternative proposals regarding use of 2020 enrollee-level EDGE data were to be adopted.

[46] 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.*

lead to Hepatitis C RXC coefficients that better reflect anticipated actual 2024 benefit year plan liability associated with Hepatitis C drugs. Specifically, the purpose of the Hepatitis C pricing adjustment is to address 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 that present a risk of creating perverse incentives by overcompensating issuers. We reassessed the pricing adjustment for the Hepatitis C RXC for the 2024 benefit year model recalibration and found that the data used for the 2024 benefit year risk adjustment model recalibration (that is, 2018, 2019, and 2020 enrollee-level EDGE data) still do not account for the significant pricing changes that we have observed for the Hepatitis C drugs due to the introduction of newer and cheaper Hepatitis C drugs. Therefore, the data that will be used to recalibrate the models needs to be adjusted because it does not precisely reflect the average cost of Hepatitis C treatments expected in the 2024 benefit year.

In making this determination, we consulted our clinical and actuarial experts, and analyzed the most recent enrollee-level EDGE data available to further assess the changing costs associated with Hepatitis C enrollees. Due to the high cost of these drugs reflected in the 2018, 2019, and 2020 enrollee-level EDGE data, without a pricing adjustment to plan liability, issuers would be overcompensated for the Hepatitis C RXC in the 2024 benefit year, and issuers could be incentivized to encourage overprescribing practices and game risk adjustment such that their risk adjustment payment is increased or risk adjustment charge is decreased. We also recognize concerns that applying a pricing adjustment that would reduce the coefficient for the Hepatitis C RXC by more than the expected decrease in costs could incentivize issuers to reduce the availability of the treatment. However, we believe that the Hepatitis C pricing adjustment we are finalizing accurately captures the costs of Hepatitis C drugs for the 2024 benefit year using the most recently available data, balances the need to deter gaming practices with the need to ensure that issuers are adequately compensated, and does not undermine recent progress in the treatment of Hepatitis C. Nevertheless, we intend to continue to reassess this pricing adjustment as part of future benefit years' model recalibrations using additional years of available enrollee-level EDGE data.

We appreciate commenters' concerns about undercompensating issuers for enrollees with serious chronic conditions. We note that HHS, in the 2023 Payment Notice (87 FR 27221 through 27230), finalized several risk adjustment model changes to address the adult and child models' underprediction for enrollees with many HCCs. Specifically, we finalized the interacted HCC counts and HCC-contingent enrollment duration factor model specifications to improve model prediction for the higher risk enrollees and ensure that issuers are being accurately compensated for these enrollees. As such, the potential for underprediction or overprediction in the HHS risk adjustment models is an area that we are consistently monitoring and addressing as needed and will continue to monitor and address in the future as part of our ongoing efforts to continually improve the HHS risk adjustment models.

Additionally, we recognize the important role that the ethical standards of providers play in preventing overprescribing of drugs that they do not believe are medically necessary and appropriate, but we believe that the Hepatitis C pricing adjustment is the most effective way to protect against perverse incentives that could affect prescribing patterns.

Comment: One commenter urged HHS to expand the pricing adjustment to other drugs, noting that biosimilar versions of *adalimumab* (Humira®), a drug that is currently classified in RXC 9 *Immune suppressants and Immunomodulators* in the adult risk adjustment models, will soon enter the market and the logic for applying a market pricing adjustment to the plan liability associated with Hepatitis C drugs may be extended to these biosimilar drugs.

Response: We did not propose or solicit comments on extending a pricing adjustment to drugs treating conditions other than Hepatitis C. As such, at this time, we will not be finalizing any pricing adjustments for the RXC 9 drug *adalimumab* or other specialty drugs with alternatives (whether generic or biosimilar) entering the market in the coming year. In the 2023 Payment Notice (87 FR 27231 through 27235), we explained our criteria for inclusion and exclusion of drugs in RXC mapping and recalibration. We stated that in extenuating circumstances where HHS believes there will be a significant impact from a change in an RxNorm Concept Unique Identifiers (RXCUI) to RXC mapping, such as: (1) evidence of significant off-label prescribing (as was the case with hydroxychloroquine sulfate);[47] (2) abnormally large changes in clinical indications or practice patterns associated with drug usage; or (3) certain situations in which the cost of a drug (or biosimilars) become much higher or lower than the typical cost of drugs in the same prescription drug category, HHS will consider whether changes to the RXCUI to RXC mapping from the applicable data year crosswalk (or, in this case, pricing adjustments) are needed for future benefit year recalibrations.

Although making a pricing adjustment due to the introduction of new drugs in a market is not the same as adjusting the RXC mappings, we take a similar approach in considering whether a pricing adjustment for new drugs in a market is needed. We do not believe there is evidence at this time that the introduction of biosimilar alternatives to *adalimumab* will create market patterns that meet any of these three criteria. Our current understanding is that the biosimilar alternatives to *adalimumab* entering the market are not analogous to the generic versions of drugs used to treat Hepatitis C. Biosimilars, in general, differ from common generic drugs and their market behaviors are expected to be distinct. Because biosimilars are made from living material (which is not the case with common generic drugs), they differ in their interchangeability and manufacturing cost savings from common generics.[48] Furthermore, although costs are expected to be lower for *adalimumab* biosimilars due to lower costs of development, the nature of the different production process for biologic drugs means that the price reductions are expected to be much smaller with biosimilars than we see with the introduction of generic medications.[49] As such, we also do not believe that the costs and prescribing patterns of *adalimumab* (and its biosimilars) will be much higher or lower than the typical cost of drugs in the same prescription drug category in the near future. Nevertheless, we will continue to monitor the prescription drug market as part of our ongoing efforts to continually improve the HHS risk adjustment models.

[47] See, for example, 86 FR 24180.

[48] See *https://www.uspharmacist.com/article/biosimilars-not-simply-generics.* See also *https://www.goodrx.com/humira/biosimilars.*

[49] See *https://www.reuters.com/business/healthcare-pharmaceuticals/abbvies-humira-gets-us-rival-costs-could-stay-high-2023-01-31/.* See also *https://info.goodrootinc.com/download-our-biosimilars-white-paper.*

c. Request for Information: Payment HCC for Gender Dysphoria

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78219), HHS requested information on adding a payment HCC for gender dysphoria to the HHS risk adjustment models for future benefit years. We thank commenters for their feedback and will take these comments into consideration if we pursue this potential risk adjustment model update for future benefit years through notice-and-comment rulemaking.

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

We are finalizing the 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 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.[50] Table 1 contains factors for each adult model, including the age-sex, HCCs, RXCs, RXC–HCC interactions, interacted HCC counts, and enrollment duration coefficients. Table 2 contains the factors for each child model, including the age-sex, HCCs, and interacted HCC counts coefficients. Table 3 lists the HHS–HCCs selected for the interacted HCC counts factors that apply to the adult and child models. Table 4 contains the factors for each infant model. Tables 5 and 6 contain the HCCs included in the infant models' maturity and severity categories, respectively.

[50] We did not propose changes to the high-cost risk pool parameters for the 2024 benefit year. Therefore, we will maintain the $1 million threshold and 60 percent coinsurance rate.

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TABLE 1: 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	0.189	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
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
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[a]	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

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
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[b]	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
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

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
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
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	Parkinsons, Huntingtons, 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

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
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
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[c]	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

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
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
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

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
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 03[d]	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
RXC 09[e]	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

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
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

a/ Starting with the 2024 risk adjustment adult models, HHS will group HCC 18 Pancreas Transplant Status and HCC 83 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.

b/ 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.

c/ 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.

d/ 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).

e/ Similar to recalibration of the 2023 risk adjustment adult models and consistent with the final policies adopted in the 2023 Payment Notice, the 2024 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 2023 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.

TABLE 2: 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
Parkinsons, Huntingtons, 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 3: HCCs Selected for the 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)*	X	X

* 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, for example, 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.

TABLE 4: 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 5: 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 6: 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

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After reviewing public comments, we are finalizing the list of factors to be employed in the HHS risk adjustment models with the following modifications. In the proposed rule (87 FR 78219 through 78226), the adult risk adjustment model factor coefficients reflected 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. In this final rule, the adult risk adjustment model factor coefficients for the 2024 benefit year have been updated to reflect the finalization of the use of the 2018, 2019 and 2020 benefit year enrollee-level EDGE data for recalibration of the 2024 benefit year risk adjustment models for all model coefficients, including the adult age-sex coefficients, as detailed in an earlier section of this rule.

We summarize and respond to public comments received on the list of factors to be employed in the HHS risk adjustment models below.

Comment: One commenter stated that the enrollment duration factors do not fully capture the financial impact of enrollment duration for consumers who enroll during SEPs, and requested HHS further investigate how the HHS risk adjustment models can be updated and improved to reflect more recent changes to SEPs.

Response: In the 2023 Payment Notice (87 FR 27228 through 27230), we changed the enrollment duration factors in the adult risk adjustment models to improve prediction for partial-year adult enrollees with and without HCCs. As described in the 2021 Risk Adjustment (RA) Technical Paper,[51] we found that the previous adult model enrollment duration factors underpredicted plan liability for partial-year adult enrollees with HCCs and overpredicted plan liability for partial-year adult enrollees without HCCs. Therefore, beginning with the 2023 benefit year, we eliminated the enrollment duration factors of up to 11 months for all enrollees in the adult models, and replaced them with new monthly enrollment duration factors of up to 6 months that would apply only to adult enrollees with HCCs. HHS did not propose and is not finalizing any changes to the enrollment duration factors as part of this rulemaking. However, as more data years become available, we will continue to investigate the performance of the enrollment duration factors. Specifically, as the SEP landscape changes and we have new data to reflect those changes,[52] we will assess the extent to which the enrollment duration factors fully capture the financial impact of enrollment duration for enrollees who enroll during an SEP.

e. CSR Adjustments

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78235), we proposed to continue including an adjustment for the receipt of CSRs in the risk adjustment models in all 50 States and the District of Columbia. We explained that 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,[53] to maintain stability and certainty for issuers for the 2024 benefit year, we proposed to maintain the CSR adjustment factors finalized in the 2019, 2020, 2021, 2022, and 2023 Payment Notices.[54] See Table 7. We also proposed to continue to use a CSR adjustment factor of 1.12 for all Massachusetts wrap-around plans in the risk adjustment PLRS calculation, as all

[51] HHS published analysis of CSR population utilization in the HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes. (2021, October 26). CMS. *https://www.cms.gov/files/document/2021-ra-technical-paper.pdf.*

[52] See, for example, CMS. (2022, October 28). Marketplace Stakeholder Technical Assistance Tip Sheet on the Monthly Special Enrollment Period for Advance Payments of the Premium Tax credit—Eligible Consumers with Household Income at or below 150% of the Federal Poverty Level. *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/150FPLSEPTATIPSHEET.*

[53] 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/2022-09/Academy_CSR_Load_Letter_09.08.22.pdf.*

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

of Massachusetts' cost-sharing plan variations have AVs above 94 percent (81 FR 12228).

We sought comment on these proposals. After reviewing the public comments, we are finalizing the CSR adjustment factors as proposed.

TABLE 7: 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

We summarize and respond to public comments received on the proposed CSR adjustment factors below.

Comment: One commenter supported using the proposed CSR adjustment factors in the HHS-operated risk adjustment program. Another commenter supported continuing to apply an adjustment for Massachusetts wrap-around plans to account for its unique market dynamics. A few commenters supported further evaluation of the CSR adjustment factors. One commenter requested evaluation of the current CSR adjustment factors in light of an absence of funding of CSR subsidies and due to the potential socioeconomic health equity issues associated with lower-than-anticipated induced utilization levels in the CSR population.[55] Another commenter requested a technical paper before future proposed rulemaking with further CSR induced demand analysis.

One commenter stated that current CSR adjustment factors, specifically when applied to CSR 87 percent and 94 percent variants, do not accurately reflect population risk and another commenter requested the risk adjustment formula reflect actual costs incurred by 87 percent and 94 percent AV enrollees.

Response: We appreciate the comments in support of these proposals and are finalizing the 2024 benefit year CSR adjustment factors as proposed. While we have studied the CSR adjustment factors, we agree continued study of the CSR adjustment factors is warranted to further assess the different options outlined in the 2021 RA Technical Paper and other potential approaches before pursuing any changes.[56] However, at this time, we are not planning to publish another technical paper with additional CSR induced demand analysis prior to pursing changes to these factors in any future proposed rulemaking. We anticipate that between the 2021 RA Technical Paper and any future notice-and-comment rulemaking, sufficient analysis and justification for any proposed changes would be provided.

Additionally, we reiterate the findings from the 2021 RA Technical Paper that the current CSR adjustment factors are predicting actual plan liability relatively accurately on average, with the nationally-approximated risk term predictive ratios for CSR 87 percent and 94 percent variants both within +/-5 percent. We also believe that the collection and extraction of additional data elements from issuers' EDGE servers, including plan ID and rating area, will help further inform our study of the CSR adjustment factors and may allow us to further consider potential socioeconomic issues in the CSR populations. Therefore, HHS intends to review the enrollee-level EDGE data with the plan ID and rating area before proposing any changes to the CSR adjustment factors in future notice-and-comment rulemaking.

Comment: A few commenters were concerned about the underprediction of zero and limited sharing CSR plan variants for American Indian/Alaska Natives (AI/AN) in the risk term of the State payment transfer formula, as outlined in the 2021 RA Technical Paper,[57] particularly in States that have a high percentage of AI/AN enrollment, because competition for these enrollees may be discouraged by this underprediction.[58] These commenters were concerned that this market dynamic would result in issuers with fewer AI/AN enrollees having the ability to more aggressively price silver plan premiums, gaining competitive advantage and depressing premium tax credits for enrollees in that State's market. One commenter recommended that HHS reframe and recalibrate the CSR adjustment factors to fully eliminate the underprediction of liability for AI/AN enrollees to best capture actual CSR experience and mitigate any existing imbalances in risk adjustment State transfers across metal and CSR plan variants.

Response: As part of our overall analysis of the CSR adjustment factors,

[55] HHS published analysis of CSR population utilization in the HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes. (2021, October 26). CMS. *https://www.cms.gov/files/document/2021-ra-technical-paper.pdf.*

[56] Ibid.

[57] Ibid.

[58] The CSR adjustment factors for zero cost sharing recipients (less than 300 percent of FPL) and limited cost sharing recipients (greater than 300 percent of FPL) for each metal level are included in Table 7 of this rule.

we will also continue to consider options for how to recalibrate and adjust the CSR adjustment factors for the zero and limited sharing CSR plan variants for future benefit years. In the 2021 RA Technical Paper, we provided an analysis that showed the underprediction of zero and limited sharing CSR plan variants for AI/AN in HHS risk adjustment and considered a variety of different options to adjust the CSR adjustment factors.[59] Because this analysis was conducted at the national level, we did not observe any trends of particular issuers, States or rating areas having a higher percentage of AI/AN enrollment as noted by the commenter. Specifically, we were extracting and using national enrollee-level EDGE data without issuer or geographic markers. Therefore, in the past and when we developed the proposed rule, we did not have the ability to analyze the distribution of the CSR populations at a more granular level (for example, at the issuer, State or rating area level) to see, for example, which issuers, States or rating areas have a high percentage of AI/AN enrollment. However, with policies finalized in the 2023 Payment Notice (87 FR 27241 through 27243) and this final rule, we will have the ability to extract and use multiple years of enrollee-level EDGE data with plan ID and rating area markers and will be able to further analyze the CSR populations at a more granular level, including analyzing whether incentives may exist in certain States with high proportions of AI/AN populations for issuers with fewer AI/AN enrollees to more aggressively price silver plan premiums in those States, to further consider potential changes to these factors for future benefit years. In the meantime, we are finalizing the CSR adjustment factors as proposed for the 2024 benefit year to maintain stability and certainty for issuers.

Comment: We also received several comments in response to a reference to the American Academy of Actuaries' letter on CSR loading in a footnote in the proposed rule.[60] These commenters objected to HHS considering any method of estimating CSR premium load factors that involves issuers using experience data or issuer pricing models to estimate the CSR load for silver plan variants. These commenters stated that they believed such a methodology is a violation of the ACA's single risk pool requirement, which requires issuers to treat all individual market enrollees as part of a single risk pool so that pricing reflects utilization of essential benefits by a standard population. These commenters shared their experience from Texas and New Mexico, where they claim aligning plan prices by AV when regulating the variation in metal level premiums resulted in large enrollment increases and enhanced affordability following premium realignment. One commenter expressed concern about using a nationally weighted CSR silver load in the rating term of the transfer formula due to variations in State CSR enrollment mixes or CSR loading requirement recommending the use of State-specific AV factors, as discussed in the 2021 RA Technical Paper. Another of these commenters suggested that anticipated premiums should instead reflect the average AV of all CSR variants.

Response: We appreciate the comments on potential approaches to change the current CSR adjustment factors and, as previously noted, are continuing to study these issues for potential updates to these factors in future benefit years. We did not propose and are not adopting any changes to the CSR adjustment factors. With policies finalized in the 2023 Payment Notice (87 FR 27241 through 27243), we have the ability to extract and use enrollee-level EDGE data with plan ID and rating area markers to further analyze the CSR populations at a more granular level to further consider potential changes to these factors for future benefit years, as well as other potential approaches. This includes consideration of the American Academy of Actuaries letter regarding accounting for the receipt of CSRs in the HHS-operated risk adjustment program and plan rating.[61] As part of this effort, we will also consider interested parties' analysis and comments on potential approaches under consideration, including the feedback provided by these commenters. We are aware of the interaction that potential future changes to the CSR adjustment factors may have with regard to the ACA's single risk pool requirement, and confirm that any changes to the CSR adjustment factors would be designed to align with other applicable Federal market reforms. We also affirm that interested parties will have an opportunity to comment on any potential changes to the CSR adjustment factors for future benefit years, as those updates would be pursued through notice-and-comment rulemaking.

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 will 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.[62] Because we are finalizing a blend of coefficients from separately solved models based on the 2018, 2019, and 2020 benefit years' enrollee-level EDGE data, we are publishing the R-squared statistic for each model separately to verify their statistical validity. The R-squared statistics for the 2024 benefit models are shown in Table 8.

[59] HHS published analysis of CSR population utilization in the HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes. (2021, October 26). CMS. *https://www.cms.gov/files/document/2021-ra-technical-paper.pdf.*

[60] 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/2022-09/Academy_CSR_Load_Letter_09.08.22.pdf.*

[61] Ibid.

[62] 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.*

TABLE 8: R-Squared Statistic for the 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

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 did not propose any changes to the formula in the proposed rule, and therefore, are not republishing the formulas in this rule. We will continue to apply the formula as finalized in the 2021 Payment Notice (86 FR 24183 through 24186)[63] 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 did not propose any changes to the high-cost risk pool parameters for the 2024 benefit year; therefore, we will maintain the $1 million threshold and 60 percent coinsurance rate.

We summarize and respond to public comments received on the HHS risk adjustment methodology below.

Comment: A few commenters asserted that using a population's history of health care utilization, as the HHS-operated risk adjustment program currently does, entrenches resource disparities and barriers to health care access, and shifts resources from issuers serving lower-income communities to issuers serving higher-income communities in the State of Massachusetts. These commenters also stated that they believe HHS should include social determinants of health (SDOH) as factors in the HHS risk adjustment models. The commenters stated that using the Statewide average premium as a scaling factor in the State payment transfer formula amplifies the transfer of funds away from issuers with low-priced provider networks, who disproportionately serve lower-income communities.

Response: We appreciate these comments, which were based on findings in a report released by the Massachusetts Attorney General's Office titled *Examination of Health Care Cost Trends and Cost Drivers 2022,*[64] but do not believe that changes to the HHS-operated risk adjustment program are warranted at this time based on this report, as the findings do not appear to be applicable to other States. Following the release of the report, we analyzed available enrollee-level EDGE data to investigate whether the findings of the report were applicable in other State markets. We found that the Massachusetts merged market exhibits a unique combination of characteristics, including a highly segmented market where some issuers serve primarily CSR enrollees while other issuers primarily serve off-Exchange enrollees, and a uniquely healthy CSR population, that create an environment in which issuers that serve low-income communities can be assessed charges in that State's market risk pools. In particular, because the HHS-operated risk adjustment program is intended to transfer funds from lower-than-average risk plans to higher-than-average risk plans, a plan with a uniquely healthy population, whether because it has a uniquely healthy CSR population or a healthy general population, can be assessed a risk adjustment charge.

No other State exhibits the same combination of unique characteristics discussed in this section as the State of Massachusetts. Therefore, we have concerns about proposing changes to the HHS-operated risk adjustment program, including changes with regard to the use of the Statewide average premium as a scaling factor in the State payment transfer formula, based on a report that is Massachusetts specific and reflects the unique market conditions of a single State. Furthermore, in light of the unique combination of characteristics of Massachusetts's CSR population discussed elsewhere in this section, we believe that under the existing HHS risk adjustment methodology, the transfer charges and payments assessed in the Massachusetts merged market risk pool reflect a reasonably accurate estimate for the relative risk incurred by issuers in that State. We also reiterate that HHS chose to use Statewide average premium and normalize the risk adjustment State payment transfer formula to reflect State average factors so that each plan's enrollment characteristics are compared to the State average and the calculated payment amounts equal calculated charges in each State market risk pool.

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

[64] See *Examination of Health Care Cost Trends and Cost Drivers 2022.* Available at *https://www.mass.gov/files/documents/2022/11/02/2022-11-2%20COST-TRENDS-REPORT_PUB_DRAFT4_HQ.pdf.*

Thus, each plan in the risk pool receives a risk adjustment payment or charge designed to compensate for risk for a plan with average risk in a budget-neutral manner. This approach supports the overall goals of the HHS-operated risk adjustment program, which are to encourage issuers to rate for the average risk in the applicable State market risk pool, to stabilize premiums, and to avoid the creation of incentives for issuers to operate less efficiently, set higher prices, or develop benefit designs or marketing strategies to avoid high-risk enrollees.[65]

We also appreciate the comments on including SDOH as factors in the HHS risk adjustment models. In the 2023 Payment Notice, HHS solicited comments on ways to incentivize issuers to design plans that improve health equity and health conditions in enrollees' environments, as well as sought comments on the potential future collection and extraction of z codes (particularly Z55–Z65), a subset of ICD–10–CM encounter reason codes used to identify, analyze, and document SDOH, as part of the required EDGE data submissions. We continue to review and consider the public comments related to the collection and extraction of z codes to inform analysis and policy development for the HHS-operated risk adjustment program. In the interim, we note that including SDOH in the HHS-operated risk adjustment models would require careful consideration because doing so could actually increase health disparities rather than reduce them. For example, if individuals who have a particular SDOH factor in risk adjustment tended to underutilize health care services relative to their health status, including that factor in the HHS-operated risk adjustment models could perpetuate, and possibly exacerbate, the under compensation of issuers for enrollees that receive that factor in risk adjustment. Such a dynamic may incentivize risk selecting behavior among issuers. Furthermore, we have concerns about the reliability of existing data for determining if an enrollee has SDOH and what documentation would be needed from the issuer to verify them.[66] We continue to analyze data in this area, especially as new enrollee-level EDGE data elements become available, and would propose any changes to the HHS risk adjustment models or HHS-operated risk adjustment program through notice-and-comment rulemaking.

[65] 84 FR 17480 through 17484.

[66] See, for example, the analysis of z codes at 87 FR 632.

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

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78237), we proposed to repeal the flexibility under § 153.320(d) for prior participant States[67] to request reductions of risk adjustment State transfers under the State payment transfer formula in all State market risk pools for the 2025 benefit year and beyond. We also solicited 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. After reviewing public comments, we are approving Alabama's requests for the 2024 benefit year and finalizing the proposal to repeal the flexibility for prior participant States to request transfer reductions for the 2025 benefit year and beyond.

a. Repeal of State Flexibility To Request Transfer Reductions

In the proposed rule (87 FR 78237 through 78238), we proposed to amend § 153.320(d) to repeal the ability for prior participant States to request a reduction in risk adjustment State transfers beginning with the 2025 benefit year. As part of this repeal, we proposed 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 proposed 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. After reviewing public comments, we are finalizing these proposals as proposed.

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.[68]

In the 2023 Payment Notice (87 FR 27236), we 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.[69] 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.[70] In the 2023 Payment Notice (87 FR 27239 through 27241), we also finalized 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

[67] 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''.

[68] 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).

[69] 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.

[70] 87 FR 27239 through 27241. See also 83 FR 16957.

addition, we indicated our intention to propose in future rulemaking to repeal the exception for prior participants beginning with the 2025 benefit year.[71]

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.[72] In addition, we noted that since establishing this framework, we have observed a lack of 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.[73]

As discussed in the proposed rule, HHS believes the complete repeal of the option for States to request reductions in risk adjustment State transfers will 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, we 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 noted that we believe a complete repeal of § 153.320(d) will 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 will protect and strengthen the ACA and make health care more accessible and affordable. For all of these reasons, we proposed to amend § 153.320(d) to repeal the flexibility for prior participant States 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. We noted in the proposed rule that if these amendments are finalized, no State will 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 summarize and respond to public comments received on the proposal to repeal the flexibility for prior participant States 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 below.

Comment: Several commenters supported the proposal to repeal the ability for States to request a reduction in risk adjustment State transfers due to concerns that the reduction in transfers would contribute to adverse selection, increase premiums, and reduce plan options. Commenters stated that reducing risk adjustment State transfers incentivizes issuers to ''cherry-pick'' lower-risk enrollees as they would not have to contribute the full difference in risk to support the cost of higher-risk individuals enrolled by other issuers. Commenters also noted that the HHS risk adjustment methodology already accounts for differences in State market conditions and that States can run their own risk adjustment programs if they do not think the HHS-operated risk adjustment program works for their State. Some commenters expressed concerns about the potential negative impacts, such as reduced plan quality and increased risk selection, of allowing transfer reductions in the prior participant State's markets. One commenter stated that repealing this flexibility would provide stability and certainty for the markets.

Conversely, several commenters opposed the proposal, stating that they support the ability for States to make their own decisions about how best to address the unique circumstances of their insurance markets. Some commenters also noted that HHS has the ability to review and reject these requests, indicating that there are appropriate guardrails in place such that States should continue to be offered this flexibility. Additionally, some commenters asserted that other States may develop the same market dynamics as the one prior participating State and should have the same ability to request reductions. One commenter noted concerns with the ability for States to run their own risk adjustment programs, due to the costs to implement such a program within a State. Finally, one commenter stated that the prior participant State had not observed any of the concerns regarding market destabilization or reduced plan offerings as a result of the requests, so the prior participant State should continue to be permitted to request transfer reductions.

Response: We agree with the comments submitted in support of this proposal and are finalizing as proposed the repeal of the exception for prior participant States to request a reduction in risk adjustment State transfers of up to 50 percent in any State market risk pool beginning with the 2025 benefit year. We reiterate that a strong risk adjustment program is necessary to support stability and address adverse selection in the individual and small group markets. We are concerned that retaining the State flexibility framework could undermine these goals in the long-term. As explained in 2023 Payment Notice and the proposed rule, our further consideration of prior feedback from interested parties, along with consideration of the State flexibility framework under E.O. 14009 and the very low level of interest from States since the policy was adopted, resulted in an evaluation of whether this flexibility should continue and in what

[71] Ibid.

[72] 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.*

[73] 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).

manner.[74] In the 2023 Payment Notice, we finalized the proposed amendments to § 153.320(d) to repeal the State flexibility framework beginning with the 2024 benefit year, with an exception for prior participant States.[75] We also announced our intention to propose in future rulemaking to repeal the exception for prior participants beginning with the 2025 benefit year to provide impacted parties additional time to prepare for the potential elimination of this flexibility.[76] After reviewing public comments on the proposed repeal of the exception for prior participant States, we are finalizing the repeal of the prior participant exception, as proposed.

As noted above and in the proposed rule, we believe that a complete repeal of the State flexibility framework in § 153.320(d) by removing the prior participant exception beginning with the 2025 benefit year will prevent the potential negative outcomes of States' risk adjustment transfer reduction requests identified by several commenters, including the possibility of risk selection or ''cherry-picking'' lower-risk enrollees, market destabilization, increased premiums, smaller networks, and less-comprehensive plan options. The prevention of these potential negative outcomes would serve to further protect and strengthen the ACA, protect enrollees from potential ''cherry-picking'' practices, and make health care coverage more accessible and affordable. As such, despite our ability to review and reject risk adjustment transfer reduction requests, we are still of the view that the State flexibility framework is inconsistent with policies described in sections 1 and 3 of E.O. 14009 and a complete repeal would better support the goals of the HHS-operated risk adjustment program and ultimately the ACA.

With respect to the prior participant State, the State experienced new entrants to the individual market for the 2022 benefit year, but it has seen issuers both entering and exiting its markets for the 2023 benefit year, so it is not clear that the State has seen market stabilization or improved plan quality since its reduction requests have been approved. A more detailed discussion of the prior participant State's market dynamics appears in the section below regarding Alabama's 2024 risk adjustment transfer reduction requests.

We agree with commenters who noted that States are best able to make their own decisions about how to address the unique circumstances of their insurance markets and remain the primary regulators of their insurance markets. We also understand that it is possible that other States may develop the same market dynamics as the one prior participating State. At the same time, however, States have shown a low level of interest in submitting requests to reduce transfers calculated by HHS under the State payment transfer formula. Between the 2020 benefit year and 2023 benefit year, all States had the opportunity to submit reduction requests under § 153.320(d), and yet only one State did so.[77] As discussed in the 2023 Payment Notice (87 FR 27240), we believed it was appropriate to provide a transition for the prior participant State, starting with the policies and amendments finalized in the 2023 Payment Notice that apply beginning with the 2024 benefit year. However, we continue to be concerned about the potential long-term impact of allowing reductions to risk adjustment State transfers in any State market risk pool, including the potential negative impacts on the program's ability to mitigate adverse selection and support stability in the individual and small group (including merged) markets. We are therefore finalizing a full repeal of the State flexibility framework (for all States) beginning in the 2025 benefit year in this final rule.

Furthermore, since the 2014 benefit year, all States have had the opportunity to operate their own risk adjustment program and, to date, only one State has done so.[78] Despite a broad range of market conditions across the 50 States and the District of Columbia, only two States have expressed interest in tailoring risk adjustment to address the unique circumstances of their insurance markets, which suggests States generally do not want to operate their own risk adjustment program. It also offers evidence that the HHS-operated risk adjustment program works across a broad range of market conditions to mitigate adverse selection in the individual and small group (including merged) markets. We also agree with commenters that the HHS risk adjustment methodology already accounts for differences in State market conditions. For example, the use of the Statewide average premium in the risk adjustment State payment transfer formula accounts for differences in State market conditions by scaling a plan's transfer amount based on the determination of plan average risk within a State market risk pool. The State payment transfer formula also includes a geographic cost factor (GCF), which adjusts at the rating area level for the many costs, such as input prices and medical care utilization, that vary geographically and are likely to affect premiums.[79]

Commenters are also correct that States continue to have the option to operate their own risk adjustment program if the State believes the risk adjustment program for the individual and small group (including merged) markets should be tailored to capture its State-specific dynamics. At the same time, we appreciate there are a number of different factors States consider when weighing whether to operate a State-based risk adjustment program, including but not limited to the costs associated with establishing and maintaining such a program. We stand ready to work with any State that is interested in operating its own risk adjustment program for the individual and small group (including merged) markets. Furthermore, now that we are collecting and extracting additional data elements—like plan ID, Zip Code, and rating area—from issuers' EDGE servers, as finalized in the 2023 Payment Notice (87 FR 27244 through 27252), we are better equipped to further evaluate State market conditions at various levels as we consider future changes to the HHS-operated risk adjustment program, as applicable. We also remain committed to working with States and other interested parties to encourage new market participants, mitigate adverse selection, and promote stable insurance markets through strong risk adjustment programs.

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

For the 2024 benefit year, HHS received requests from Alabama to reduce risk adjustment State transfers for its individual[80] and small group markets by 50 percent. As in previous years, Alabama asserted that the HHS-operated risk adjustment program does not work precisely in the Alabama market, clarifying that they do not assert

[74] See 87 FR 27239 through 27241. Also see 87 FR 78237 through 78238.

[75] 87 FR 27239 through 27241.

[76] Ibid.

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

[78] Massachusetts operated a State-based risk adjustment program for the 2014 through 2016 benefit years.

[79] See ''March 31, 2016 HHS-Operated Risk Adjustment Methodology Meeting Discussion Paper,'' CMS (2016, March 24), available at *https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/downloads/ra-march-31-white-paper-032416.pdf* for more information on the GCF.

[80] 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.

that the risk adjustment formula is flawed, only that it produces imprecise results in Alabama, which has an ''extremely unbalanced market share.'' The State reported that its review of 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 reported that its review of 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.

In the proposed rule (87 FR 782378), we sought comment on Alabama's requests to reduce risk adjustment State transfers in its individual and small group markets by 50 percent for the 2024 benefit year. The request and additional documentation submitted by Alabama were posted under the ''State Flexibility Requests'' heading at *https://www.cms.gov/cciio/programs-and-initiatives/premium-stabilization-programs* and under the ''Risk Adjustment State Flexibility Requests'' heading at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance#Premium-Stabilization-Programs.*

After reviewing the public comments, we are approving Alabama's requests to reduce risk adjustment State transfers in its individual and small group markets by 50 percent for the 2024 benefit year. We summarize and respond to public comments received on Alabama's reduction requests below.

Comment: A few commenters supported Alabama's requests to reduce risk adjustment State transfers in its individual and small group markets by 50 percent for the 2024 benefit year. These commenters stated that the HHS-operated risk adjustment program is not effective in Alabama due to its extreme market dynamics and that the State has not seen a loss of broad network, platinum, or gold plans as some interested parties had feared would result from the reductions in prior years.

However, other commenters opposed Alabama's 2024 benefit year reduction requests, stating that the requested reductions would diminish the effectiveness of the HHS-operated risk adjustment program. One commenter stated that there was no mathematical reason why the presence of one large issuer would preclude the HHS-operated risk adjustment program from functioning appropriately in Alabama.

Some commenters also asserted that the State did not meet its burden to substantiate the requests under the criteria established in § 153.320(d). These commenters argued that the State did not consider in its analysis changes to the risk adjustment models, issuer participation, market conditions, benefit design offerings, network breadth, premium changes, or consumer behavior. A few of these commenters suggested that the State be required to provide more detailed analysis with its requests about the impact of transfer reductions on premiums and issuer participation. One of these commenters provided detailed data it previously submitted in comments in response to Alabama's reduction requests for the 2023 benefit year, asserting the requested individual market transfer reduction would again increase premiums for one impacted Alabama issuer by an amount greater than the *de minimis* threshold (that is, more than 1 percent increase in its premiums) for the 2024 benefit year. This commenter noted that, based on their experience from the 2022 benefit year (the first year for which the State requested and HHS approved a 50 percent reduction in risk adjustment State transfers calculated by HHS for the individual market), the 50 percent reduction in Alabama individual market transfers for 2022 led to an approximately 2 percent increase in their premiums for that year, which exceeds the *de minimis* threshold and was approved by the State in the issuer's rate filings.[81] This commenter stated that they anticipated the impact for the 2024 benefit year, were HHS to approve Alabama's requests, would be similar.

Finally, a few commenters stated that if HHS were to approve Alabama's requests, it should approve percentage reductions no higher than what it approved for the 2023 benefit year; that is, 25 percent in the individual market and 10 percent in the small group market.[82]

Response: We appreciate the comments in support of HHS's approval of Alabama's 2024 benefit year reduction requests and are approving Alabama's requests to reduce risk adjustment transfers for the 2024 benefit year in the individual and small group markets by 50 percent, as Alabama met the criteria set forth in § 153.320(d)(4)(i)(B).

We continue to believe and recognize that risk adjustment is critical to the proper functioning of the individual and small group (including merged) markets, and we acknowledge commenters' concerns that approving requested reductions in risk adjustment transfers could impact the effectiveness of the HHS-operated risk adjustment program, which is why we are repealing the exception for prior participant States to request risk adjustment transfer reductions beginning with the 2025 benefit year, as discussed in detail in the preamble section above. However, under existing HHS regulations, Alabama was permitted to submit a reduction request for the 2024 benefit year,[83] and they did so in the manner set forth in § 153.320(d)(1).[84] As such, we are obligated to consider Alabama's request consistent with the regulatory framework applicable for the 2024 benefit year.

Our review and approval of the risk adjustment State transfer reduction requests submitted by Alabama for the 2024 benefit year are guided by the framework and criteria established in regulation under § 153.320(d) applicable to prior participants. Consistent with § 153.320(d)(1)(iv), prior participants are required to demonstrate their requests satisfy the *de minimis* impact standard. Under this standard, the requesting State is required to show that the requested transfer reduction would not cause premiums in the relevant market risk pool to increase by more than 1 percent. For the 2024 benefit year, § 153.320(d)(4) provides that we will approve State reduction requests if we determine, based on a review of the State's submission, along with other relevant factors, including the premium impact of the reduction, and relevant

[81] Blue Cross and Blue Shield of Alabama Comment Letter. (2023, January 27). CMS. *https://www.regulations.gov/comment/CMS-2022-0192-0100.*

[82] See 87 FR 27208 at 27236 through 27239.

[83] As explained in the 2023 Payment Notice, we finalized amendments to § 153.320(d), including the creation of the prior participant exception following our further consideration of the State flexibility framework under E.O, 14009. See 87 FR 27240. We also announced our intention to repeal the prior participant exception in future rulemaking beginning with the 2025 benefit year to provide impacted parties additional time to prepare for this change and potential elimination of this flexibility. Ibid.

[84] The State's request must also include supporting evidence and analysis demonstrating the State-specific factors that warrant any adjustment to more precisely account for the differences in actuarial risk in the applicable market risk pool, as well as identify the requested adjustment percentage of up to 50 percent for the applicable market risk pools. See 45 CFR 153.320(d)(1)(i) and (ii). In addition, the State must submit the request by August 1 of the benefit year that is 2 calendar years prior to the applicable benefit year, in the form and manner specified by HHS. See 45 CFR 153.320(d)(2).

public comments, that the requested reduction would have a *de minimis* impact on the necessary premium increase to cover the transfers for issuers that would receive reduced transfer payments.[85]

The evidence provided by Alabama in support of its requests to reduce risk adjustment State transfers by 50 percent in its individual and small group markets was sufficient to justify its request under the *de minimis* requirement for HHS approval under § 153.320(d)(4)(i)(B). We further note that Alabama requested that, consistent with § 153.320(d)(3), HHS not publish certain information in support of its request because it contained trade secrets or confidential commercial or financial information. 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 the HHS Freedom of Information Act (FOIA) 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.[86] Consistent with the State's request, we posted a redacted version of the supporting evidence for Alabama's request. However, when evaluating the State's reduction requests, we reviewed the State's un-redacted supporting analysis, along with other data available to HHS and the relevant public comments submitted within the applicable comment period for the proposed rule. We conducted a comprehensive analysis of the available information and found the supporting evidence submitted by Alabama to be sufficient to support its 2024 benefit year requests.

We recognize there is some level of uncertainty regarding future market dynamics, including their potential impact on future benefit year transfers. However, to align with the annual pricing cycle for health insurance coverage, the applicable risk adjustment parameters (including approval or denial of State flexibility reduction requests for the 2024 benefit year from prior participants) must generally be finalized sufficiently in advance of the applicable benefit year to allow issuers to consider such information when setting rates.[87] As such, there will always be an opportunity for some uncertainty regarding the precise impact of future methodological changes (such as the risk adjustment model changes applicable beginning with the 2023 benefit year) or unforeseen events (such as unwinding and its impact on enrollment and utilization).

With respect to Alabama's 2024 benefit year requests, our review of the evidence submitted by Alabama in support of its transfer reduction requests was sufficient, along with other information available to HHS and timely submitted comments, to confirm the requests meet the criteria for approval set forth in § 153.320(d)(4)(i)(B).

For the individual market, the State provided information in support of its 50 percent reduction request, including its analysis that the reduction requested would have a *de minimis* impact on necessary premium increases. In alignment with our approach in previous years' consideration of the reduction requests, we analyzed the information provided by the State in support of its request, along with additional data and information available to HHS, separately by market and found that the request meets the *de minimis* regulatory standard in the individual market.

More specifically, we began our review of the State's individual market request with consideration of available 2021 EDGE data[88] and the State's submitted analysis. Using the most recent 2021 plan-level data available to us,[89] we estimated transfer calculations as a percent of premiums, which indicated that the risk adjustment payment recipient would not have to increase premiums by 1 percent or more to cover a 50 percent reduction in individual market transfers. Therefore, our analysis of the 2021 EDGE data supports the State's submitted analysis that the 50 percent reduction in individual market transfers for the 2024 benefit year would meet the *de minimis* regulatory standard.

We also considered detailed comments that provided evidence of changing price and market share positions, using 2021 and 2022 data, that raised questions about the impact a 50 percent reduction in individual market transfers would have on premiums. One commenter (an issuer in Alabama's individual market) stated that the 50 percent reduction in individual market transfers approved by HHS for the 2022 benefit year caused them to increase premiums by more than 2 percent.[90] The commenter believed the 25 percent reduction in individual market transfers for the 2023 benefit year would also violate the *de minimis* standard but did not provide data to this effect. However, as discussed in the prior paragraph, our analysis of the 2021 EDGE data did not provide any evidence to support these commenters' claims.

Therefore, to further consider these comments, including the prior year premium analysis from an issuer in Alabama, we analyzed open enrollment plan selection and premium data for the individual market in Alabama for the 2023 benefit year. However, due to issuers entering and exiting the Alabama individual market between the 2022 and 2023 benefit years, we found the open enrollment data were not comparable between benefit years, and we were unable to reasonably determine the effects of the transfer reductions for the 2022 benefit year on the 2023 benefit year individual market dynamics. Therefore, similar to our analysis of the 2021 EDGE data, our analysis of the 2023 benefit year open enrollment data did not align with the commenter's analysis or otherwise confirm premiums would increase by more than one (1) percent and led us to have some concerns about the commenters' estimates using a previous year's analysis that did not take into consideration new data or recent

[85] HHS is also required to publish State reduction requests and to make the State's supporting evidence available to the public for the comment, with certain exceptions. See 45 CFR 153.320(d)(3). HHS must also publish any approved or denied State reduction requests. Ibid.

[86] See § 153.320(d)(3).

[87] See 45 CFR 153.320(d)(2) and (3). Also see the 2019 Payment Notice (83 FR 16955 through 16960), which explained the timing for this process was intended to permit plans to incorporate approved adjustments in their rates for the applicable benefit year.

[88] Similar to our approach in considering Alabama's reduction requests in previous years, we considered the most recent EDGE data available (for example, for the 2023 benefit year, we considered 2020 EDGE data as part of the analysis). This included consideration of available EDGE premium and risk adjustment transfer data.

[89] Issuer specific BY 2021 risk adjustment transfers can be found in *Summary Report on Permanent Risk Adjustment Transfers for the 2021 Benefit Year.* (2022, July 19). CMS. *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2021.pdf.* For BY 2021, the issuer specific EDGE premium and enrollment data used for this analysis have not been made public. However, plan-level QHP rates are available in the *Health Insurance Public Use Files.* (2021). CMS. *https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.*

[90] Commenter's analysis available at BCBSAL Comment Letter on 2024 NBPP AL RA Transfer Flexibility Request. (2023, January 27). CMS. *https://www.regulations.gov/comment/CMS-2022-0192-0100.* Issuer specific BY 2021 EDGE data and BY 2023 open enrollment data are not publicly available. However, plan-level QHP rates are available in the *Health Insurance Exchange Public Use Files* (2021, 2022, 2023). CMS. *https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.*

changes in market participation in Alabama's individual market.

For the small group market, the State provided information in support of its 50 percent reduction request, including its analysis that the reduction requested would have a *de minimis* impact on necessary premium increases. HHS also analyzed enrollment and plan-level data for Alabama's small group market for 2023 in reviewing Alabama's transfer reduction request for its small group market. Due to a lack of robust enrollment data for the small group market,[91] we considered the most recent available EDGE premium and enrollment plan-level data available for the small group market to further analyze the request, as in past years. Similar to the individual market analysis, our analysis of the 2021 EDGE data supports the State's submitted analysis that the 50 percent reduction in small group market transfers for the 2024 benefit year would meet the *de minimis* regulatory standard. Using the most recent 2021 plan-level data available to us,[92] we estimated transfer calculations as a percent of premiums, which indicated that the risk adjustment payment recipient would not have to increase premiums by 1 percent or more to cover a 50 percent reduction in small group market transfers.

Therefore, as the review of information has determined that Alabama's 2024 benefit year reduction requests for its individual and small group markets would not exceed the *de minimis* threshold, we will approve the amount of the reductions requested pursuant to § 153.320(d)(4)(i)(B). The data and analysis available to us do not support a reduction smaller than what was requested by the State.

In addition, the suggestion that the presence of one large issuer would not preclude the HHS-operated risk adjustment program from functioning as intended in the State's markets is not pertinent to HHS's determination on the reduction requests, as the sole criteria we have to evaluate the 2024 benefit year requests is the *de minimis* standard in § 153.320(d)(4)(i)(B).

Following our consideration of the State's submission and public comments, we are approving Alabama's requests to reduce risk adjustment State transfers by 50 percent in its individual and small group markets for the 2024 benefit year. With the repeal of the prior participant exception in § 153.320(d), the 2024 benefit year is the last year Alabama will be able to request reductions to HHS calculated transfers under the State payment transfer formula.

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

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78238), we proposed, beginning with the 2023 benefit year, to collect and extract from issuers' EDGE servers through 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, and to include this indicator in the enrollee-level EDGE Limited Data Set (LDS) made available to qualified researchers upon request once available. We also proposed to extract plan ID and rating area data elements issuers have submitted to their EDGE servers from certain benefit years prior to 2021. We sought comment on these proposals. After reviewing public comments, we are finalizing both proposals as proposed.

Section 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 [93] in States where HHS operates the program on behalf of a State.[94] 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 through a distributed data collection model that prevented the transfer of individuals' personally identifiable information (PII). Then, in several subsequent rulemakings,[95] 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,[96] as well as informing policy and improving the integrity of other HHS Federal health-related programs.[97] 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 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.[98] [99]

a. Collection and Extraction of the QSEHRA Indicator

We are finalizing, as proposed, that beginning with the 2023 benefit year, issuers will be required to collect and submit a QSEHRA indicator as part of the required risk adjustment data that issuers make accessible to HHS from

[91] HHS does not have the same open enrollment plan selection and premium data on the small group market in Alabama as it does for the individual market in Alabama; therefore, EDGE premium and enrollment plan-level data were used for the small group market assessment.

[92] Issuer specific BY 2021 risk adjustment transfers can be found in *Summary Report on Permanent Risk Adjustment Transfers for the 2021 Benefit Year.* (2022, July 19). CMS. *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2021.pdf.* For BY 2021, the issuer specific EDGE premium and enrollment data used for this analysis have not been made public. However, plan-level QHP rates are available in the *Health Insurance Public Use Files.* (2021). CMS. *https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.*

[93] Also see §§ 153.700 through 153.740.

[94] 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/Paperwork ReductionActof1995/PRA-Listing-Items/CMS-10401.*

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

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

[97] 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 to the extent such use of the data is otherwise authorized by, required under, or not inconsistent with applicable Federal law. See 87 FR 27243; 87 FR 630 through 631. Examples of other HHS Federal health-related programs include 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. Ibid.

[98] 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.*

[99] 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.

their respective EDGE servers in States where HHS operates the risk adjustment program. This new data element will 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.[100] We are also finalizing, as proposed, 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).

Beginning with the 2023 benefit year, we will 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. HHS will also provide additional details on what constitutes a good faith effort to ensure collection and submission of the QSEHRA indicator in the future. HHS will 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.[101]

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. 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.

In the 2023 Payment Notice (87 FR 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 will 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 will capture both on and off Exchange enrollees.

The same is also true for QSEHRA information and we therefore proposed to apply the same approach for the QSEHRA indicator. Currently, the FFEs and SBE–FPs collect information about QSEHRAs from all applicants to determine whether they are eligible for an SEP, as individuals and their dependents who become newly eligible for a QSEHRA may be eligible for an 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 proposed 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 will be used to capture whether a particular enrollee's health care coverage involves (or does not involve) a QSEHRA, and we proposed to structure this data element for EDGE data submissions similar to current collections, where possible.

We also proposed, 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 proposed 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.

In conjunction with the proposal to collect and extract this new data element, we also proposed 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 further noted 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 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.[102] [103] In addition, consistent with how we created the LDS in prior years, we would continue to exclude data from the LDS that could lead to identification of certain enrollees.[104]

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

[101] 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.

[102] See CMS. (2020, June). Data Use Agreement. (Form CMS–R–0235L). *https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS-R-0235L.pdf.* See also 84 FR 17486 through 17490.

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

[104] 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.*

We summarize and respond to public comments received on the proposals related to the collection and extraction of a QSEHRA indicator below.

Comment: Several commenters supported the collection and extraction of a QSEHRA indicator, including the proposed transition for implementation. One commenter, while supporting the proposal, did not believe a QSEHRA indicator should factor into risk adjustment analyses or calculations, stating that issuers currently have limited information about HRA enrollment, and therefore should not be penalized for not submitting HRA data.

Many commenters opposed the proposal to collect and extract a QSEHRA indicator, citing significant operational concerns with collecting and reporting a QSEHRA indicator, including that the data are not currently or routinely collected, are difficult to obtain, are inconsistent, unreliable, and complex, and therefore, would provide little insight in policy analysis using these data, and would impose a significant burden on issuers to determine how to collect and report this data and then implement the required changes.

Response: We are finalizing, as proposed, the collection and extraction of a QSEHRA indicator, including the proposed transition for implementation. While we understand the concerns raised over the use of QSEHRA in risk adjustment, particularly that there is currently limited information about the population enrolled in QSEHRA and their associated risk, we continue to believe that it is important to collect this information to allow us to understand the associated risk profile of this population and inform our analysis about whether any refinements to the HHS risk adjustment methodology should be examined or proposed through notice- and- comment rulemaking. Consistent with the established policies governing the permitted uses of the enrollee-level EDGE data, the additional information collected through the QSEHRA indicator will also be used to inform policy analysis and potential updates to the AV Calculator, other HHS individual or small group (including merged) market programs, the PHS Act requirements enforced by HHS that are applicable market-wide, or other HHS Federal health-related programs.

To further explain, similar to the collection and reporting of an ICHRA indicator finalized in the 2023 Payment Notice, collection of a QSEHRA indicator will allow HHS to examine whether there are any unique actuarial characteristics of the QSEHRA population (such as the health status of participants), and provide a more thorough picture of the actuarial characteristics of the HRA population and how or whether HRA participation is impacting individual and small group (including merged) market risk pools. A QSEHRA indicator will also allow HHS to analyze whether the risk profile of participants in QSEHRAs differs from participants in ICHRAs as ICHRAs differ with respect to standards related to employer eligibility, employee eligibility, restrictions on allowance amounts, and eligibility for PTCs (among others). While data that may be used to populate a QSEHRA indicator may be limited or incomplete at this time, we continue to believe that collecting this information is valuable, will better inform potential refinements to the HHS-operated risk adjustment program in future years, and will improve our understanding of these markets. As occurs with any new data collection requirement, HHS expects that over time, collection and submission of a QSEHRA indicator will improve as issuers gain experience with and develop processes for collecting and reporting the indicator. In addition, we will not use the QSEHRA indicator or any analysis that relied upon the indicator to pursue changes to our policies until we conduct data quality checks and ensure the response rate is adequate to support any analytical conclusions. Therefore, we continue to believe that the benefits of finalizing the proposal related to the collection and extraction of a QSEHRA indicator outweigh potential concerns about reliability and consistency of data reporting.

Further, we proposed and are finalizing the adoption of a transitional approach for collecting the QSEHRA indicator under which issuers will be required to populate this new QSEHRA indicator using data they already have or collect for the 2023 and 2024 benefit years. This approach recognizes issuers may need time to develop processes for collection and validation of this new data element. Then, beginning with the 2025 benefit year, issuers will be required to populate the field using available sources and, in the absence of an existing source to populate the QSEHRA indicator for particular enrollees, issuers will be required to make a good faith effort to ensure collection of this data element. HHS will provide additional details on what constitutes a good faith effort to ensure collection and submission of the QSEHRA indicator in the future. Any issuers meeting this standard and making a good faith effort to ensure collection and submission of the QSEHRA indicator beginning with the 2025 benefit year data will not be penalized for being unable to submit this information for a particular individual. Similarly, HHS does not intend to penalize issuers who are unable to populate the QSEHRA indicator with existing data sources during the transitional approach for 2023 and 2024 benefit year data submissions.

We acknowledge concerns that the new data collection could impose additional administrative burden and may require operational changes to develop, test, and validate submission of these data elements. As further detailed in the section IV.C of this rule, we have estimated the burden and costs associated with this new data collection. Currently, all issuers that submit data to their EDGE servers have automated the creation of data files that are submitted to their EDGE servers for the existing required data elements, and each issuer will need to update their file creation process to include the new data element, which will require a one-time administrative cost. In addition to adding this one-time cost, we also estimate that collection and submission of the new data element will require an additional one hour of work by a management analyst on an annual basis. This estimate recognizes that information to populate the QSEHRA indicator data field is not routinely collected by all issuers at this time.

Because we are adopting a transitional approach, under which issuers will be required to populate the QSEHRA indicator data fields using data they already have or collect for the 2023 and 2024 benefit years, issuers are not required to make any changes to the manner in which they currently collect the QSEHRA data element for the 2023 and 2024 benefit year submissions. This transition period allows additional time for issuers to develop processes for collection and validation of the data required for the new data fields. We are further mitigating the burdens associated with the collection and submission of this new data element by structuring it similar to current collections, where possible. Similar to the ICHRA indicator, the QSEHRA indicator will capture whether a particular enrollee's health care coverage involves (or does not involve) a QSEHRA. HHS will provide additional operational and technical guidance on how issuers should submit this new data element to their respective EDGE servers via the applicable benefit year's EDGE Server Business Rules and the

EDGE Server Interface Control Document, as may be necessary. After consideration of comments, we continue to believe that the benefits of collecting and extracting this data element outweigh the burdens and costs associated with the new requirement.

Comment: Many commenters requested that HHS obtain QSEHRA information from other sources, such as plan administrators and/or employers.

Response: While we understand commenters' requests that we obtain QSEHRA information from other sources, such as plan administrators or employers, we decline to adopt this recommendation. We are finalizing the proposal to collect this new data element through issuers' EDGE server data to ensure that the QSEHRA data can be extracted and aggregated with other claims and enrollment information data made accessible to HHS by issuers of risk adjustment covered plans through their respective EDGE servers. This collection and extraction with claim data would not be possible if the QSEHRA data were collected from other sources, such as from plan administrators or employers.[105] As outlined in the proposed rule, similar to the ICHRA indicator, we considered that the FFEs and SBE–FPs collect information about QSEHRA from all applicants to determine whether they are eligible for an SEP, as individuals and their dependents who become newly eligible for a QSEHRA may be eligible for an SEP. We further recognize that SBEs also collect similar information from their applicants to determine SEP eligibility. However, because the enrollee-level EDGE data uses a masked enrollee ID, HHS similarly would not be able to match the QSEHRA data collected by Exchanges for SEP purposes and the enrollee-level EDGE data set. Relying on QSEHRA information provided by Exchanges also would not provide a complete picture of this HRA population as it would not include QSHERA enrollment associated with health insurance coverage purchased outside of Exchanges.

In addition, we understand 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 health insurance coverage. We proposed and are finalizing the policy 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. Some other sources that an issuer could use include information provided directly to issuers by consumers who seek to enroll in coverage directly with the issuer, as well as information provided to the issuer by employers or plan administrators. To limit the burden associated with populating this indicator, we will structure this data element for EDGE data submissions similar to current collections, where possible, and generally intend to use the same structure for the ICHRA and QSEHRA indicators. That is, similar to the ICHRA indicator, the QSEHRA indicator will capture whether a particular enrollee's health insurance coverage involves (or does not involve) a QSEHRA. HHS will provide additional operational and technical guidance on how issuers should submit this new data element to their respective EDGE servers, as may be necessary.

Comment: Many commenters indicated that low uptake of QSEHRAs make the data unnecessary to collect due to the limited impact these HRAs could have on risk adjustment, and that collecting and reporting of a QSEHRA indicator was generally inappropriate or unnecessary for risk adjustment purposes. Many commenters requested additional information on HHS' rationale for collecting QSEHRA data, and additional guidance on the collection and extraction of a QSEHRA indicator.

Response: We disagree with the comments that suggested it is inappropriate to consider the impact of the HRA population on the HHS-operated risk adjustment program, and those that similarly suggested low enrollment in QSEHRAs makes this proposal unnecessary. The purpose of collecting and extracting the QSEHRA indicator is to allow HHS to conduct analyses to examine whether there are any unique actuarial characteristics of this enrollee population and to investigate what impact (if any) QSEHRA participation is having on State individual and small group (including merged) market risk pools to inform risk adjustment policy development. As discussed above, the QSEHRA indicator will be used to capture whether a particular enrollee's health care coverage involves (or does not involve) a QSEHRA and will provide a more thorough picture of the actuarial characteristics of the HRA population and how or whether HRA participation is impacting individual and small group (including merged) market risk pools; and allow HHS to investigate whether the risk profile of enrollees with QSEHRAs differ from enrollees with ICHRAs. Currently, we do not have data on enrollment by individuals with QSEHRAs to analyze the risk associated with these enrollees and the impact this population may have on the individual and small group (including merged) market or the HHS-operated risk adjustment program. The rules regarding ICHRAs and QSEHRAs both became effective in 2020; thus, there is limited amount of data regarding the ICHRA and QSEHRA populations in general. Further, a recent report by HRA Council 2022 [106] highlighted that the number of both ICHRAs and QSEHRAs has increased substantially from 2020 to 2022. Therefore, including this data as part of the required EDGE data submissions will provide HHS with a more accurate and complete view and distribution of risk in the individual and small group (including merged) markets. The additional information collected through the QSEHRA 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, such as examination of the risk profile of partial year enrollees with ICHRAs or QSEHRA given the potential for those populations to enroll through an SEP. Similarly, this information will also help inform policy analysis and potential updates to the AV Calculator, other HHS individual or small group (including merged) market programs, the PHS Act requirements enforced by HHS that are applicable market-wide or other HHS Federal health-related programs.

We also acknowledge commenters' request for additional information on submission of the QSEHRA indicator, and similar to the ICHRA indicator, we will 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.

b. Extracting Plan ID and Rating Area

In addition to collecting and extracting a QSEHRA indicator, we proposed to extract the plan ID [107] and

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

[106] For details of this report, see *https://hracouncil.wildapricot.org/resources/Documents/2022_HRAC_Data_FullReport_Final.pdf.*

[107] 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*

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, we determined that to aid in annual model recalibration, as well as in our 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, the PHS Act requirements enforced by HHS that are applicable market-wide, 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,[108] we did not believe that this proposal would increase burden on issuers. We also did not propose any changes to the accompanying policies finalized in the 2023 Payment Notice with respect to these data elements and the enrollee-level EDGE Limited Data set (LDS). Although we recognized 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 summarize and respond to public comments received on the proposed extraction of plan ID and rating area data elements for certain benefit years prior to 2021 below.

Comment: Many commenters supported the extraction of plan ID and rating area data elements for earlier benefit years of EDGE data and their use in risk adjustment. However, many commenters opposed the proposal to extract the plan ID and rating area data elements from issuers' EDGE servers for certain benefit years prior to 2021, citing concerns regarding privacy and security of patients' personally identifiable information (PII) and protected health information (PHI). One commenter requested that CMS reconsider their extraction altogether, as well as the extraction of zip code and subscriber ID data as finalized in the 2023 Payment Notice.

Response: We are finalizing, as proposed, the extraction of plan ID and rating area data elements for certain benefit years of EDGE data prior to 2021 as we believe that the collection of these additional data will allow HHS to better assess actuarial risk in the individual and small group (including merged) market risk pools, examine historical trends, and consider changes to improve the HHS-operated risk adjustment program. Consistent with previously finalized policies regarding the permitted uses of the enrollee-level EDGE data, HHS may also use these additional data to inform analysis and policy development for the AV Calculator and other HHS individual and small group (including merged) market programs, the PHS Act requirements enforced by HHS that are applicable market-wide, as well as other HHS Federal health-related programs.[109]

We acknowledge the concerns raised regarding the need to protect the privacy and security of patients' PII and PHI, however, we generally disagree that the extraction of plan ID and rating area data elements for these additional benefit years would increase risk of disclosure of enrollee PII, nor do they fall under the category of PHI according to the HIPAA Privacy Rule.[110] As noted in the 2023 Payment Notice (87 FR 27245), while we do not believe this data collection causes risk to the privacy or security of patients' PII, 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, we continue to believe it is appropriate to exclude these data elements (plan ID and rating area) from the LDSs. As such, HHS will not include these data elements in the LDS files made available to qualified researchers upon request.

HHS remains committed to protecting the privacy and security of enrollees' sensitive data as initially outlined in the 2014 Payment Notice (77 FR 15434, 15471, 15498, 15500; § 153.720) regarding the risk adjustment data collection approach, which encompasses PII. As noted above, in the 2014 Payment Notice (78 FR 15497 through 15500; § 153.720), we established an approach for obtaining the necessary data for risk adjustment calculations in States where HHS operates the program through a distributed data collection model that prevented the transfer of individuals' sensitive data. We did not propose and are not finalizing any changes to the distributed data collection approach applicable to the HHS-operated risk adjustment program. As explained in the proposed 2014 Payment Notice (77 FR 73118), using a distributed data collection model[111] means HHS does not directly receive data from issuers,[112] which limits transmission of sensitive data.[113] This general framework remains unchanged. Issuers of risk adjustment covered plans will continue to provide HHS access to the applicable required risk adjustment data elements through the distributed data environment (that is, the issuer's secure EDGE server) in the HHS-specified electronic formats by the applicable deadline.[114] Issuers will continue to retain control over their data assets subject to the requirements of the HHS-operated risk adjustment program. HHS will also continue to require issuers to use a unique masked enrollee

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.

[108] 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.

[109] See, for example, the 2018 Payment Notice, 81 FR 94101; the 2020 Payment Notice, 84 FR 17488; and the 2023 Payment Notice, 87 FR 27241–27252.

[110] 45 CFR 164.512(a).

[111] Under this model, each issuer submits to its EDGE server the required data in HHS-specified formats and must make these data accessible to HHS for use in the HHS-operated risk adjustment program. See 78 FR 15497.

[112] 77 FR 73162, 73182 through 73183. This policy was finalized in the 2014 Payment Notice final rule. See 78 FR 15497 through 15500.

[113] See 78 FR 15500. We explained that data are particularly vulnerable during transmission, and that the distributed data collection model eliminates this risk.

[114] See 45 CFR 153.610(a). See also 45 CFR 153.700 through 153.740.

identification number for each enrollee that cannot include PII and PHI,[115] along with maintaining the other existing data safeguards to protect enrollee PII and PHI.[116] [117] [118] [119] The policies finalized in this rule regarding the extraction of plan ID and rating area for certain benefit years prior to 2021 do not alter the distributed data collection approach or otherwise change any of the existing protections for enrollee PII and PHI under the HHS-operated risk adjustment program.

We also did not propose and are not finalizing any changes to the final policies adopted in the 2023 Payment Notice related to the collection and extraction of zip code and subscriber indicator.[120] The collection and extraction of these two data elements will begin with the 2023 benefit year. In addition, in the 2023 Payment Notice (87 FR 27249), we finalized the proposal to extract the plan ID and rating area data elements beginning with the 2021 benefit year. Since finalizing that proposal, we 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. For example, we found HHS collection and extraction of plan ID allows HHS to conduct deeper analyses when confronted with minor data anomalies to see if these trends are in fact reflective of the market or if targeted outreach to specific issuers is necessary to address data errors or potential misinterpretation of the EDGE server business rules and other applicable data requirements to improve the EDGE data quality for future benefit years. After considering comments, we are finalizing the proposals related to the collection and extraction of plan ID and rating area for the additional prior benefit years beginning with the 2017 benefit year enrollee-level EDGE data.

As previously explained, the collection and extraction of these data elements for the additional prior benefit years will help HHS further assess risk patterns and the impact of risk adjustment policies by providing valuable insight into historical trends. For example, rating area data for these additional benefit years will provide HHS with more granular data to examine and assess risk patterns and impacts based on geographic differences over time. These data will therefore be useful to examine whether changes should be proposed to the HHS risk adjustment methodology through notice-and-comment rulemaking, as well as to assist with analysis and policy development for the AV Calculator and other HHS individual and small group (including merged market) programs, the PHS Act requirements enforced by HHS that are applicable market-wide, and other HHS Federal health-related programs.

Comment: Some commenters opposed to the extraction of plan ID and rating area data elements questioned the appropriateness of using these data elements for purposes beyond the HHS-operated risk adjustment program and the AV Calculator.

Response: We acknowledge commenters concerns regarding use of the plan ID and rating area data elements use for purposes beyond the HHS-operated risk adjustment program and the AV Calculator. However, we disagree that the use of these data elements should be limited to only the HHS-operated risk adjustment program and the AV Calculator.

In several prior rulemakings,[121] we finalized policies for the extraction and use of enrollee-level EDGE data beginning with the 2016 benefit year. HHS began the collection and extraction of enrollee-level EDGE data to provide HHS with more granular data to use for recalibrating the HHS risk adjustment models and to use actual data from issuers' individual and small group (and merged) market populations, as opposed to the MarketScan® commercial database that approximates these populations, for model recalibration purposes.[122] We also previously finalized the use of the extracted masked enrollee-level EDGE data to inform updates to the AV Calculator and methodology,[123] conduct policy analysis and calibrate HHS programs in the individual and small group (including merged) markets and the PHS Act requirements enforced by HHS that are applicable market-wide,[124] [125] as well as informing policy and improving the integrity of other HHS Federal health-related programs.[126] The finalized policies related to the use of enrollee-level data extracted from issuers' EDGE servers and summary level reports produced from remote command and ad hoc queries enhance our ability to develop and set policy and limit the need to pursue alternative burdensome data collections from issuers. The use of plan ID and rating area from the 2017, 2018, 2019, and 2020 benefit year data sets beyond the risk adjustment program and AV Calculator is consistent with these previously finalized policies, including the use of these two data elements beginning with the 2021 benefit year data set for other HHS individual and small group (including merged) market programs, the PHS Act requirements enforced by HHS that are applicable market-wide, as well as other HHS Federal health-related programs.

Consistent with the use of these data elements to help further assess risk patterns for use in analysis and development of risk adjustment and AV Calculator policies, plan ID and rating area will also support HHS analysis and policy development for other HHS individual and small group (including merged) market programs, the PHS Act requirements enforced by HHS that are applicable market-wide, as well as other

[115] See 45 CFR 153.720. See also 78 FR 15509 and 81 FR 94101.

[116] As we explained in the 2018 Payment Notice, use of masked enrollee-level data safeguards enrollee privacy and security because masked enrollee-level data does not include PII. See 78 FR 15500.

[117] In addition to use of masked enrollee IDs and masked claims IDs, another protection for enrollee PII is the exclusion of enrollee date of birth from the data issuers must make accessible to HHS on their EDGE servers.

[118] The LDS policies are additional examples of protections for enrollee PII. Under these policies, HHS makes available only an LDS of certain masked enrollee-level EDGE data elements and 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 disclosure of the information and prohibits the recipient from identifying the information. See, for example, 84 FR 17486 through 17490 and 87 FR 27243 through 27252. Also see Data Use Agreement. CMS. *https://www.cms.gov/research-statistics-data-and-systems/files-for-order/data-disclosures-data-agreements/overview.* Further details on limited data set files available at *Limited Data Set (LDS) Files.* CMS. *https://www.cms.gov/research-statistics-data-and-systems/files-for-order/data-disclosures-data-agreements/dua_-_newlds.*

[119] The final policies to exclude plan ID, rating area and ZIP code from the LDS is also part of our commitment to protect enrollee PII to mitigate the risk that entities that receive the LDS could identify individual members, particularly in areas with a small number of issuers. See, for example, 87 FR 27243 through 27252.

[120] See 87 FR 27241 through 27252.

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

[122] 81 FR 94101.

[123] Ibid.

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

[125] See 81 FR 94101 and 84 FR 17488.

[126] As detailed in the 2023 Payment Notice, HHS can use the extracted EDGE data and reports 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 to the extent such use of the data is otherwise authorized by, required under, or not inconsistent with applicable Federal law. See 87 FR 27243; 87 FR 630 through 631. Examples of other HHS Federal health-related programs include 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. Ibid.

HHS Federal health-related programs. In particular, extra benefit years of these data will be beneficial for testing policy options over multiple years of data. For example, we want to assess whether the scope of EHBs are equal to benefits provided under a typical employer plan under section 1302(b)(2)(A) of the ACA at the State level, and that analysis would benefit greatly from being tested on additional benefit years of data. As such, while we acknowledge the comments expressing concern over the use of this data for purposes beyond HHS risk adjustment and the AV Calculator, we decline to limit the use of these data to only those two areas. The utility of the plan ID and rating area data elements, along with zip code and subscriber indicator, in annual model recalibration and policy analysis to support HHS individual and small group (including merged) market programs, the PHS Act requirements enforced by HHS that are applicable market-wide, and other Federal-health related programs outweighs any gains from not finalizing the extraction of plan ID and rating area from certain prior benefit years as proposed or repealing the EDGE data extraction and permitted use policies finalized in the 2023 Payment Notice.

Comment: One commenter specifically requested that HHS consider releasing the plan ID and rating area data elements as part of the EDGE LDS by aggregating the information at the county level to assuage privacy and security concerns.

Response: While we recognize including the plan ID and rating area data elements may enhance the usefulness of the LDS for researchers, 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. While aggregating data at the county level, as suggested, could mitigate this concern in many cases, it would not completely eliminate the possibility that counties with small numbers of issuers could be identified by these data elements. We also did not propose to release these data as part of the LDS at the county level and decline to adopt the suggestion as part of this final rule.

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

HHS proposed a risk adjustment user fee for the 2024 benefit year of $0.21 PMPM. We sought comment on this proposal. After review of the comments received, we are finalizing the proposed risk adjustment user fee for the 2024 benefit year as proposed.

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 final 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.[127] 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.[128] 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 proposed 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 estimated 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 projected 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, due to the increased PTC subsidies provided for in the American Rescue Plan Act of 2021 (ARP).[129] [130] In light of the passage 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 projected increased 2021 enrollment levels to remain steady through the 2025 benefit year.[131] Because this provision of the IRA is expected to promote continued higher enrollment, we proposed a slightly lower risk adjustment user fee of $0.21 PMPM.

We summarize and respond to public comments received on the proposed 2024 benefit year risk adjustment user fee rate below.

Comment: We received a few comments in support of the 2024 benefit year risk adjustment user fee rate.

Response: We appreciate the support and are finalizing, as proposed, a risk adjustment user fee rate for the 2024 benefit year of $0.21 PMPM.

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

HHS will conduct HHS–RADV under §§ 153.350 and 153.630 in any State

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

[128] Ibid.

[129] ARP. Public Law 117–2 (2021).

[130] 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.*

[131] Inflation Reduction Act. Public Law 117–169 (2022).

where HHS is operating risk adjustment on a State's behalf.[132] The purpose of HHS–RADV is to ensure issuers are providing accurate high-quality information to HHS, which is crucial for the proper functioning of the HHS-operated risk adjustment program. HHS–RADV also ensures that risk adjustment transfers reflect verifiable actuarial risk differences among issuers, rather than risk score calculations that are based on poor quality data, thereby helping to ensure that the HHS-operated risk adjustment program assesses charges to issuers with plans with 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 (IVA) entity. The issuer provides demographic, enrollment, and medical record documentation for a sample of enrollees selected by HHS to its IVA entity for data validation. Each issuer's IVA is followed by an SVA, which is conducted by an entity HHS retains to verify the accuracy of the findings of the IVA. Based on the findings from the IVA, or SVA (as applicable), HHS conducts error estimation to calculate an HHS–RADV error rate. The HHS–RADV error rate is then applied to adjust the plan liability risk scores 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.[133]

a. Materiality Threshold for Risk Adjustment Data Validation

Beginning with 2022 benefit year HHS–RADV, we proposed 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.[134] We are finalizing the change to the HHS–RADV materiality threshold definition as proposed.

Consistent with the application of the current materiality threshold definition and accompanying exemption under § 153.630(g)(2), we proposed that 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. We did not propose any changes to the regulatory text at § 153.630(g)(2) or to the other accompanying policies. We solicited comments on this proposal as well as sought 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 definition should begin to apply.

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.[135] 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.[136] Issuers below the materiality threshold are subject to an IVA approximately every 3 years, barring any risk-based triggers that warrant more frequent audits.

Under the new materiality threshold definition, beginning with the 2022 benefit year of HHS–RADV, issuers that fall below 30,000 BMM Statewide will be exempt from participating in the annual HHS–RADV IVA and SVA audit 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 will warrant more frequent audits). To determine whether an issuer falls under the materiality threshold, its BMM will 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.[137] 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 (for example, if 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 will be subject to the default data validation charge in accordance with § 153.630(b)(10) and may be subject to other enforcement action. Lastly, an issuer that qualifies for an exemption under § 153.630(g)(2) from HHS–RADV requirements for a particular benefit year will 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 identified as outliers in that benefit year of HHS–RADV.

We summarize and respond to public comments received on the proposed change to the HHS–RADV materiality threshold definition from $15 million in total annual premiums Statewide to 30,000 total BMM Statewide beginning

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

[133] HHS transitioned from a prospective application of HHS–RADV error rates for non-exiting issuers to apply HHS–RADV error rates to the risk scores and risk adjustment State transfers of the benefit year being audited for all issuers beginning with the 2020 benefit year of HHS–RADV. See 85 FR 77002–77005.

[134] Activities related to the 2022 benefit year of HHS–RADV generally began in March 2023, when issuers could start selecting their IVA entity, and IVA entities could 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* and the 2022 Benefit Year HHS–RADV Timeline (March 1, 2023), available at *https://regtap.cms.gov/uploads/library/HRADV_2022_timeline_5CR_022323.pdf.*

[135] 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 § 153.630(g)(1). Issuers with 500 or fewer BMM Statewide are not subject to random or targeted sampling.

[136] 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).

[137] See § 153.620(b) and (c).

with the 2022 benefit year of HHS–RADV below.

Comment: Most commenters supported the proposal to change the HHS–RADV materiality threshold definition from $15 million in total annual premiums Statewide to 30,000 total BMM, 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. One commenter agreed that the proposed change to the materiality threshold definition will continue to ease the administrative burden associated with HHS–RADV audits.

Many of these commenters asserted that a BMM-based threshold would be more consistent over time and across geographies as the threshold would not be impacted by premium increases or variation in health care costs. Another commenter stated that the proposed BMM-based threshold would eliminate the need for the materiality threshold to be updated over time. One commenter agreed that shifting the materiality threshold to a BMM basis would align with the 500 BMM threshold used to exempt very small issuers from HHS–RADV. This commenter also noted that the alternative proposal to increase the threshold from $15 million in total annual premiums Statewide to $17 million in total annual premiums indicates that a non-indexed dollar threshold could increase the number of issuers subject to annual HHS–RADV audits over time.

However, one commenter opposed changing the materiality threshold to 30,000 BMM and stated that allowing some issuers to be exempt for annual HHS–RADV audit requirements reduces accountability and transparency. One commenter encouraged HHS to consider changing the materiality threshold for HHS–RADV to a percentage of Statewide member months to reduce the burden of HHS–RADV on issuers that do not materially impact a State's risk adjustment transfers. Another commenter asked that HHS investigate how to balance the frequency of issuers randomly sampled each year within a parent company and stated that historical random samples have not produced a balanced volume of issuers year to year.

Response: After considering comments, we are finalizing this policy as proposed to change the HHS–RADV materiality threshold definition from $15 million in total annual premiums Statewide to 30,000 total BMM Statewide beginning with the 2022 benefit year of HHS–RADV. Consistent with the original adoption of the materiality threshold for HHS–RADV, we believe that this policy and updated definition will continue to ease the administrative burden of annual HHS–RADV requirements for smaller issuers of risk adjustment covered plans that do not materially impact risk adjustment transfers. We also continue to believe that this exemption will have a minimal impact on HHS–RADV as issuers of risk adjustment covered plans below the 30,000 BMM threshold are estimated to represent less than 1.5 percent of enrollment in risk adjustment covered plans nationally. We believe that continuing to use a threshold representing risk adjustment covered plans that cover less than 1.5 percent of membership nationally promotes the goals of HHS–RADV while also considering the burden of such a process on smaller issuers.

As explained in the proposed rule (87 FR 78242 through 78243), since we established the materiality threshold definition of $15 million in total premiums, 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. Therefore, we believe that it is necessary and appropriate to update the materiality threshold definition to better align with current costs to complete an IVA. We estimated the current cost of the IVA to be approximately $170,000 per an issuer. To continue the overall design of the materiality threshold policy and effectively limit the proportion of an issuer's premiums that will be used to cover IVA costs to one (1) percent, we would need to increase the materiality threshold to $17 million in total annual premiums Statewide. While we considered using another dollar value to update the materiality threshold definition, we believe that using BMMs instead of a dollar threshold ensures that the materiality threshold definition under § 153.630(g)(2) will continue to exempt small issuers that face a disproportionally higher burden for conducting HHS–RADV audit, even in situations where PMPM premiums grow overtime. We therefore proposed and are finalizing a materiality threshold of 30,000 BMM Statewide, which translates to approximately $17 million in total annual premiums Statewide on average across markets.

Shifting the materiality threshold under § 153.630(g)(2) to a BMM basis will 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. As part of this change, we considered whether the new BMM-based threshold would significantly impact other issuers of risk adjustment covered plans. We analyzed historical data on issuers of risk adjustment covered plans and found that the pool of issuers falling below a 30,000 BMM Statewide threshold does not significantly differ from the current pool of issuers falling below a $15 million total annual premiums Statewide threshold.[138] Therefore, we do not anticipate that the new materiality threshold definition will change the current estimated burdens of the annual HHS–RADV requirements or significantly impact other issuers of risk adjustment covered plans. While we would expect the number of issuers falling under a premium-dollar-based materiality threshold to decrease overtime as PMPM premiums grow, we expect the BMM-based threshold to produce a consistent pool of issuers subject to random and targeted sampling over time and across State market risk pools.

We did not consider using a percentage of Statewide member months as the metric for the materiality threshold as that metric does not have a relationship with the costs to conduct HHS–RADV. As such, after considering comments, we are finalizing the new materiality threshold definition of 30,000 BMM as proposed, beginning with the 2022 benefit year of HHS–RADV. As noted above, the materiality threshold was initially set after considering the fixed costs associated with hiring an IVA entity and submitting results to HHS, which may represent a large portion of some issuers' administrative costs. We estimated that 30,000 BMM Statewide translates to approximately $17 million in total annual premiums Statewide on average across markets, and therefore anticipate that issuers above this threshold will not spend more than one (1) percent of their premiums on covering the estimated $170,000 cost of the initial validation audit.

Finally, we do not believe that it is necessary to investigate the balance of the frequency of issuers randomly sampled each year within a parent company. The purpose of conducting random audits is for these audits to be random and not controlled to limit the frequency that specific issuers, including issuers within a particular parent company, are selected. We also note that in addition to conducting

[138] See 87 FR 78242 through 78243.

random audits of issuers of risk adjustment covered plans that fall below the materiality threshold definition, issuers that fall below the materiality threshold definition can be selected to participate in HHS–RADV due to the targeted sampling based on the identification of risk-based triggers that warrant more frequent audits.[139]

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

Beginning with 2021 benefit year HHS–RADV, we proposed to remove the policy to only apply an exiting issuer's HHS–RADV results if that issuer is a positive error rate outlier.[140] We proposed 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. We solicited comments on this proposal. After reviewing the public comments, we are finalizing the removal of this policy as proposed.

We did not propose any other changes to the policies regarding HHS–RADV adjustments for issuers that exit the market, and therefore, will otherwise maintain the existing framework for determining whether an issuer is an exiting issuer. As such, the issuer will 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 will not be considered an exiting issuer. 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) will be considered an exiting issuer and will be exempt from HHS–RADV under § 153.630(g)(4). Individual market issuers offering or selling any new individual market coverage in the State in the subsequent benefit year will be required to participate in HHS–RADV, unless another exemption applies.

We summarize and respond to public comments received on the proposal to remove the policy to only apply an exiting issuer's HHS–RADV results if that issuer is a positive error rate outlier beginning with the 2021 benefit year below.

Comment: All commenters who commented on this policy change supported the proposal to remove the policy that prevented the application of an exiting issuer's HHS–RADV results when the issuer is a negative error rate outlier. A few commenters agreed that it is no longer necessary to treat exiting issuers differently from non-exiting issuers when an issuer is a negative error rate outlier given the transition to the concurrent application of HHS–RADV results to the risk scores and risk adjustment transfers of the benefit year being audited for all issuers.

Response: We agree with commenters that the policy that limited the application of exiting issuers' HHS–RADV results to situations where the issuer was identified as a positive error rate outlier in the applicable benefit year of HHS–RADV is no longer needed. We are finalizing the removal of this policy and will begin adjusting the plan liability risk scores for all positive and negative error rate outlier issuers (inclusive of exiting and non-exiting issuers) beginning with the 2021 benefit year of HHS–RADV.

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

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78224), we sought comment on discontinuing the use of the Lifelong Permanent Conditions (LLPC) list[141] and the use of non-EDGE claims starting with the 2022 benefit year of HHS–RADV. We solicited comment on all aspects of these potential changes, including the applicability date. We also requested comment on the extent that issuers and their IVA entities have relied on these policies and on how these potential changes may impact issuers. After reviewing the public comments, we will discontinue the use of the LLPC list and the policy that permitted the use of non-EDGE claims beginning with the 2022 benefit year of HHS–RADV. We will update the HHS–RADV Protocols to capture these changes for the 2022 benefit year and beyond.

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.[142] 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 diagnosis 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.[143] 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 a 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 solicited comments on the discontinuance of the use of the LLPC list beginning with the 2022 benefit year of HHS–RADV.

Similarly, we sought 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

[139] See § 153.630(g)(2).

[140] 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.

[141] 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.*

[142] 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 117.

[143] 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.*

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.[144] Under the non-EDGE claims policy, 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.[145] 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 solicited comments on discontinuing the use of non-EDGE claims in HHS–RADV beginning with the 2022 benefit year.

We summarize and respond to public comments received on discontinuing the use of the LLPC list and the use of non-EDGE claims in HHS–RADV below.

Comment: Several commenters supported discontinuing the use of the LLPC list and a few commenters supported discontinuing the use of non-EDGE claims. Many of these commenters raised data integrity concerns created by the allowance of the use of the LLPC and non-EDGE claims in HHS–RADV. Some commenters asserted there is a current misalignment between EDGE Server Business Rules and HHS–RADV that creates opportunities for issuers to submit data to the EDGE server without following the EDGE Server Business Rules and then receive credit for this data in HHS–RADV. Several commenters supported consistency between the EDGE Server Business Rules and what is allowable in HHS–RADV by discontinuing the use of the LLPC list and non-EDGE claims in HHS–RADV. One of these commenters asserted that the LLPC list creates an asymmetry between the rules auditors use for HCC validation and the rules issuers use for submitting HCCs to EDGE by granting auditors a more permissive set of rules for HCC validation, which thereby allows an issuer's risk score to reflect the strength of their compliance department. Another of these commenters asserted that ending the policy that permitted the use of non-EDGE claims in HHS–RADV will provide consistency between the data submission and its validation.

One commenter stated that discontinuing the LLPC list will level the playing field for all issuers. Two commenters expressed concerns about the use of dated information to justify diagnoses and upcoding in the current benefit year. One of these commenters expressed concern that the LLPC list was created as an administrative convenience despite there being a wide range of treatments and outcomes within the same diagnosis on the LLPC list. Another commenter raised concerns about individuals with diagnoses on the LLPC list enrolling in a new plan during periods when these diagnoses do not require treatment and the issuers of the new plans covering these individuals receiving credit for those LLPC HCCs in HHS–RADV. This commenter also suggested that, under a concurrent risk adjustment model, issuers should get credit for diagnoses that are treated during the benefit year being risk adjusted and should not be allowed to rely on historic data or documentation from before the applicable coverage period.

Response: HHS agrees with commenters that supported the discontinuation of the LLPC list and non-EDGE claims in HHS–RADV as we seek to better align HHS–RADV policies with the EDGE Server Business Rules. We also believe that issuers have gained years of experience with EDGE data submissions and HHS–RADV activities, such that it is now appropriate to discontinue use of the LLPC list and non-EDGE claims in HHS–RADV. The LLPC list was not created to supplement or replace the EDGE Server Business Rules that issuers must follow to submit diagnoses conditions to EDGE with the necessary medical record documentation. Instead, HHS created the LLPC list in the early years of HHS–RADV to ease the burden of medical record retrieval for lifelong conditions in HHS–RADV by simplifying and standardizing coding abstraction for IVA and SVA entities. The conditions included in the LLPC list are those that require ongoing medical attention and are typically unresolved once diagnosed. While a range of treatments and outcomes may exist within the same diagnosis on the LLPC list, the HHS–HCC diagnostic classification is a key component of the HHS risk adjustment models. The basis of the HHS risk adjustment model uses health plan enrollee diagnoses to predict medical expenditure risk. To do this, tens of thousands of diagnostic codes are grouped into a smaller number of organized condition categories that aggregate into HCCs to produce a diagnostic profile of each enrollee.[146] The HCCs in the HHS risk adjustment models were selected to reflect salient medical conditions and cost patterns for adult, child, and infant subpopulations. The models produce coefficients for each HCC that incorporate the range of treatments and outcomes for those diagnoses as they represent the marginal predicted plan liability expenditures of an enrollee with that HCC given that enrollee's other risk markers. The HHS risk adjustment models also include interacted HCC counts factors beginning with the 2023 benefit year that will further capture the range of plan liability that may exist within the same diagnoses. For these reasons, we believe that continuing the policy to permit use of the LLPC list is no longer necessary and its removal will better align HHS–RADV guidance with the EDGE Server Business Rules, as well as ensure that audit entities follow the same standard coding principles and guidelines for HHS–RADV that issuers must follow when submitting data to EDGE. As detailed in the HHS–RADV Protocols, issuers and entities should refer to the conventions in the ICD–10–CM and ICD10–PCS classification, ICD–10–CM Official Coding Guidelines for Coding and Reporting, and the American Hospital Association (AHA) Coding Clinic Standard for coding guidance, including the coding of chronic conditions.[147]

[144] 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.*

[145] Under the current policy, 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 claims 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.

[146] See The HHS–HCC Risk Adjustment Model for Individual and Small Group Markets under the Affordable Care Act, Medicare & Medicaid Research Review, Volume 4, Number 3 (2014) available at *https://www.cms.gov/mmrr/Downloads/MMRR2014_004_03_a03.pdf.* Also see, for example, Chapter 2: HHS–HCC Diagnostic Classification of the March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting Discussion Paper (March 24, 2016) available at *https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/downloads/ra-march-31-white-paper-032416.pdf.*

[147] See, for example, Section 9.2.6 Phase 5—Health Status Validation of the 2021 Benefit Year PPACA HHS Risk Adjustment Data Validation (HHS–RADV) Protocols (November 9, 2022) available at *https://regtap.cms.gov/uploads/library/*

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Although we have no evidence that enrollees with HCCs on the LLPC list are switching plans when their conditions are inactive, HHS agrees that the LLPC list may create the opportunity, in certain circumstances, for issuers to receive credit for HCCs when the enrollee did not receive care or require active treatment during the applicable enrollment-period. Thus, as outlined above and in the proposed rule, we believe that the LLPC list is no longer necessary 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.[148] Now that issuers have gained sufficient experience with the HHS–RADV Protocols and have consistently met data integrity criteria for their EDGE data submissions,[149] HHS will discontinue use of the LLPC list and the use of non-EDGE claims beginning with the 2022 benefit year of HHS–RADV. We will update the HHS–RADV Protocols applicable to the 2022 benefit year and beyond to capture these changes.

We also generally disagree with concerns of upcoding in the HHS-operated risk adjustment program. First, the vast majority of enrollees in risk adjustment covered plans do not have HCCs, and therefore, there are limited opportunities for upcoding to exist in the HHS-operated risk adjustment program. As of the 2021 benefit year, over 75 percent of enrollees of risk adjustment covered plans in the individual non-catastrophic risk pool did not have a single HCC.[150] In addition, over time, we have implemented risk adjustment model specifications to mitigate the potential for upcoding, such as the HCC coefficient estimation groups, which reduce risk score additivity within disease groups and limit the sensitivity of the risk adjustment models to upcoding, and the interacted HCC counts model specification, which is restricted to enrollees with at least one severe illness or transplant HCC, and thus, reduces concerns of issuers inflating overall HCC counts.[151] [152] Moreover, the HHS–RADV program serves as an additional safeguard for upcoding by auditing the issuer submitted data, and we have not seen conclusive evidence of upcoding on EDGE. Regardless, we will continue to monitor trends in the HHS-operated risk adjustment program and utilize HHS–RADV to validate the accuracy of data submitted by issuers for use in calculations under the State payment transfer formula in the HHS risk adjustment methodology.

Comment: A few commenters supported discontinuing the use of the LLPC list and the use of non-EDGE claims due to concerns related to the use of the supplemental file. One of these commenters asserted that a small number of issuers use the supplemental file for a disproportionate share of their plan liability risk scores and recommended prohibiting use of the LLPC list and non-EDGE claim documentation to validate supplemental diagnoses. This commenter urged HHS to limit the use of the supplemental file to a percent of plan liability risk score and asked HHS to reevaluate HCCs that are more prevalent in the supplemental file or are associated with lower-cost individuals when added through the supplemental file. This commenter also asked HHS to clarify that discontinuing the use of the LLPC list and non-EDGE claims would end the use of documentation for prior-year or non-EDGE encounters to support supplemental HCCs on EDGE. Another commenter supported the use of the supplemental file and asserted that the purpose of the supplemental diagnosis files is to facilitate accurate and complete coding.

Response: We agree with comments that support the use of supplemental file and generally clarify that issuers have never been allowed to use the LLPC list to support supplemental diagnosis codes in supplemental file submissions. The supplemental file allows issuers to submit supplemental diagnosis codes for the limited circumstances in which relevant diagnoses may be missed or omitted on a claim or during an encounter submission, or in which diagnoses requires deletion for a claim accepted to the issuer's EDGE server. Issuers are required to follow the EDGE Server Business Rules when submitting diagnoses through the supplemental file. Supplemental diagnosis codes must be supported by medical record documentation and comply with standard coding principles and guidelines, be linked to a previously submitted and accepted EDGE server medical claim, and be the result of medical service(s) that occurred during the data collection period for a given benefit year.[153] [154]

With these limitations in place, we do not believe that it is necessary or appropriate to limit supplemental file submissions to a percentage of plan liability risk score. Moreover, in

HRADV_2021_Benefit_Year_Protocols_5CR_110922.pdf.

[148] See § 153.20. Risk adjustment covered plan means, for the purpose of the risk adjustment program, any health insurance coverage offered in the individual or small group market with the exception of grandfathered health plans, group health insurance coverage described in § 146.145(b) of this subchapter, individual health insurance coverage described in § 148.220 of this subchapter, and any plan determined not to be a risk adjustment covered plan in the applicable federally certified risk adjustment methodology.

[149] As noted in the proposed rule (87 FR 78245), all States received an interim risk adjustment summary report from the 2017 benefit year through 2021 benefit year of the HHS-operated risk adjustment program. Since issuance of the proposed rule, we released the 2022 benefit year interim risk adjustment results. As noted in the 2022 benefit year interim risk adjustment report, five States were ineligible for inclusion on the basis of one or more credible issuers in those markets failing to meet the applicable thresholds for data quantity and/or quality evaluations by the applicable deadline. See the Interim Summary Report on Permanent Risk Adjustment for the 2022 Benefit Year (March 17, 2023), available at *https://www.cms.gov/cciio/programs-and-initiatives/premium-stabilization-programs/downloads/interim-ra-report-by2022.pdf.* However, across eligible States, we calculated a data completion rate of 91.7 percent in the 2022 benefit year interim risk adjustment report, which is an increase from the data completion rate of 90.8 percent in the 2021 benefit year interim risk adjustment report. Ibid. We therefore continue to believe issuers have had sufficient time to gain experience with EDGE data submissions, and HHS–RADV activities, such that it is appropriate to reconsider and move forward with discontinuing the LLPC list and non-EDGE claims policies beginning with the 2022 benefit year of HHS–RADV, as proposed.

[150] See Table 4: Percent of Enrollees with HCCs, 2017–21 of the Summary Report on Permanent Risk Adjustment Transfers for the 2021 Benefit Year (July 19, 2022) available at *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2021.pdf.*

[151] For example, diabetes diagnosis codes are organized in a Diabetes hierarchy, consisting of three CCs arranged in descending order of clinical severity and cost, from CC 19 Diabetes with Acute Complications to CC 20 Diabetes with Chronic Complications to CC 21 Diabetes without Complication. A person may have diagnosis codes in multiple CCs within the Diabetes hierarchy, but once hierarchies are imposed, that enrollee would only be assigned the single highest HCC in the hierarchy. To limit diagnostic upcoding by severity in the Diabetes hierarchy, we have constrained the three HCCs to have the same coefficient in risk adjustment. As such, issuers cannot get more credit towards their risk score by upcoding within the Diabetes hierarchy.

[152] As discussed in the 2021 RA White Paper, one of our considerations for proposing the interacted HCC count model specifications was our belief that by limiting the interacted HCC counts factors to certain severe illness and transplant HCCs, we would restrict the scope for coding proliferation and effectively mitigate the potential for gaming. Page 59–60 *https://www.cms.gov/files/document/2021-ra-technical-paper.pdf.*

[153] To see the complete list of processing rules for the supplemental file, see Section 8.4 General Supplemental Diagnosis Code File Processing Rules of the EDGE Server Business Rules (ESBR) Version 22.0 (November 2022) available at *https://regtap.cms.gov/reg_librarye.php?i=3765.*

[154] While supplemental file diagnosis codes may be linked to accepted EDGE server medical claims that are not risk adjustment eligible, only supplemental file diagnosis codes that are linked to risk adjustment-eligible claims accepted by the EDGE server will be used in risk adjustment and HHS–RADV.

response to comments, we analyzed enrollee condition categories by diagnosis source in the 2018, 2019 and 2020 HHS–RADV data, and we do not have concerns of HCCs that are more prevalent in the supplemental file or are associated with lower-cost individuals when added through the supplemental file. Our analysis found that issuers mostly use the supplemental file as a way to provide more evidence of a condition. We also did not propose and are not finalizing any changes to the framework applicable to the use or submission of supplemental files to issuers' EDGE servers.

Furthermore, supplemental file diagnoses cannot be linked to non-EDGE claims as these claims are not on EDGE. The discontinuation of the non-EDGE claims policy means issuers will no longer be able to submit claims that are not accepted onto EDGE to validate diagnoses for their IVA (or SVA, as applicable), and the discontinuation of the LLPC list means issuers will no longer be able to submit prior-year documentation for their IVA (or SVA, as applicable). Both of these changes will apply beginning with the 2022 benefit year of HHS–RADV. In addition, consistent with existing requirements, the medical record documentation submitted by the issuer for their IVA (or SVA, as applicable) must meet standard coding principles and guidelines for abstraction of the diagnosis, to support EDGE claims or supplemental diagnosis codes.[155]

Comment: Several commenters opposed discontinuing the use of the LLPC list and non-EDGE claims due to concerns that this would hinder issuers' ability to accurately capture health care costs and be appropriately compensated for enrollee risk. One commenter stated that the discontinuance of the LLPC list and non-EDGE claims will limit their ability to identify and coordinate the most appropriate care for enrollees with LLPC diagnoses. This commenter also noted that the use of non-EDGE claims improves the capture of diagnoses on the LLPC list and suggested that the removal of these policies contradicts the purpose of the ACA to ensure coverage of pre-exiting conditions. A few commenters stated that the LLPC list helps capture diagnoses that might otherwise only be reflected in pharmacy costs. One commenter stated that plans are already losing out on capturing many chronic conditions because the HHS-operated risk adjustment program does not allow a plan to code conditions based on medication. Another commenter suggested that conditions with high pharmacy costs that are not recognized by the RXC model, such as hemophilia, will only be captured by the specialist responsible for the condition and not by other provider types like primary care physicians. This commenter recommended studying which high-cost conditions on the LLPC list are not represented by the RXC model, but have high costs associated with them regardless of whether a diagnosis is billed directly during the course of a benefit year.

Response: We agree there are some benefits associated with the LLPC list and non-EDGE claims policy, that were developed in the early years of HHS–RADV. The 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 as issuers were gaining experience with the HHS–RADV Protocols and addressing any lingering challenges submitting claims to their EDGE servers. It did not, however, supersede or replace the rules for submitting the diagnosis codes to EDGE servers that are used to determine enrollee risk. To capture enrollee risk, issuers must submit enrollee claims data and diagnosis codes to EDGE servers following the EDGE Server Business Rules and standard coding principles and guidelines.[156]

Similarly, the use of non-EDGE claims in HHS–RADV allowed issuers to submit medical records associated with non-EDGE claims to their IVA entity for HCC validation purposes in certain situations. This protocol was also designed to ease the burden as issuers were gaining experience with the HHS–RADV Protocols and addressing any lingering challenges submitting claims to their EDGE servers. As noted in the proposed rule, issuers consistently meet data integrity criteria for their EDGE data submissions.[157] Therefore, HHS does not believe that the discontinuance of the use of the LLPC list or non-EDGE claims in HHS–RADV will impact issuers' ability to accurately capture health care costs and enrollee risk. Further, HHS believes issuers have now gained sufficient experience with the HHS–RADV Protocols such that it is also no longer necessary to continue these policies beginning with the 2022 benefit year of HHS–RADV.

Discontinuing the use of the LLPC list and non-EDGE claims should also not impact providers' or issuers' ability to coordinate the most appropriate care for enrollees with LLPC diagnoses. If anything, enrollees with better-coordinated care should be more likely to have their diagnoses documented on a risk adjustment-eligible claim during the benefit year, which should then be captured in the issuer's EDGE data submission. Further, HHS does not believe the removal of the LLPC list will contradict the purpose of the ACA to ensure coverage of pre-existing conditions. Issuers should continue to follow standard coding principles and guidelines, which include guidelines regarding the treatment of chronic conditions, to capture diagnoses among enrollees with pre-existing conditions. We believe that updating the HHS–RADV Protocols to discontinue the use of the LLPC list and non-EDGE claims beginning with the 2022 benefit year of HHS–RADV aligns with the goals of the HHS-operated risk adjustment program and HHS–RADV, as issuers will have a stronger incentive to encourage enrollees to access care within the benefit year so the risk can be captured on a risk adjustment-eligible claim. These updates to the HHS–RADV Protocols will also address concerns raised by some interested parties that issuers could passively receive credit for an HCC when the enrollee did not receive care or require active treatment during the applicable benefit year.

We also do not agree that discontinuing the use of the LLPC list will prevent the capture of diagnoses that are being actively managed and are associated with pharmacy costs. If a patient with hemophilia or other chronic conditions is receiving care or active treatment, whether from a specialist or primary care provider, the diagnosis should be documented on a claim submitted to the issuer's EDGE server. Additionally, we anticipate the issuer would also be encouraging the patient with such chronic conditions to access care during the benefit year as part of its general wellness, prevention, or other health promotion activities.

We further note that our purpose for adding RXCs to the risk adjustment models was to impute missing diagnoses and to indicate severity of illness.[158] These prescription drug-based classes for the HHS risk adjustment adult models were developed using empirical evidence on frequencies and predictive power; clinical judgment on relatedness, specificity, and severity of RXCs; and

[155] 45 CFR 153.630(b)(7). See, for example, Section 9.2.6 Phase 5—Health Status Validation of 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.*

[156] Ibid.

[157] 87 FR 78245. Also see supra note 14947.

[158] 81 FR 94074 through 94084

professional judgment on incentives and likely provider responses to the classification system.[159] We carefully considered the selection of high-cost drugs for inclusion to avoid overly reducing the incentives for issuers to strive for efficiency in prescription drug utilization and the selection of drugs in areas exhibiting a rapid rate of technological change, as a drug class that is associated with a specific, costly diagnosis in one year may no longer be commonly used for that condition the next. As a result, there is a limited number of prescription drug classes included in the HHS risk adjustment adult models, and the RXCs included are select drug classes (and in some cases, specific drugs) that are closely associated with particular diagnoses. The same medication may be prescribed for multiple conditions, and therefore, a condition cannot be substantiated based solely on medication. To receive credit for an HCC in HHS–RADV, the condition needs to be linked to a risk adjustment eligible claim that has been accepted by the EDGE server with appropriate medical record documentation supporting diagnosis or treatment regardless of whether that HCC is also represented by an RXC in the HHS risk adjustment adult models. We continuously monitor, assess and update the drugs for mapping to RXCs in the adult risk adjustment models, and we may further investigate drugs associated with high-cost chronic conditions that are not currently represented by the RXC model in the future.

Comment: Several commenters opposed discontinuing the use of the LLPC list and non-EDGE claims policy due to concerns of provider coding practices. Some of these commenters stated that LLPC diagnoses are taken into consideration by providers during medical decision making, and are sometimes treated, regardless of whether they separately appear on a claim. One commenter shared they have observed an ongoing issue where providers are not consistently capturing the care provided for conditions diagnosed in prior-year claims.

Other commenters noted that many LLPCs are captured in medical history or surgical history notes and may not be included in any notes on current treatment. One commenter asserted that issuers with narrow networks or limited out-of-network benefits have a great ability to influence provider coding practices and ensure all diagnoses are recorded on claims. One commenter urged HHS to consider regulatory differences across States, and noted that issuers in their State are required by State law to cover behavioral treatment for autism from some providers without a referral from a diagnosing provider.

Response: The LLPC list and the non-EDGE claims policies are part of the HHS–RADV Protocols and, as noted above, were adopted in the early years of HHS–RADV to streamline and simplify the process while issuers gained experience with HHS–RADV activities and EDGE data submissions. They do not, however, supplement or replace the data submission requirements or EDGE Server Business Rules that issuers must follow to submit claims to their EDGE servers, including the rules governing the necessary medical record documentation to support each condition, diagnosis or treatment on each claim. Consistent with § 153.710(a) through (c), EDGE Server Business Rules for the HHS-operated risk adjustment program that govern EDGE data submissions direct that EDGE server data submissions are claim-based and follow standard coding principles and guidelines.[160] EDGE Server Business Rules also require that diagnosis codes submitted on risk adjustment-eligible claims to the EDGE server be related to medical services performed during the patient's visit.[161]

It is the issuer's responsibility to submit complete and accurate data for each benefit year to their respective EDGE server by the applicable deadline.[162] Issuers are also responsible for helping their respective IVA entities retrieve provider medical records and documentation sufficient to support the conditions, diagnosis and treatment information submitted to the issuer's EDGE server for the applicable benefit year.[163] Issuers should work with their providers to ensure they are following correct coding guidelines to support acceptance of medical claims and diagnoses submitted to the issuer's EDGE server.[164] We have not seen evidence that issuers with narrow networks or limited out-of-network benefits have a greater ability to influence provider coding practices. Issuers in the individual and small group (including merged) markets are allowed to develop provider networks and out of network benefit designs in accordance with applicable State and Federal requirements. These types of plans and benefit designs are subject to the same rules and requirements of the HHS-operated risk adjustment program as all issuers, including but not limited to the processes to conduct the HHS–RADV audits. We also note that HCCs associated with behavioral diagnoses such as autism are not included on the LLPC list. Additionally, we clarify that HHS–RADV does consider and accommodate differences across States, such as with respect to provider credentialing requirements. For example, medical records submitted for HHS–RADV must be from an acceptable physician/practitioner specialty type licensed to diagnose in that State and must be authenticated by the provider.

We continue to consider ways to improve the HHS–RADV audit process to address State regulatory differences. In the past, we recognized concerns regarding limitations imposed under certain States' medical privacy laws that could limit providers' ability to furnish mental and behavioral health records for HHS–RADV purposes, and in response, we updated § 153.630(b)(6) to permit use of abbreviated mental or behavioral health assessments for HHS–RADV in situations where a provider is subject to State (or Federal) privacy laws that prohibit the provider from providing a complete mental or behavioral health record to HHS.[165] HHS appreciates regulatory differences across States being brought to our attention and will continue to consider these differences, such as those associated with behavioral diagnoses, when developing policies.

Issuers should also develop and communicate with providers the applicable policies and procedures that providers will need to follow to support the issuer's business needs, including the issuer's submission of data to their EDGE server and subsequent validation

[159] See, for example, 81 FR 94075 through 94076.

[160] See, for example, Table 49: 'Standard Code Sets and Sources' of the EDGE Server Business Rules (ESBR) Version 22.0 (November 2022) available at *https://regtap.cms.gov/uploads/library/DDC-ESBR-110122-5CR-110122.pdf,* which lists the standard code sets and sources the EDGE server uses to verify submitted codes during data submission.

[161] 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.*

[162] See 45 CFR 153.610, 153.700, and 153.730.

[163] See 45 CFR 153.630(b)(6). Also see 45 CFR 153.620(a) and (b).

[164] See, for example, Table 49: 'Standard Code Sets and Sources' of the EDGE Server Business Rules (ESBR) Version 22.0 (November 2022) available at *https://regtap.cms.gov/uploads/library/DDC-ESBR-110122-5CR-110122.pdf,* which lists the standard code sets and sources the EDGE server uses to verify submitted codes during data submission.

[165] See the 2019 Payment Notice, 83 FR 16967 through 16969. Also see Section 9.2.6.7—Acceptable Medical Record Source of 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.*

of such data in HHS–RADV. If an issuer is aware of incorrect or incomplete coding practices by a provider, the issuer should work to resolve the incorrect or incomplete coding practices with the provider and should not rely on the use of the LLPC list or non-EDGE claims to address provider coding concerns.

We are discontinuing the use of the LLPC list and the non-EDGE claims beginning with the 2022 benefit year. As such, beginning with the 2022 benefit year of HHS–RADV, issuers will no longer be able to submit non-EDGE claims to their IVA entities to supplement EDGE claims reviewed during HHS–RADV and the LLPC list will also no longer be available for use by the IVA (and SVA) entities in HHS–RADV. We will update the HHS–RADV Protocols applicable to the 2022 benefit year and beyond to capture these changes. In addition, we continue to encourage issuers to examine ways to encourage providers to follow coding guidelines and capture all relevant diagnoses on claims and notes related to current treatments.

Comment: Several commenters expressed concern that discontinuing the LLPC list and non-EDGE claims policy in HHS–RADV would increase issuer dependence on provider's medical document retrieval. Some of these commenters disagreed with HHS that issuers' ability to capture conditions is based on experience with HHS–RADV or EDGE data submissions, and instead asserted that accurately capturing conditions depends on documentation received from providers. One of these commenters shared that they request thousands of records every year that they never receive. A few commenters raised concerns of claims processing time impacting issuers' ability to submit diagnoses and claims information to their EDGE servers, as well as validate the data in HHS–RADV. One of these commenters stated that the inconsistent nature of chart retrieval necessitates the continuation of the non-EDGE claims policy to allow issuers to submit medical records associated with a risk adjustment-eligible claim that missed the deadline for EDGE submission. Another one of these commenters stated that a significant number of HCCs are contained on facility claims for services that are often furnished late in the year, which leaves issuers without enough time to include them in EDGE data submissions. Another one of these commenters noted that claims data on EDGE is often incomplete due to the nature of claims adjudication processes and the use of non-EDGE claims in HHS–RADV remedies this by allowing issuers to capture conditions in HHS–RADV that may have been missed in EDGE data submissions.

Response: After consideration of comments, HHS is discontinuing of the use of the LLPC list and non-EDGE claims in HHS–RADV beginning with 2022 benefit year HHS–RADV and generally encourages issuers to work with providers to improve processes for medical record retrieval. Once the LLPC list and non-EDGE claim policy are discontinued, to receive credit for an HCC in HHS–RADV, the condition will need to be linked to a risk adjustment eligible claim that is accepted by the EDGE server with the appropriate medical record documentation supporting the diagnosis or treatment on the claim. Issuers should develop and communicate with providers the policies and procedures they need to comply with to support the issuer's complete submission of data to their EDGE server and validation of that data in HHS–RADV. If issuers are aware of providers that are unresponsive to documentation requests, the issuer should work with those providers to resolve the concerns. To assist issuers in medical record retrieval, we created an HHS–RADV Provider Medical Record Request Memo on CMS letterhead, available via the HHS–RADV Audit Tool, that issuers can use when engaging with providers to obtain medical record documentation to support HHS–RADV.[166]

Additionally, HHS allows issuers until April 30th of the following applicable benefit year, or until the next applicable business day if April 30th does not fall on a business day, to submit all final claims, supplemental diagnosis codes, and enrollment data for the applicable benefit year of risk adjustment to their respective EDGE servers.[167] The purpose of establishing the EDGE data submission deadline several months after the close of the benefit year is to give issuers time to collect all necessary claims information, including facility claims, as we recognize there are often hospital stays that begin at the end of the year and cross into the next.[168]

In addition, we recognize that issuers may sometimes experience delays in the submission of claims by providers and facilities, as well as reprocess claims submitted to their EDGE servers after the applicable benefit year's data submission deadline. However, issuers are not permitted to submit additional data or correct data already submitted to their EDGE servers after the applicable benefit year's deadline and remain responsible for ensuring the completeness and accuracy of the data submitted to their EDGE servers by the applicable data submission deadline.[169] This deadline is applicable to all issuers of risk adjustment covered plans to create a level playing field and to create a clear deadline for when the previous benefit year needs to be closed out so transfers can be calculated. Given that HHS–RADV is an audit of data issuers submit to EDGE, claims that miss the deadline for EDGE submission should generally not be used to support HCC validation in HHS–RADV. As previously explained, the LLPC list and use of non-EDGE claims policies were adopted in the early years of HHS–RADV to help simplify and streamline the process as issuers gained experience with the HHS–RADV Protocols and addressed any lingering challenges with the EDGE data submission process. HHS believes it is now appropriate to end these policies as there is clear evidence that issuers are now sufficiently familiar with these operations. In fact, HHS rarely observes claims processing times preventing issuers from meeting applicable EDGE data submission deadlines, as all States were included in interim risk adjustment summary reports for the 2017 through 2021 benefit years.[170] This means that, from the 2017 through 2021 benefit years, all issuers of risk adjustment covered plans with 0.5 percent or more of market share submitted at least 90 percent of a full year of medical claims to their EDGE servers by the applicable deadline, as well as met data quality evaluation checks. HHS recognizes there can be challenges in the document retrieval process and continues to welcome feedback from stakeholders on ways HHS can further support issuers with document retrieval for HHS–RADV.

[166] See Section 9.2.6.2—Medical Record and Chart Retrieval of 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.*

[167] See § 153.730.

[168] See, for example, the 2014 Payment Notice, 78 FR 15434 (explaining the EDGE data submission deadline " . . . provides for ample claims runout to ensure that diagnoses for the benefit year are captured, while providing HHS sufficient time to run enrollee risk score, plan average risk, and payments and charges calculations and meet the June 30 deadline described at the redesignated § 153.310(e) . . .")

[169] 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.*

[170] See supra note 14947.

Comment: Several commenters recommended maintaining the LLPC list in HHS–RADV and extending it to also apply to EDGE data submissions. A few commenters raised concerns about conflicting rules between HHS–RADV Protocols and the standard coding principles and guidelines that issuers must follow to submit data to their EDGE servers. One of these commenters noted AHA Coding Clinic guidance disallowing abstraction of chronic conditions from past medical history and supported HHS alignment of the EDGE Server Business Rules and the HHS–RADV Protocols, including with respect to the treatment of chronic conditions found in the past medical history section of the medical record. Another commenter stated the need for greater clarity to ensure consistent coding guidelines across providers, issuers and IVA entities, and asserted that discontinuing the use of LLPC list would exacerbate inconsistent interpretations of standard coding guidelines across issuers and IVA entities. This commenter stated that Coding Clinic Guidance has increased confusion of the standard coding guidelines and urged HHS to intervene with the Coding Clinic process and to not relinquish authority to the Coding Clinic.[171] This commenter also noted that the LLPC list is widely appreciated by IVA entities that lack coding experience and knowledge.

Response: HHS is discontinuing the use of the LLPC list and non-EDGE claims in HHS–RADV beginning with the 2022 benefit year HHS–RADV. This change does not change coding guidance for the HHS-operated risk adjustment program or the EDGE Server Business Rules.[172] Issuers are still required to follow standard coding principles and guidelines when submitting data to EDGE.

As previously explained, HHS created the LLPC list in the early years of HHS–RADV to assist with coding abstraction for IVA and SVA entities as issuers gained experience with HHS–RADV and addressed any lingering EDGE data submission challenges, but the LLPC list was never a supplement to or replacement for the EDGE Server Business Rules. As such, we do not believe it is appropriate to extend the use of the LLPC list to EDGE data submissions. The HHS-operated risk adjustment program relies on EDGE server data to identify risk incurred by the issuer, measured using the issuer's claims from only the current benefit year. Extending the use of the LLPC list to EDGE data submissions could result in an issuer receiving credit for risk that they did not incur in the benefit year, and thereby create an EDGE server data integrity issue. Rather, we believe that issuers have now gained sufficient experience with HHS–RADV and EDGE data submission processes such that it is appropriate at this time, to promote consistency between the EDGE Server Business Rules and the HHS–RADV Protocols, to discontinue the use of the LLPC list beginning in the 2022 benefit year of HHS–RADV. The EDGE Server Business Rules require issuers to comply with standard coding principles and guidelines, which include any guidelines regarding the treatment of chronic conditions found in the past medical history section of the medical record.[173]

We affirm that, with the removal of the LLPC list, IVA entities will no longer be permitted to rely on the treatment of chronic conditions found in the past medical history section of the medical record to validate enrollee health status. This policy change, along with the discontinuation of the non-EDGE claims policy, will apply beginning with the 2022 benefit year of HHS–RADV. Consistent with the IVA requirements in § 153.630(b) and the applicable standards established by HHS, IVA entities will continue to be required to follow the ICD–10–CM and ICD–10 PCS classifications, Official Guidelines for Coding and Reporting and the American Hospital Association (AHA) Coding Clinic, along with professional judgment, to abstract diagnoses during health status validation.[174] Advice published in Coding Clinic does not replace the instruction in the ICD–10–CM and ICD–10–PCS classification or the Official Guidelines for Coding and Reporting. HHS cannot provide specific coding guidance for the purposes of HHS–RADV, and it is not our role to resolve disputes between coding clinic guidance.[175] [176] We believe that it is important for coding clinics to remain independent of HHS' influence to promote consistency and ensure diagnosis validation in accordance with industry standards. Although the SVA entity performs a second validation audit on a subsample of IVA Entity submission data to verify the IVA findings, issuers must ensure that their IVA Entities are reasonably capable of performing an IVA according to the requirements and standards established by HHS, which includes validating the risk score of each enrollee in the sample by validating medical records according to industry standards for coding and reporting.[177]

d. HHS–RADV Discrepancy and Administrative Appeals Process

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78245), we proposed to shorten the window under § 153.630(d)(2) for issuers to confirm the findings of the SVA (if applicable),[178] or file a discrepancy report, to within 15 calendar days of the notification by HHS, beginning with the 2022 benefit year of HHS–RADV. To effectuate this proposed amendment, we proposed the following four revisions to § 153.630(d): (1) remove the reference to the calculation of the risk score error rate as a result of HHS–RADV; (2) revise § 153.630(d)(2) to establish that the attestation and discrepancy reporting window for the SVA findings (if applicable) will 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; (3) redesignate current paragraph (d)(3) as paragraph (d)(4); and (4) add a new § 153.630(d)(3) to

[171] See, for example, ICD–10–CM/PCS Coding Clinic, Second Quarter 2022, Page 30 to 31, Reporting Additional Diagnoses in Outpatient Setting.

[172] When abstracting a diagnosis, HHS–RADV interested parties should reference, in sequential order, the conventions in the ICD–10–CM and ICD10–PCS classification, ICD–10–CM Official Coding Guidelines for Coding and Reporting, the AHA Coding Clinic. See, for example, Section 9.2.6.3—Medical Record Review and Diagnosis Abstraction of 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.*

[173] See, for example, Table 49: 'Standard Code Sets and Sources' of the EDGE Server Business Rules (ESBR) Version 22.0 (November 2022) available at *https://regtap.cms.gov/reg_librarye.php?i=3765,* which lists the standard code sets and sources the EDGE server uses to verify submitted codes during data submission.

[174] See § 153.630(b)(2). Also see, for example, section 9.2.6 Phase 5—Health Status Validation of the HHS of 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.*

[175] On behalf of HHS, the Center for Consumer Information and Insurance Oversight (CCIIO), a component within CMS, performs functions related to the operation of the HHS–RADV program and promulgates standards governing the establishment by issuers of the EDGE server that is used for the HHS risk adjustment data collection process.

[176] See Section 9.2.6.11—Medical Record Abstraction of the HHS of 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.*

[177] See § 153.630(b)(2) and (b)(7)(iv).

[178] 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.

maintain the current attestation and discrepancy reporting window for the calculation of the risk score error rate, which provides 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 proposed 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), to add a reference to paragraph (d)(3). We sought comment on this proposal and the accompanying conforming amendments.

After reviewing the public comments, we are finalizing this provision as proposed. We summarize and respond to public comments received on the proposal and accompanying proposed amendments to shorten the window to 15 calendar days to confirm the SVA findings or file a discrepancy report, under § 153.630(d)(2), beginning with the 2022 benefit year HHS–RADV below.

Comment: Some commenters generally supported shortening the window to confirm the SVA findings 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. Other commenters stated that shortening the window would have a positive impact on reporting HHS–RADV adjustments for medical loss ratio (MLR) by supporting more timely reporting of these amounts. One commenter stated that, based on their experience, 15-calendar days provides sufficient time to respond to the SVA findings notification from HHS.

However, some commenters were opposed to the proposal to shorten the SVA attestation and discrepancy reporting timeframe from 30 to 15 days and instead recommended maintaining the existing 30-calendar day window. These commenters stated that they believed that the proposed 15-day timeline would not provide adequate time for issuers to complete a thorough review of the SVA findings. Another commenter suggested that the timeframes could be shortened elsewhere in the HHS–RADV process to keep the 30-day timeframe for the SVA attestation and discrepancy reporting process. This commenter also noted it would be helpful for issuers to receive their HHS–RADV error rates sooner for use in pricing.

A few commenters asserted that a 15-calendar day window would create internal challenges and operational burden in cases that require data extraction or information from clinical staff. One of these commenters noted that diverting the attention of Medical Directors to reviewing SVA findings would strain care and utilization management services, and thus, negatively impact members.

One commenter stated that shortening the window may cause issuers to appeal matters preemptively that would not have otherwise been appealed. This commenter also disagreed with HHS' rationale that the shortened window is appropriate because the SVA finding attestation and discrepancy reporting process is limited to the small number of issuers that have insufficient pairwise agreement between the IVA and SVA. The commenter indicated when an issuer receives SVA findings, an issuer's IVA results may raise material concerns that could impact other issuers in HHS–RADV, including the reporting of discrepancies due to insufficient pairwise agreement that have the potential of having substantial financial impacts and the issuer's risk score error rate calculation.

Response: After consideration of comments received, we are finalizing the proposal to shorten the SVA attestation and discrepancy reporting window from 30 to 15 calendar days as proposed. We are also finalizing the conforming amendments to §§ 153.630(d), 153.710(h)(1) and 156.1220(a)(4)(ii) to implement this change to the SVA attestation and discrepancy reporting window as proposed. We agree with commenters that this change will help to support timely reporting of the HHS–RADV adjustments to risk adjustment State payment transfers in issuers' MLR reports.

We also believe that shortening the attestation and discrepancy reporting window related to SVA results will improve HHS' ability to finalize SVA findings results prior to release of the applicable benefit year HHS–RADV Results Memo and the Summary Report of Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers for the applicable benefit year and prior to the MLR Reporting deadline. These reports are time-sensitive publications that cannot be developed until all SVA discrepancies are resolved and SVA findings are finalized. Our experience is also similar to the commenter who shared their perspective that a 15-day window is sufficient time to respond to the SVA findings notification from HHS. We further note that a 15-calendar-day SVA 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.

Although we appreciate the concerns expressed by some commenters, especially the potential internal challenges, operational burden, and potential downstream impacts on members, we believe the positive effects to reporting, combined with experience suggesting the 15-day window is feasible, provide sufficient countervailing support to shortening the window. HHS continues to believe that shortening the SVA window will benefit issuers by facilitating the issuance of more timely reports that can be used in pricing, including improving HHS' ability to finalize SVA findings results prior to release of the applicable benefit year HHS–RADV Results Memo and the Summary Report of Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers for the applicable benefit year.

We appreciate the request to shorten other timeframes in the HHS–RADV process to maintain the 30-day window for the SVA attestation and discrepancy reporting window, and while HHS continually considers process improvements to find more efficient ways to conduct HHS–RADV, we do not believe there are other areas we could shorten timelines for the processes at this time. These comments are also outside the scope of this rulemaking as we did not propose shortening any other HHS–RADV timelines in the proposed rule.

Additionally, as previously explained, the shortened window for the SVA attestation and discrepancy reporting window generally impacts a limited number of issuers. That is, our experience indicates that few issuers have insufficient pairwise agreement between the IVA and SVA such that they receive SVA findings; therefore, only few issuers would even have the option to file an SVA discrepancy. Of the issuers that receive SVA findings, our experience is that only a subset will actually file a discrepancy, and therefore, based on this experience, HHS believes only a very small number of issuers will be impacted by this change in future benefit years of HHS–RADV. Because a very small number of issuers will be impacted and the SVA discrepancy window will still be available for those issuers to raise material concerns, including those that could impact other issuers in HHS–RADV, the shortened SVA attestation and discrepancy reporting window mitigates concerns regarding financial

impacts and the issuer's risk score error rate calculation.

We also do not believe that shortening the SVA attestation and discrepancy reporting window may cause issuers to appeal matters preemptively. Issuers are bound by the requirements of § 156.1220, specifically paragraph (a)(4)(ii) which provides that notwithstanding § 156.1220(a)(1), 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), it was so identified and remains unresolved.

Finally, the shortened window also does not change the underlying burden for an issuer to attest or file a discrepancy of its SVA results as those tasks generally remain the same. Instead, this change only relates to the timeframe to complete these activities, but the existing overall burden hours to complete these tasks remains unchanged.[179] We recognize this change may have a short-term impact, such as diverting the attention of Medical Directors to reviewing SVA findings on a shorter timeline, but we expect the same staff and resources would generally be involved. Therefore, we do not expect this change will result in significant long-term downstream impacts to members. For all of the reasons outlined above, we believe the benefits of the shortened attestation and discrepancy reporting window for an issuer to attest to or file a discrepancy for its SVA findings under new § 153.630(d)(2) from 30 to 15 calendar days outweigh the reasons to maintain the 30-day window.

8. EDGE Discrepancy Materiality Threshold (§ 153.710)

We are finalizing, as proposed, the regulatory amendment from the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78247) to 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.[180] We are also finalizing, as proposed, the conforming amendment to § 153.710(h)(1) to add a reference to new § 153.630(d)(3).

As we explained in the proposed rule, the EDGE discrepancy materiality threshold final policy was intended 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. 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 proposed to amend § 153.710(e) to align with this final policy. We also proposed to amend § 153.710(h)(1) to add a reference to new proposed § 153.630(d)(3) to align with the changes discussed in section III.A.7.d. of this preamble (HHS–RADV Discrepancy and Administrative Appeals Process), to shorten the SVA attestation and discrepancy reporting period. We sought comment on the proposed amendments to § 153.710.

After reviewing the public comments, we are finalizing these amendments as proposed. The following is a summary of the comment we received and our response.

Comment: One commenter supported the proposal to update the EDGE discrepancy materiality threshold captured in § 153.710(e) 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. This commenter also asked that HHS consider applying the same threshold to reporting discrepancies because it would allow issuers to discontinue reporting minor discrepancies, which requires significant time and resources.

Response: We are finalizing the amendment to the EDGE discrepancy materiality threshold such 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, as proposed. We did not propose and are not finalizing a threshold for reporting EDGE discrepancies. Issuers must continue to report all discrepancies to HHS for HHS to determine whether they are material and actionable.[181]

We are also finalizing the conforming amendment to add a reference to the new § 153.630(d)(3) to the introductory text in § 153.710(h)(1). For a discussion of the comments related to the shortening of the SVA window to confirm, or file a discrepancy for SVA findings to 15 days, see the preamble discussion in section III.A.7.d. of this rule (HHS–RADV Discrepancy and Administrative Appeals Process).

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

1. Exchange Blueprint Approval Timelines (§ 155.106)

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78247), we proposed 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 Exchange, or from an SBE–FP to a State Exchange. At § 155.106(a)(3) (for FFE or SBE–FP to State Exchange transitions) and (c)(3) (for FFE to SBE–FP transitions), we proposed 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 State Exchange 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 stated in the proposed rule (87 FR 78206, 78247) that we believed the current timeline by which a State must gain Exchange Blueprint approval did not sufficiently support States' need to work with HHS to finalize and submit an approvable Exchange Blueprint.

Section 155.106 currently requires States to have an approved or conditionally approved Exchange Blueprint 14 months prior to an SBE–FP to State Exchange 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 a

[179] For information on the associated burdens, see OMB Control Number 0938–1155 (CMS–10401—''Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment).

[180] See 86 FR 24194 through 24195.

[181] See § 153.710(d)(2). Also see 83 FR 16970 through 16971. See also, for example, CMS. (2022, October 25). *Evaluation of EDGE Data Submissions for the 2022 Benefit Year. https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/edge_2022_qq_guidance.pdf.*

State Exchange, or 3 to 6 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 substantial technical assistance to States as they design, finalize, and implement their Exchange operations. The transition from a FFE to a SBE–FP or State Exchange, or SBE–FP to State Exchange, 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.

Finalizing our proposal to require Exchange Blueprint approval or conditional approval prior to an Exchange's first open enrollment period will allow States the additional time and flexibility if needed, that, in our experience, is necessary to support the development and finalization of an approvable Exchange Blueprint, as well as for completion of the myriad of activities necessary to transition QHP enrollees in the State to a new Exchange model and operator. We are 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 timeline that reflects the realities of the time necessary 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 sought comment on this proposal, including comments related to how transitioning State Exchanges could provide greater transparency to consumers regarding the Exchange Blueprint approval process.

After reviewing the public comments, we are finalizing this provision as proposed. We summarize and respond to public comments received on the proposed Exchange Blueprint approval timelines at § 155.106 below.

Comment: Multiple commenters supported the proposal that States receive approval on their Blueprint applications to operate a State Exchange or SBE–FP prior to their first open enrollment (rather than 14 months or 3 months before, as previously applicable), noting that the additional time for States to obtain approval of its Blueprint application will help States better implement State Exchange or SBE–FP requirements and prepare for State Exchange or SBE–FP operations.

Response: We agree that revising the current timelines by which a State must have an approved or conditionally approved Exchange Blueprint as proposed will permit States additional time to implement State Exchange or SBE–FP requirements.

Comment: One commenter suggested that States transitioning to State Exchanges could aim to provide greater transparency to consumers regarding the Blueprint approval process by adding information to their board meetings and making consumers aware of those meetings.

Response: We acknowledge this suggestion that States transitioning to State Exchanges should aim to provide greater transparency to consumers, however, this is outside the scope of this proposal.

Comment: A few commenters opposed the proposal, stating that without assurance of HHS' approval of the transition per current timelines, impacted interested parties in States transitioning to State Exchanges or SBE–FPs could face associated implementation risks. These commenters noted that issuers, as an example, require adequate time to implement operational changes necessary to accommodate a State transitioning to a State Exchange, such as changes to information technology systems, member communications, and marketing materials, with the goal of minimizing consumer confusion.

Response: We recognize the importance of interested parties, such as issuers and agents and brokers, in a State's transition to either a State Exchange or SBE–FP. The revision to the current timelines in § 155.106(a)(3) and (c)(3) does not circumvent the substantial technical assistance we provide to States as they design, finalize, and implement their Exchange operations. This 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. Moreover, as part of a State's transition, States are required to consult on an ongoing basis with interested parties, under § 155.130, to make them aware of transitioning activities and progress, with the goal of maximizing a seamless consumer experience. As such, we expect a State transitioning to a State Exchange or SBE–FP to coordinate well in advance with interested parties around its progress and the likelihood of implementing the applicable Exchange model operations for its intended first year of open enrollment.

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

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78248), we proposed 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 will eliminate barriers to coverage access by maximizing pathways to enrollment.

Section 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, for, among other things, the establishment and operation of Exchanges. Under 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.[182] 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

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

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 them 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. We have 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 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 just beginning to establish operations. 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.[183]

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,[184] Routine Use No. 1 provides that the FFEs may share consumer information with HHS grantees, including Navigators and other non-Navigator assistance personnel in FFE States, who have been engaged by HHS 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 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, we have enacted a number of measures designed to ensure that Assisters are properly safeguarding the personally identifiable information of all consumers they assist. As part of their annual certification training, we require 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, we believe that our 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 we have 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 assistance 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 proposed to delete § 155.210(d)(8). The repeal of § 155.210(d)(8) will 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 proposed 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 in the proposed rule (87 FR 78249), we are 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 will 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 sought comment on this proposal.

After reviewing the public comments, we are finalizing this provision as proposed. We summarize and respond to public comments received on the proposed repeal of the provisions that prevent Assisters from going on door-to-door or using other unsolicited means of direct contact to provide enrollment assistance to consumers below.

Comment: The vast majority commenters supported this proposal, stating that it will help reduce uninsured rates and health disparities; improve health literacy in rural and underserved communities; and reduce burden on consumers, especially those experiencing social determinants of health that negatively affect health care

[183] 79 FR 30240.

[184] 78 FR 63211, 63215.

access and quality (for example, lack of transportation) or have inflexible job schedules; and immunocompromised individuals. Commenters also frequently noted that Navigators provide a key role in Medicaid and CHIP enrollments and have trusted relationships in the community. Health Centers commented that they appreciated the increased flexibility to go out into the community and reach patients who need the most support. Lastly, commenters stated that the proposal was particularly important to maintaining health insurance enrollments in light of Medicaid unwinding.

Response: We agree that that door-to-door consumer education, outreach, and enrollment can be a useful and effective method for addressing the concerns raised by commenters. We appreciate the overwhelming support for this proposal and agree that it will help Assisters continue to build trusted relationships in the community, which may result in an overall reduction in uninsured rates and reduce health disparities.

Comment: Several commenters recommended reinstating previous requirements to have two Navigator organizations in each State, with one being a local trusted non-profit that maintains a principal place of business within their Exchange service area.

Response: We agree that having two Navigator organizations in each State to provide face-to-face assistance could further help consumer assistance personnel understand and meet the specific needs of the communities they serve, foster trust between consumer assistance personnel and community members, and encourage participation in the Assister programs by individuals whose backgrounds and experiences reflect those of the communities they serve. However, we maintain that the two per State requirement may be too restrictive for Assister organizations already successfully providing remote assistance. In many circumstances, remote assistance may be more effective or practical than face-to-face assistance, particularly when an Assister is providing services to difficult-to-reach individuals or populations. Additionally, during the COVID PHE, usage of alternate methods of interactions with consumers, such as through telecommunication and digital health care tools, became more widespread. We believe that reaching as many consumers as possible is important as we approach Medicaid unwinding and strive to continually increase health insurance program enrollments. We train and entrust Assisters to help in the manner requested by the consumer, when possible.

Comment: Some commenters had mixed reactions to the proposal, supporting the intent but expressing concerns about protecting consumers against fraud. Some commenters specifically recommended that we withdraw or rewrite this section to protect consumers more adequately from fraud, by requiring Assisters going door-to-door to provide identification, records of enrollment transactions, and clear instructions on how to cancel any completed enrollments, as well as additional training to ensure Assisters obtain the consent of the household member in charge of financial matters.

Response: We appreciate the commenters' concerns and agree with them about protecting consumers against fraud. We have taken various measures to protect consumers against fraud. For example, we have recently updated the privacy and security requirements included in all Assister organizations agreements in consultation with the CMS security and privacy subject matter experts. We will continue to work on improving these requirements to ensure we are in alignment with current best practices to safeguard consumer privacy and security information.

We believe that current requirements adequately require Assisters to obtain informed consent from consumers. Assisters who complete an enrollment transaction must obtain a consent form from the consumer before collecting PII to carry out authorized Assister functions. In the *Standard Operating Procedures Manual for Assisters in the Individual Federally-facilitated Marketplaces Consumer Protections: Privacy and Security Guidelines* [185] we also encourage Assisters to ensure consumers take possession of their enrollment documents during in-person appointments (though Assisters can provide postage materials and/or mail a paper application on a consumer's behalf as long as the consumer consents to the Assister's retaining the application for this purpose). Assisters can add a specific consent to the Navigator's or certified application counselor's model authorization form so that consumers can consent to having their application mailed on their behalf.

We also have ways for a consumer to verify the legitimacy of Assisters such as requesting Assisters furnish a certificate of training completion from HHS that contains their name and unique Assister ID number, or simply requesting their name and Assister ID number, which consumers can verify by calling the Marketplace Call Center.

Lastly, we appreciate the constructive feedback on additional measures we may take to protect consumers from fraud and will take these into consideration in future rulemaking, training, and policy guidance.

Comment: Some commenters opposing the proposal expressed concerns about privacy and unwanted solicitations, and suggested that allowing door-to-door enrollments would compromise Assister impartiality and create confusion and misunderstanding among consumers. Commenters also opined that Assisters do not have the ability to project income for consumers with multiple sources of income. Commenters also suggested we have argued in the past that educating the public in conjunction with marketing creates confusion. Lastly, commenters stated that there is a prohibition against door-to-door enrollment by FFE agents and brokers which should be applied equally to Assisters.

Response: We appreciate the commenters' feedback but we have taken great strides to ensure the privacy and security of consumers' information through a variety of mechanisms. This includes requiring Assisters to obtain consumer consent to access their PII to carry out authorized Assister functions via an authorization form which must be maintained by the Assister organization for six years. Assisters also provide the FFE Privacy Policy to consumers they are assisting with enrollment, which explains how their PII will be used and safeguarded. This is also publicly available at *HealthCare.gov/privacy/*. Additionally, Assisters undergo certification training that includes modules on Privacy, Security, and Fraud Prevention Strategies, and Assister organizations must have policies and procedures for the collection, use, protection, and securing of PII. We also note that certification training includes modules that help to build trust from consumers by providing best practices for serving vulnerable and underserved populations, working with consumers with disabilities, providing language access, and doing all these things in a culturally sensitive manner.

We consider Assisters to be able to assist consumers with multiple streams of income. Assisters are required to know and understand the Exchange-related components of the PTC reconciliation process and understand

[185] *https://marketplace.cms.gov/technical-assistance-resources/sop-privacy-security-guidelines.pdf.*

the availability of IRS resources on this process. They also are required to provide referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to the Exchange application and enrollment process and PTC reconciliations.

Lastly, there is no current Federal prohibition on door-to-door enrollments by agents and brokers in the FFEs and this comment is inaccurate based on current regulations for agents and brokers.

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 or 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 the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78249), we proposed 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))

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78249), we proposed 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 the suspension of their Exchange agreement(s) or to request reconsideration of termination of their Exchange agreement(s), respectively. We are finalizing this proposal as proposed, which will 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 (g)(5) to § 155.220 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.[186] 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 Exchanges on the Federal platform, including utilizing the Classic Direct Enrollment (Classic DE) and Enhanced Direct Enrollment (EDE) Pathways, during this 90-day period.[187] [188] As previously explained, immediate suspension is critical in these circumstances to stop additional potentially fraudulent enrollments through the FFEs and SBE–FPs.[189] 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.[190] 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.[191] [192]

We 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.[193] 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 on the Federal platform 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 noncompliance finding(s).[194] [195] More

[186] See 81 FR 12258 through 12264. Also see 80 FR 75525 through 75526.

[187] 45 CFR 155.220(g)(5)(iii).

[188] The agent, broker, or web-broker must continue to protect any personally identifiable information accessed during the term of their Exchange agreement(s). See, for example, 45 CFR 155.220(g)(5)(iii) and 155.260.

[189] See, for example, 81 FR 12258 through 12264.

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

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

[192] 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).

[193] See 45 CFR 155.220(g)(1) through (4). Also see, for example, 78 FR 37047 through 37048 and 78 FR 54076 through 54081.

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

[195] 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

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 Exchanges on the Federal platform, and is not permitted to assist individuals in applying for APTC and CSRs for QHPs.[196] [197] 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 noted in the proposed rule (87 FR 78250) that we believe allowing HHS additional time to complete the review would be beneficial.

We noted in the proposed rule (87 FR 78250) that we were cognizant 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 on the Federal platform, we noted that 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 previously, this additional time is warranted to accommodate particularly complex situations that require significant resources and time. We noted that we expect not all reviews are so complex that they will 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 also noted that we believe 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 [198] to 135 days.[199]

We noted that we believe this is not an unreasonable maximum timeframe, 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 on the Federal platform. 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 on the Federal platform when the misconduct may cause imminent or ongoing harm to consumers or the effective and efficient administration of Exchanges. We also further emphasized that the proposed extension to allow for up to 45 days for HHS to review rebuttal evidence in these situations represents the maximum timeframe.[200] 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,

opportunity to resolve the matter upon providing notice to the agent, broker, or web-broker. Ibid.

[196] 45 CFR 155.220(g)(4).

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

[198] 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, 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 new review period (day 45), as finalized in this rule, and lift the suspension, that would mean the agent's Exchange agreement(s) would have been suspended for only 52 days.

[199] For example, 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 new review period (day 45), as finalized in this rule, and lift the suspension, that agent's Exchange agreement(s) would be suspended for a maximum of 135 days.

[200] 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.

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 § 155.220(g)(1) include, but are not limited to, violations of the Exchange privacy and security standards.[201] 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.[202] As noted in the proposed rule (87 FR 78206, 78251), 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 noted that 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 proposed 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).[203] [204]

For these reasons, we proposed 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 proposed 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 sought comment on this proposal.

After reviewing the public comments, we are finalizing this proposal 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, as proposed. We summarize and respond to public comments received on the proposed extension of time to review suspension rebuttal evidence and termination reconsideration requests (''extended review windows'') below.

Comment: Multiple commenters expressed their support of these extended review windows. These commenters noted they believe the extended review windows are necessary to allow for proper review of complex cases. However, some of these commenters encouraged HHS to attempt to resolve suspension and termination reviews as quickly as possible and to not use the extra review time if it is not needed.

Response: We appreciate these comments and are finalizing the amendments to § 155.220(g)(5)(i)(B) and (h)(3) as proposed. As previously noted, we expect that not all reviews are so complex that they will require the use of this additional time, and that in cases where agents, brokers, and web-brokers present compelling evidence to rebut allegations of noncompliance, we believe that we will be able to resolve the vast majority of those reviews without the use of this additional time. We will continue to strive to resolve all suspension and termination reviews expeditiously and will not utilize the maximum review windows allowed unless necessary.

Comment: One commenter expressed concern that the extended review windows are too lengthy, especially during Open Enrollment.

Response: We disagree that these extended review windows are too lengthy, even during Open Enrollment. While we have acknowledged that this additional time could delay the ability of agents, brokers, and web-brokers to conduct business, particularly during Open Enrollment, we believe extending the review windows will be beneficial when dealing with complex cases that involve review of extensive evidence submitted by the agent or broker, revisiting multiple consumer complaints, and conducting additional outreach. Additionally, as previously stated, we believe that these extended review windows will only impact a very small percentage of agents, brokers, and web-brokers. This is because prior to suspending or terminating an agent or broker's Exchange agreement(s), HHS has already conducted a thorough investigation and concluded that the agent, broker, or web-broker in question is likely involved in fraudulent or noncompliant behavior. Furthermore, these extended review windows represent the maximum suspension or termination period possible. Therefore, we believe this approach strikes the appropriate balance because it maintains the agent's, broker's, or web-broker's ability to submit additional information for reconsideration after a suspension or termination while also protecting consumers from potential harm, including during Open Enrollment, and supporting the efficient and effective administration of the Exchanges on the Federal platform.

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

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78251), we proposed amendments to § 155.220(j)(2)(ii) to require agents, brokers, or web-brokers assisting with and facilitating enrollment in coverage 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

[201] 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.

[202] Ibid.

[203] 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).

[204] 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.

authorized representative designated in compliance with § 155.227, prior to application submission. We proposed 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 proposed 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 agent, broker, or web-broker providing assistance. Lastly, we proposed that 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 conducted consistent with § 155.220(c)(5), (g), (h) and (k). As noted in the proposed rule, these proposed changes would require amending § 155.220(j)(2)(ii), creating new § 155.220(j)(2)(ii)(A), and redesignating current § 155.220(j)(2)(ii)(A) through (D) without change as § 155.220(j)(2)(ii)(B) through (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 Exchanges on the Federal platform and to assist individuals in applying for APTC 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.[205] 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.[206]

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. We noted in the proposed rule (87 FR 78252) that 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 will 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 erroneous information, such as U.S. citizens attesting to not having a Social Security number (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. We noted that 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 will serve as an additional safeguard and procedural step to ensure the accuracy of the application information submitted to Exchanges on the Federal platform. Thus, we proposed 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 proposed to establish in new proposed § 155.220(j)(2)(ii)(A) standards for what constitutes adequate documentation that eligibility

[205] 45 CFR 155.220(c)(1). Also see, for example, 77 FR 18334 through 18336.

[206] 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).

application information has been reviewed and confirmed to be accurate by the consumer or their authorized representative. First, we proposed 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 did 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 proposed 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 representative to a communication sent by the agent, broker, or web-broker, or other similar means or methods that we specify in guidance. We also invited comment on whether there may be other acceptable methods of documentation that we 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 noted that we were 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 Exchanges on the Federal platform.

We also proposed 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 proposed 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, would be required to 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, broker, or web-broker assisting them. We noted that we believe 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 noted that we believe the 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 proposed 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 proposed 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.[207] 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.[208] Therefore,

[207] 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.

[208] 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 (for example, compliance reviews) may occur several years after the applicable coverage year.

consistent with other Exchange maintenance of records requirements,[209] we proposed to capture in new proposed § 155.220(j)(2)(iii)(A)(*2*) that agents, brokers, and web-brokers would be required to 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 sought comment on these proposals.

After reviewing the public comments, we are finalizing these proposals as proposed. We are making an edit to new § 155.220(j)(2)(ii) to add a missing comma before the reference to section 1411(b) of the ACA. This is a nonsubstantive edit that does not impact or otherwise change the new requirements or policies related to the obligation for agents, brokers and web-brokers to provide the FFEs and SBE–FPs with correct information under § 155.220(j)(2)(ii) that are being finalized in this rule, as proposed.

We summarize and respond to public comments received on the proposals 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 and the associated document retention policy below.

Comment: Many commenters supported these proposals, stating they would protect consumers by helping prevent incorrect APTC determinations, and as a result, consumers potentially owing additional money to the IRS when they file their Federal income tax returns. Other commenters stated that these proposals would help encourage compliance and aid investigations of misconduct by agents, brokers, and web-brokers.

Response: We agree with these commenters and appreciate their support of these proposals. We are finalizing these proposals as proposed.

Comment: Numerous commenters expressed concerns the proposals would impose heavy burdens on agents, brokers, and web-brokers due to the additional time that would be required for agents, brokers, and web-brokers to implement and come into compliance with these new requirements. Some of these commenters stated the additional time required to meet these new requirements would be more burdensome during the Open Enrollment Period. Other commenters stated that they believed the additional time associated with implementing and complying with these new requirements would discourage consumers from enrolling in coverage through the FFEs and SBE–FPs, as well as agents, brokers, and web-brokers from assisting consumers in the FFEs and SBE–FPs.

Response: We recognize these new requirements will likely require agents, brokers, and web-brokers to spend more time with each consumer to ensure and 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 and that this may affect agents, brokers, and web-brokers more so during the Open Enrollment Period. However, we believe the benefits of the new requirements outweigh any potential negative impact on agents, brokers, web-brokers, or consumers. It is imperative that consumers' Exchange applications contain accurate information when determining eligibility. As discussed in the proposed rule (87 FR 78252), if consumers' income determinations are not accurate, they could face serious financial harm when reconciling their taxes. In addition, submission of incorrect information on an application may lead to a DMI. Some DMIs, if left unresolved, can lead to a termination of a consumer's Exchange coverage. Ensuring consumers, or their authorized representatives, have reviewed their application information and attested to its accuracy will help mitigate these issues. Further, these new requirements will support the efficient operation of the FFEs and SBE–FPs by helping reduce the number of applications with incorrect information, limiting the number of DMIs that need to be investigated, and expediting our ability to investigate and resolve disputes related to inaccurate consumer information being entered on an eligibility application, which will also benefit agents, brokers, web-brokers and consumers.

In addition, as discussed in the proposed rule (87 FR 78252 through 78253), we did not propose to specify a method for documenting that eligibility application information has been reviewed and confirmed to be accurate by the consumer or their authorized representative to provide agents, brokers, or web-brokers the flexibility to establish protocols and methods that will meet their needs in the most efficient manner.

Given this flexibility, and that the fact that these new requirements are simply building on existing requirements,[210] we do not believe that they will discourage many agents, brokers, or web-brokers from assisting consumers in the FFEs and SBE–FPs or that Exchange enrollment will drop by a significant percentage, if at all. In fact, we believe that these new requirements, which are intended to protect consumers, prevent fraud and abusive conduct, and ensure the efficient and effective operation of the Exchanges on the Federal platform, will encourage more consumers to purchase health insurance through the Exchanges. We will, however, monitor Exchange enrollment data and agent, broker, and web-broker participation in future years to analyze if these new requirements have a noticeable negative impact.

Comment: Some commenters suggested these new requirements would add a disproportionate burden on smaller agencies and independent agents, brokers, and web-brokers, particularly with regard to the initial costs of implementing these new requirements. These commenters stated larger agencies are better equipped to implement these new requirements and absorb the costs associated with them.

Response: We acknowledge that larger agencies may be better equipped to implement these new requirements. There will be upfront costs associated with implementing these new requirements, including potentially purchasing recording software, upgrading storage capacity, or hiring new personnel. Larger agencies typically have more resources to allocate towards meeting new industry standards, as is the case in other business fields as well. However, we do not believe these new requirements will be cost prohibitive to smaller agencies or independent agents, brokers, and web-brokers. As discussed above, we are not mandating the method by which agents, brokers, and web-brokers must meet these new requirements. Therefore, smaller agencies and independent agents, brokers, and web-brokers have the flexibility to meet these requirements utilizing the most efficient and cost-effective method that meets their business needs. Additionally, as mentioned previously, these new requirements are simply building on existing requirements,[211] which we believe will alleviate the burdens and costs associated with these new

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

[210] See § 155.220(j)(2)(ii).

[211] See § 155.220(j)(2)(ii).

requirements for agents, brokers, and web-brokers of all sizes.

Comment: Multiple commenters stated they believed these new requirements would be more difficult to implement over the phone, which would negatively impact consumers without internet access (that is, lower income) or those who are less proficient with technology.

Response: We disagree that these requirements will be more difficult to implement over the phone than with respect to other enrollment methods. As is the case today, consumers will be able to enroll in QHPs and apply for APTC and CSRs for such coverage over the phone, in-person, and via the internet. The flexibility to choose what method is utilized to document that eligibility application information has been reviewed and confirmed to be accurate by the consumer or their authorized representative will allow agents, brokers, and web-brokers to implement these new requirements in a manner that is least burdensome to them. Agents, brokers, and web-brokers may also use this flexibility to implement different methods to comply with these requirements depending on the circumstances of each consumer they are assisting. Different implementation methods include, but are not limited to, obtaining the signature of the consumer or their authorized representative (electronic or otherwise), verbal confirmation by the consumer or their authorized representative that is captured in an audio recording, where legally permissible, or a written response (electronic or otherwise) from the consumer or their authorized representative to a communication sent by the agent, broker, or web-broker.

As such, to implement these new requirements for over-the-phone enrollments, where legally permissible and in accordance with applicable requirements,[212] agents, brokers, and web-brokers can record phone conversations with consumers or their authorized representatives to comply with § 155.220(j)(2)(ii)(A). For example, during these conversations, an agent, broker, or web-broker may ask the consumer if they have reviewed their application information, the information is accurate, and they understand the attestations involved. A recording of the consumer's response to these questions, if it meets the requirements in § 155.220(j)(2)(ii)(A), would be sufficient to meet these new requirements. We understand that saving recorded conversations may be more difficult than other mediums due to the digital space requirements and recording software needed, but is not an excessive burden as there are numerous recording software options to choose from and external hard drives are widely available for purchase. Where legally permissible, it will be the choice of the agent, broker, or web-broker if recording phone conversations is the best method for them to implement these requirements for over-the-phone enrollments. At the same time, we recognize there may be reasons agents, brokers and web-brokers would also want to have other methods available for over-the-phone enrollments. For example, in situations where a phone recording is not possible, agents, brokers and web-brokers may send the consumer or their authorized representative an email or text message after talking with them over the phone. The consumer or their authorized representative may respond to this email or text message, acknowledging they have reviewed the eligibility application information and confirmed its accuracy prior to application submission. When in-person assistance is provided, the agent, broker or web-broker may want to offer the recording methods and other options that it uses for over-the-phone enrollments. The agent, broker, or web-broker may also want to implement a method for in-person assistance that involves obtaining the signature of the consumer or authorized representative (electronic or otherwise) given the face-to-face nature of the interaction. Similarly, agents, brokers and web-brokers should consider what methods meets their business needs, and those of their consumers, for enrollments over the internet. While we are not mandating that agents, brokers, and web-brokers adopt all of these different implementation methods, we encourage agents, brokers and web-brokers to exercise this flexibility in a manner that accommodates the various enrollment methods they use with their respective consumers. Additionally, if an agent, broker, or web-broker is not able to accommodate a consumer (for example, the consumer does not have access to the internet or is less proficient with technology but the specific agent, broker, or web-broker only engages in enrollments via the internet), the consumer may find another agent, broker, or web-broker that can meet their needs.

We believe these new requirements will help protect consumers, including those who may be in underserved groups, rather than inhibit their enrollment in Exchange coverage, as well as ensure the efficient and effective operation of the Exchanges on the Federal platform. Further, we frequently see unauthorized enrollments impact underserved groups of consumers in greater numbers than other groups. Often, agents, brokers, and web-brokers who engage in noncompliant or fraudulent behavior target low-income consumers or consumers with limited English proficiency. By requiring that agents, brokers, and web-brokers document that consumers or their authorized representatives have reviewed and verified their application information prior to submission, we believe that these consumer harms and the impact on underserved groups can be mitigated.

Comment: Multiple commenters expressed concerns regarding the disclosure of consumers' personally identifiable information (PII). These commenters stated that they believe these new requirements would lead to more improper disclosures of consumer PII as agents, brokers, and web-brokers would be storing more consumer PII than in the past.

Response: We do not believe these new requirements will lead to more improper disclosures of consumer PII. These new requirements do not require agents, brokers, and web-brokers to record or maintain any consumer PII in addition to the consumer PII an agent, broker, or web-broker currently records and maintains. The new requirements include ensuring a consumer or their authorized representative has reviewed and attested that their application information is correct prior to submission and that this is documented and maintained by the agent, broker, or web-broker for a minimum of 10 years. This 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 assisting agent, broker, or web-broker. The only piece of PII required for this documentation is the consumer's name, which an agent, broker, or web-broker would already be recording and maintaining in their files.

A recorded conversation, during an over-the-phone enrollment or otherwise, could potentially contain more consumer PII than what the regulations require, as additional consumer

[212] We recognize that there are Federal and State laws that govern the legality of recording phone calls and conversations that may impact an agent, broker, or web-broker's ability to record phone or oral communications with consumers or that may require an agent, broker, or web-broker to obtain the consumer's consent prior to recording such communications (see, for example, 18 U.S.C. 2511).

information may be revealed during the conversation and the enrollment process. However, we do not believe this will lead to more improper disclosures of consumer PII. Agents, brokers, and web-brokers are already required to adhere to applicable State or Federal laws concerning the safeguarding of consumer PII, including § 155.220(g)(4) and (j)(2)(iv), and HIPAA.[213] These same requirements and protections continue to apply. Additionally, an agent, broker, or web-broker that elects to implement the phone recording method to meet these new requirements would only be required to record the portion of the conversation in which the consumer or consumer's representative confirms that they have reviewed and attested that their application information is correct prior to submission to demonstrate compliance, which would reduce the amount of consumer PII in the recorded conversation. This would further reduce or eliminate the potential of improper disclosures of consumer PII.

Comment: One commenter suggested the IRS provide the consumer income information that is to be entered on each Exchange application.

Response: We appreciate the commenter's suggestion, but generally note the consumer is in the best position to project their future income and is the individual generally responsible for providing application information, including information regarding income.[214] To determine if a consumer is eligible for financial assistance, such as APTC, prior to enrollment, an estimate for income must be entered prior to the eligibility determination process. As many consumers enroll in health coverage prior to a new calendar year, the income amount they enter is an estimate based on available data, including income in prior years, as well as what consumers believe their income will be in the upcoming plan year. The IRS will not have income data for the consumer for the year of coverage until the consumer files a tax return for the year of coverage. This typically does not occur until the next calendar year. By that time, the year of coverage will have ended so this income data from the IRS will not provide a timely income projection for the upcoming year of coverage. Recognizing income amounts provided by consumers on eligibility applications are projections, the statute generally requires HHS to verify income information on Exchange applications with the Department of Treasury.[215] As such, the ACA established an approach that collects information about estimated income for the upcoming plan year from the consumer, the person in the best position to make such projections, with a verification of that information from a trusted source, the Department of Treasury and IRS.

Comment: Several commenters stated that we should allow agents, brokers, and web-brokers to meet these new requirements under § 155.220(j)(2)(ii) and the new requirements related to documenting consumer consent under § 155.220(j)(2)(iii) during the same consumer interaction and/or within the same document.

Response: Agents, brokers, and web-brokers are not prohibited from documenting that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or the consumer's authorized representative and documenting the receipt of consent from the consumer or the consumer's authorized representative pursuant to § 155.220(j)(2)(ii) and (iii), respectively, during the same conversation with the consumer, or within the same document, as long as the documentation complies with the requirements set forth in § 155.220(j)(2)(ii)(A) and (B) and (j)(2)(iii)(A) through (C).

Comment: Some commenters stated that we should not take enforcement action against agents, brokers, or web-brokers who act in good faith to comply with these new requirements and who enter information on a consumer's Exchange application that the consumer has attested to be true, but that turns out to be inaccurate. Specifically, these commenters indicated accurate income projections for consumers who are self-employed or work flexible hours are difficult, and thus, can often end up being inaccurate. Some commenters also suggested that we should only enforce these requirements against agents, brokers, and web-brokers, and not against issuers, as issuers are not directly involved in enrolling consumers in Exchange coverage.

Response: We do not initiate enforcement actions against agents, brokers, and web-brokers who act in good faith to provide the FFEs and SBE–FPs with correct information and where there is a reasonable cause for the failure to provide correct information.[216] We understand that income projections are purely estimates and a consumer's yearly income may be different than projected, especially for those who are self-employed or work flexible hours. As such, assuming the agent, broker or web-broker meets the applicable requirements and maintains the necessary documentation, we believe the situation described by these commenters is an example in which an agent, broker, or web-broker has acted in good faith and there is a reasonable cause for the failure to provide correct information such that no enforcement action would be taken and no penalties would be imposed. In addition, we note that the requirements contained in § 155.220(j)(2)(ii)(A) apply specifically to agents, brokers, and web-brokers, and not to issuers.

Comment: A few commenters suggested the proposed record retention period of 10 years is too long for agents, brokers, and web-brokers to maintain the documentation required by § 155.220(j)(2)(ii)(A). Another commenter stated we should have the record retention period match align with the required record retention period of the State where the consumer is enrolled.

Response: Please see the accompanying information collection section IV.F (ICRs Regarding Providing Correct Information to the FFEs (§ 155.220(j)) of this final rule for the response to these comments.

Comment: We also received several comments related to agents, brokers, and web-brokers switching their National Producer Numbers on consumers' applications, a lack of respect towards agents, brokers, and web-brokers, and agent, broker, and web-broker commissions, which were outside the scope of these proposals.

Response: Although we appreciate these commenters' interest in the policies governing consumer review and attestation of their application information prior to submission, given that these comments are out-of-scope with regard to these specific proposals, we decline to comment on them at this time.

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

We proposed to amend § 155.220(j)(2)(iii) to require agents, brokers, or web-brokers assisting with and facilitating enrollment in coverage through FFEs and SBE–FPs or assisting

[213] See, for example, § 155.260, 45 CFR part 164, subparts A and E, and the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, H.R. 3103, 104th Cong.

[214] See sections 1411(b)(3) and 1412(b)(2) of the ACA and redesignated § 155.220(j)(2)(ii)(E).

[215] See sections 1411(c)(3) and 1412(b)(2) of the ACA and redesignated § 155.220(j)(2)(ii)(E).

[216] See § 155.220(j)(3), which states ''If an agent, broker, or web-broker fails to provide correct information, he, she, or it will nonetheless be deemed in compliance with paragraphs (j)(2)(i) and (ii) of this section if HHS determines that there was a reasonable cause for the failure to provide correct information and that the agent, broker, or web-broker acted in good faith.''

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 proposed 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 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 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 proposed 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 proposed 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 in coverage 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. As provided in the proposed rule (87 FR 78254), 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 proposed this standard because, as noted in the proposed rule (87 FR 78254), we believe that it will 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 proposed 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 proposed to establish in proposed new § 155.220(j)(2)(iii)(A) through (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 proposed 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 noted that we did 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 proposed 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. We proposed that 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 that the documentation include the date consent was given, the name of the consumer or their authorized representative, the 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. We noted that if agents, brokers, and web-brokers have already adopted consent documentation processes consistent with this proposed framework, no changes would be required. We noted in the proposed rule (87 FR 78206, 78254) that 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 noted that we 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 to 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 proposed 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, as noted in the proposed rule (87 FR 78254 through 78255), 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 noted that we expect the information in the consent documentation will 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 proposed 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 its 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.[217] 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.[218] Therefore, consistent with other Exchange maintenance of records requirements,[219] we proposed to capture in new proposed § 155.220(j)(2)(iii)(C) that agents, brokers, and web-brokers would be required to 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 sought comment on these proposals, including whether there are other means or methods of documentation that we should consider specifying are permissible for purposes of documenting the receipt of consent from consumer or their, qualified employers, or qualified employees.

After reviewing the public comments, we are finalizing these proposals as proposed. We are making a technical update to § 155.220(j)(2)(iii)(A) to add in the phrase ''or other similar means or methods that HHS specifies in guidance'' to align with and capture the proposed policy, as reflected in the preamble of the proposed rule, and which is being finalized in this final rule, as proposed.

[217] 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.

[218] 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 (for example, compliance reviews) may occur several years after the applicable coverage year.

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

We summarize and respond to public comments received on the proposals related to the documentation of consumer consent and the associated document retention policy below.

Comment: Multiple commenters expressed their support of these proposals. These commenters stated they believed these new requirements would help eliminate unauthorized enrollments and protect consumers. Many of these commenters recommended that we allow agents, brokers, and web-brokers to maintain the flexibility to determine the method by which they will meet these requirements.

Response: We agree with these commenters and are finalizing these proposals as proposed. As discussed in the proposed rule, to ensure continued flexibility for agents, brokers, and web-brokers, we have not mandated a specific method by which agents, brokers, and web- brokers must meet these requirements. The technical update we are making to § 155.220(j)(2)(iii)(A) to add in the phrase ''or other similar means or methods that HHS specifies in guidance'' aligns the regulatory text with the preamble and further emphasizes this flexibility, as the means or methods by which acceptable documentation may be obtained by agents, brokers, and web-brokers are not being mandated and may be updated by HHS in guidance.

Comment: Some commenters expressed concern these new requirements would impose heavy burdens on agents, brokers, and web-brokers due to the additional time that would be required for agents, brokers, and web-brokers to implement and come into compliance with these new requirements. Some of these commenters stated the additional time required to meet these new requirements would be more burdensome during the Open Enrollment Period. Other commenters stated the additional time associated with implementing and complying with these new requirements would discourage consumers from enrolling in coverage through the FFEs and SBE–FPs, as well as agents, brokers, and web-brokers from assisting consumers in the FFEs and SBE–FPs.

Response: We recognize these new requirements will likely require agents, brokers, and web-brokers to spend more time with each consumer to ensure that consumer consent is documented and that this may affect agents, brokers, and web-brokers more so during the Open Enrollment Period. However, we believe the benefits of these new requirements

outweigh any potential negative impact on agents, brokers, web-brokers, or consumers. Existing rules require agents, brokers, and web-brokers to obtain consumer consent prior to assisting them with Exchange enrollment or applying for APTC and CSRs for QHPs.[220] Therefore, we believe that requiring a record of that consent be documented and maintained will not add significant burdens on agents, brokers, and web-brokers.

Additionally, as discussed in the proposed rule (87 FR 78254), we believe having a reliable record of consent will help with the resolution of 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; the resolution of consumer complaints; and minimize the risk of fraudulent activities such as unauthorized enrollments. Finally, as discussed in the proposed rule (87 FR 78254), we did not propose to specify a method for documenting that consumer consent was provided. This flexibility will allow each individual agent, broker, or web-broker to establish protocols and methods that will meet their needs in the most efficient manner. We believe this flexibility, and that the fact that these new requirements are simply building on existing requirements,[221] will minimize the burdens associated with implementing these new requirements. In fact, we believe that these new requirements, which are intended to protect consumers, prevent fraud and abusive conduct, and ensure the efficient and effective operation of the Exchanges on the Federal platform, will encourage more consumers to purchase health insurance through the Exchanges. We will, however, monitor Exchange enrollment data and agent, broker, web-broker participation in future years to analyze if these new requirements have a noticeable negative impact.

Comment: Multiple commenters expressed concerns regarding the disclosure of consumers' PII. These commenters stated that they believe these new requirements would lead to more improper disclosures of consumer PII as agents, brokers, and web-brokers would be storing more consumer PII than in the past.

Response: We do not believe these new requirements will lead to more improper disclosures of consumer PII. These new requirements do not require agents, brokers, and web-brokers to record or keep consumer PII beyond what an agent, broker, or web-broker currently records and maintains. Section 155.220(j)(2)(iii)(A) requires that agents, brokers, and web-brokers document the receipt of consent from a consumer or the consumer's authorized representative. Under § 155.220(j)(2)(iii)(B), such documentation is required to include a description of the scope, purpose, and duration of the consent provided, the date consent was given, the name of the consumer or their authorized representative, the name of the agent, broker, web-broker, or agency being granted consent, and a process through which the consumer or their authorized representative may rescind the consent. The only piece of PII required for this documentation is the consumer's name, which an agent, broker, or web-broker would already be recording and maintaining in their files.

A recorded conversation, during an over-the-phone enrollment or otherwise, could potentially contain more consumer PII than what the regulations require, as additional consumer information may be revealed during the conversation and the enrollment process. However, we do not believe this will lead to more improper disclosures of consumer PII. Agents, brokers, and web-brokers are already required to adhere to applicable State or Federal laws concerning the safeguarding of consumer PII, including § 155.220(g)(4) and (j)(2)(iv), and HIPAA.[222] These same requirements and protections continue to apply. Additionally, an agent, broker, or web-broker that elects to implement the phone recording method to meet these new requirements would only be required to record the portion of the conversation in which the consumer or consumer's representative provides consent to demonstrate compliance, which would reduce the amount of consumer PII in the recorded conversation. This would further reduce or eliminate the potential of improper disclosures of consumer PII.

Comment: Some commenters suggested these new requirements would add a disproportionate burden on smaller agencies and independent agents, brokers, and web-brokers, particularly with regard to the initial costs of implementing these new requirements. These commenters stated larger agencies are better equipped to implement these new requirements and absorb the costs associated with them.

Response: We acknowledge that larger agencies may be better equipped to implement these new requirements. There will be upfront costs associated with these new requirements, potentially including purchasing recording software, upgrading storage capacity, or hiring new personnel. Larger agencies typically have more resources to allocate towards meeting new industry standards, as is the case in other business fields as well. However, we do not believe these new requirements will be cost prohibitive to smaller agencies or independent agents, brokers, and web-brokers. As discussed above, we are not mandating the method by which agents, brokers, and web-brokers must meet these new requirements. Therefore, smaller agencies and independent agents, brokers, and web-brokers have the flexibility to meet these requirements utilizing the most efficient and cost-effective method that meets their business needs. Additionally, as mentioned previously, these new requirements are simply building on existing requirements to obtain consumer consent prior to assisting with or facilitating enrollment through an FFE or assisting the individual in applying for APTC and CSRs for QHPs,[223] which we believe will alleviate the burdens and costs associated with these new requirements for agents, brokers, and web-brokers of all sizes.

Comment: Multiple commenters stated they believed these new requirements would be more difficult to implement over the phone, which would negatively impact consumers without internet access (that is, lower income) or those who are less proficient with technology.

Response: We disagree that these requirements will be more difficult to implement over the phone than with respect to other enrollment methods. As is the case today, consumers will be able to enroll in QHPs and apply for APTC and CSRs for such coverage over the phone, in-person, and via the internet. The flexibility to choose what method is utilized to document that consumer consent has been obtained will allow agents, brokers, and web-brokers to implement these new requirements in a manner that is least burdensome to them. Agents, brokers, and web-brokers may also use this flexibility to implement different methods to comply with these requirements depending on the circumstances of each consumer

[220] See 45 CFR 155.220(j)(2)(iii).

[221] See 45 CFR 155.220(j)(2)(iii).

[222] See, for example, 45 CFR 155.260, 45 CFR part 164, subparts A and E, and the Health Insurance Portability and Accountability Act of 1996, Public Law 104–191, H.R. 3103, 104th Cong (42 U.S.C. 1320d–2).

[223] See § 155.220(j)(2)(iii).

they are assisting. Different implementation methods include, but are not limited to, obtaining the signature of the consumer or their authorized representative (electronic or otherwise), verbal confirmation by the consumer or their authorized representative that is captured in an audio recording, where legally permissible, or a written response (electronic or otherwise) from the consumer or their authorized representative to a communication sent by the agent, broker, or web-broker.

As such, to implement these new requirements for over-the-phone enrollments, where legally permissible and in accordance with applicable requirements,[224] agents, brokers, and web-brokers can record phone conversations with consumers or their authorized representatives to comply with § 155.220(j)(2)(iii)(A) and (B). For example, during these conversations, an agent, broker, or web-broker may ask the consumer or the consumer's authorized representative if they have provided consent. A recording of the consumer's or their authorized representative's response to this question, if it meets the requirements in § 155.220(j)(iii)(A) and (B), would be sufficient to meet these new requirements. We understand that saving recorded conversations may be more difficult than other mediums due to the digital space requirements and recording software needed, but is not an excessive burden as there are numerous recording software options to choose from and external hard drives are widely available for purchase. Where legally permissible, it will be the choice of the agent, broker, or web-broker if recording phone conversations is the best method for them to implement these requirements for over-the-phone enrollments. At the same time, we recognize there may be reasons agents, brokers and web-brokers would also want to have other methods available for over-the-phone enrollments. For example, in situations where a phone recording is not possible, agents, brokers and web-brokers may send the consumer or their authorized representative an email or text message after talking with them over the phone. The consumer or their authorized representative may respond to this email or text message, acknowledging they have provided consent. When in-person assistance is provided, the agent, broker or web-broker may want to offer the recording methods and other options that it uses for over-the-phone enrollments. The agent, broker, or web-broker may also want to implement a method for in-person assistance that involves obtaining the signature of the consumer or authorized representative (electronic or otherwise) given the face-to-face nature of the interaction. Similarly, agents, brokers and web-brokers should consider what methods meets their business needs, and those of their consumers, for enrollments over the internet. While we are not mandating that agents, brokers, and web-brokers adopt all of these different implementation methods, we encourage agents, brokers and web-brokers to exercise this flexibility in a manner that accommodates the various enrollment methods they use with their respective consumers. Additionally, if an agent, broker, or web-broker is not able to accommodate a consumer (for example, the consumer does not have access to the internet or is not proficient with technology but the specific agent, broker, or web-broker only engages in enrollments via the internet), the consumer may find another agent, broker, or web-broker that can meet their needs.

We believe these new requirements will help protect consumers, including those who may be in underserved groups, rather than inhibit their enrollment in Exchange coverage. Further, we frequently see unauthorized enrollments impact underserved groups of consumers in greater numbers than other groups. Often, agents, brokers, and web-brokers who engage in noncompliant or fraudulent behavior target low-income consumers or consumers with limited English proficiency. By requiring that agents, brokers, and web-brokers document that consumers or their authorized representatives have provided their consent, we believe that these consumer harms and the impact on underserved groups can be mitigated. In addition, requiring agents, brokers, and web-brokers to document that consumer consent was received and to maintain the record for 10 years will provide us with more conclusive evidence when pursuing enforcement actions against agents, brokers, or web-brokers for potentially fraudulent activities.

Comment: Multiple commenters suggested these new requirements related to the documentation of consumer consent are unnecessary as the requirement to obtain consumer consent already exists, either under Federal or State law or in the agent, broker, or web-broker's Exchange agreement(s).

Response: We disagree that these new requirements related to the documentation of consumer consent are unnecessary or duplicative of existing requirements. While agents, brokers, and web-brokers are currently required to obtain consumer consent prior to providing the consumer with assistance pursuant to § 155.220(j)(2)(iii), this section does not currently require agents, brokers, or web-brokers to document the receipt of consent and maintain such documentation for a specified period of time. As discussed in the proposed rule (87 FR 78254), we believe requiring such documentation of consent is crucial for two reasons. First, we believe this requirement will help minimize the risk of fraudulent activities, such as unauthorized enrollments. Second, it will help us resolve disputes and adjudicate claims related to the provision of consumer consent.

Comment: One commenter suggested that the documentation of consumer consent requirement is unnecessary as unauthorized enrollments in Exchange coverage do not occur for consumers under the age of 65.

Response: We have observed numerous unauthorized Exchange enrollments that have occurred for consumers under the age of 65. This is especially true with regard to consumers with limited English proficiency or underserved populations, including unhoused individuals. We believe these new requirements will help mitigate the risk of unauthorized enrollments for consumers of all ages.

Comment: Several commenters stated that we should allow agents, brokers, and web-brokers to meet these new requirements under § 155.220(j)(2)(iii) and the new requirements related to documenting that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or the consumer's authorized representative under § 155.220(j)(2)(ii) during the same consumer interaction and/or within the same document.

Response: Agents, brokers, or web-brokers are not prohibited from documenting that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or the consumer's authorized representative and documenting the receipt of consent from the consumer or the consumer's authorized representative pursuant to § 155.220(j)(2)(ii) and (iii), respectively, during the same conversation with the consumer, or within the same document, as long as the documentation

[224] We recognize that there are Federal and State laws that govern the legality of recording phone calls and conversations that may impact an agent, broker, or web-broker's ability to record phone or oral communications with consumers or that may require an agent, broker, or web-broker to obtain the consumer's consent prior to recording such communications (see, for example, 18 U.S.C. 2511).

complies with the requirements set forth in § 155.220(j)(2)(ii)(A) and (B) and (j)(2)(iii)(A) through (C).

Comment: Some commenters recommended that we allow consumers to grant consent to multiple agents, brokers, or web-brokers simultaneously.

Response: As noted in the proposed rule (87 FR 78254), we are not directing agents, brokers, or web-brokers on how to comply with these new documentation requirements. In the Model Consent Form [225] that accompanied the proposed rule, we included an option for a consumer to provide consent to an agency rather than an individual agent, broker, or web-broker. At this time, providing consent to an agency or multiple agents, brokers, or web-brokers simultaneously is permitted, provided the consent documentation complies with the requirements contained in § 155.220(j)(2)(iii).

Comment: A few commenters suggested the proposed record retention period of 10 years is too long for agents, brokers, and web-brokers to maintain the documentation required by § 155.220(j)(2)(iii)(C). Another commenter stated we should have record retention period align with the record retention period of the State where the consumer is enrolled.

Response: Please see the accompanying information collection section IV.F. (ICRs Regarding Providing Correct Information to the FFEs (§ 155.220(j)) of this final rule for the response to these comments.

Comment: One commenter suggested we define what consent is so that it may be standardized. This commenter also suggested we delay implementation of these documentation requirements until PY 2025, or exercise enforcement discretion with regard to those agents, brokers, and web-brokers making good-faith efforts to meet these requirements during PY 2024.

Response: After considering these comments, we decline to define consent. We believe the term consent is unambiguous and the new requirements in § 155.220(j)(2)(iii)(A) through (C) will provide agents, brokers, and web-brokers with a clear picture of what obtaining and documenting the receipt of consent requires under § 155.220(j)(2)(iii). In addition, we decline to delay implementation of these requirements until PY 2025. As noted in the proposed rule (87 FR 78254) and above, the goal of these requirements is to prevent fraudulent activities such as unauthorized enrollments, to help resolve disputes between agents, brokers, and web-brokers and consumers related to consumer consent, reduce consumer harm, and support the efficient operation of the Exchanges. If we delay implementation of these documentation requirements, consumers may be negatively impacted when that impact could have been avoided. Additionally, we do not plan on targeting agents, brokers, or web-brokers who are acting in good faith to meet these new requirements. Our primary goal is to address situations involving noncompliance by actors who are not acting in good faith, with a particular focus on fraudulent activities in the FFEs and SBE–FPs. Our experience shows long-standing patterns of this activity with the potential to impact a large number of consumers with potentially severe consequences (for example, termination of coverage, unanticipated tax liability).

Comment: We also received several comments that were outside the scope of these proposals related to the documentation of consumer consent, including the need to have the Exchange(s) obtain and maintain consent documentation instead of the agent, broker, or web-broker, as well as having the Exchange(s) email consumers when changes on an application are made.

Response: Although we appreciate the commenters' interest in policies governing the documentation of consumer consent, given that these comments are out-of-scope with regard to these specific proposals, we decline to comment on them at this time.

4. Eligibility Standards (§ 155.305)

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

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78255), we proposed 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 from the IRS will 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 § 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 section 36B(f) of the Code and its implementing regulations 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 operational costs of the current policy are significant and can be improved to provide a better consumer experience, while also preserving an Exchange's duty to protect program integrity. 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), notifies 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 proposed 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 and its implementing regulations, 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

[225] CMS. (Dec. 14, 2022). *CMS Model Consent Form for Marketplace Agents and Brokers.* PRA package (CMS–10840, OMB 0938–XXXX). *https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10840.*

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, *Premium Tax Credit (PTC).* 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 (because the Exchange is prohibited from sending protected tax information to an individual who may not be the tax filer). Notices to the applicant's household contact can be confusing because of the multiple reasons listed. Both 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 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.'' [226] Enrollees who make 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 proposed the changes to § 155.305(f)(4) described in the proposed rule (87 FR 78255 through 78257). HHS' and the 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, we are 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 one 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 2 consecutive tax years (specifically, years for which tax data will be utilized for verification of household income and family size), Exchanges will 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 will 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 will 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.

We believe in ensuring consumers have access to affordable coverage and place high value on consumers maintaining continuity of coverage in the Exchange, as we have 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, we believe it is imperative that any change to the current FTR operations be done carefully and that we 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 health insurance coverage for needed medical care.

Therefore, given these challenges that both Exchanges and consumers have faced with the requirement to file and reconcile, we proposed to revise § 155.305(f)(4) under which Exchanges will not be required, or permitted, to determine consumers ineligible for APTC due to having an FTR status for only one year. Given that our experience running FTR shows continued issues with compliance with the requirement to file and reconcile, we proposed that beginning on January 1, 2024, an applicant's FTR status will trigger an Exchange determination that the applicant is ineligible for APTC only if the applicant has an FTR status for 2 consecutive years (specifically, 2

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

consecutive years for which tax data will be utilized for verification of household income and family size).

Due to the COVID–19 PHE starting in 2020, for PYs 2021 and 2022, we temporarily paused ending APTC for enrollees with an FTR status due to IRS processing delays of 2019 Federal income tax returns.[227] We then extended this pause for the PY 2023 in July 2022 and included flexibility for State Exchanges that operate their own eligibility and enrollment platforms to take similar action.[228] As a result of these changes, 55 percent of enrollees who were automatically re-enrolled during 2021 open enrollment with an FTR status remained enrolled in Exchange coverage as of March 2021. In contrast, only 12 percent of 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.

We proposed to continue to pause APTC denials based on a failure to reconcile until HHS and the IRS are able to implement the new FTR policy. Until the IRS can update its systems to implement the new FTR policy, and we can notify the Exchange of an enrollee's consecutive two-year FTR status, the Exchange would not determine enrollee's ineligible for APTC based on either the one-year or two-year FTR status. We believe that removing APTC after 2 consecutive years of an FTR status instead of one would help consumers avoid gaps in coverage by increasing retention in the Exchange even if they have failed to reconcile for one year, and would 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 2 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 2 years, been given ample notification of their obligation to file and reconcile and have nevertheless failed to do so.

We sought comment on these proposals, especially from States and other interested parties regarding tax burdens on consumers which would inform our decision on this proposal.

After reviewing the public comments, we are finalizing this provision as proposed, except that the final rule will become effective on the general effective date of the final rule, instead of January 1, 2024. As detailed in the responses to comments on these policies, some commenters sought clarity on when the policy would become effective, and others were concerned that changing the FTR policy would threaten the integrity of APTC available to eligible consumers. By allowing the policy to become generally effective prior to January 1, 2024, we are solidifying flexibility for HHS and IRS to resume FTR operations as soon as HHS and IRS are ready to begin. HHS will provide at least three months' notice to consumers and other interested parties prior to resuming FTR operations. We originally proposed a technical correction 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. However, upon further review, this technical correction is not necessary because we believe that the original wording of the rule more accurately reflected how information is passed through the Federal Data Services Hub, and therefore, we are not finalizing this technical correction. Finally, we clarify that Exchanges must continue to pause APTC denials based on a failure to reconcile for one year under the currently effective regulation, or 2 years under the regulation we finalize here, until HHS and the IRS are able to implement the FTR policy.

We summarize and respond to public comments received on the proposed rule that an applicant's FTR status will result in an Exchange finding that the applicant is ineligible for APTC only if the applicant has an FTR status for 2 consecutive tax years.

Comment: Many commenters agreed with the proposal that an applicant's FTR status will result in an Exchange determination that the applicant is ineligible for APTC only if the applicant has an FTR status for 2 consecutive tax years. Commenters agreed that the two-year FTR proposal better protects financially vulnerable enrollees compared to the current one-year FTR process. Several commenters added that Exchanges still face operational challenges, and enrollees should not be financially penalized in the case of an unintentional technical issue within the Exchange. A commenter also stated the proposed change will positively promote continuity of coverage for consumers enrolled in Exchange coverage. Additionally, many commenters stated that the proposal would allow for more consumer education on the requirement to file and reconcile past APTC received and the process for doing so, while protecting consumers from accruing large tax liabilities over multiple years.

Response: We agree that the proposed FTR policy will improve continuity of coverage for consumers by ensuring that consumers do not become uninsured because their Exchange coverage becomes unaffordable after losing APTC. Continuity of coverage is especially important for consumers with chronic health conditions such as cancer. Additionally, the proposed policy would protect consumers from incurring large tax liabilities over multiple years, which may especially benefit consumers with household incomes over 400 percent of the Federal poverty level (FPL), who are not subject to APTC repayment caps, and whose potential tax liability from failing to reconcile APTC may be larger. Nonetheless, it is still a statutory requirement[229] that consumers file their Federal income taxes and reconcile past APTC received, regardless of their FPL level or risk for tax liability, and we will continue to implement policies that work towards ensuring that only those consumers who are eligible to receive APTC continue to do so. We believe that the proposed policy strikes a balance between protecting consumers from large tax liabilities, such as those with household incomes above 400 percent of the FPL, while also ensuring program integrity for all Exchanges.

Comment: A few comments from State Exchanges supported the proposal but asked that we provide clear and early information about the technical specifications and processes that will be required to implement the FTR rule as proposed within State Exchange's systems.

Response: We agree that clear communication about technical specifications and the processes that will be required to implement the FTR

[227] 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.*

[228] 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.*

[229] Internal Revenue Code section 36B; 26 CFR 1.36B 4(a)(1)(i); *see also https://www.irs.gov/affordable-care-act/individuals-and-families/premium-tax-credit-claiming-the-credit-and-reconciling-advance-credit-payments#Advance.*

rule would be beneficial. As such, we will work with all parties involved to make sure the FTR process is explained clearly prior to and during implementation.

Comment: A few commenters, including several State Exchanges, supported the policy, but requested clarification on the intended implementation timeline of the new FTR proposal. Commenters requested adequate time to implement necessary technical changes, allow Medicaid unwinding efforts to be completed, and ensure alignment with IRS provisions and systems.

Response: In the proposed rule (87 FR 78256), we stated that policy would become effective on January 1, 2024. The proposed FTR regulation provided that ineligibility based on FTR status would apply when IRS notifies HHS and HHS then notifies the Exchanges that a tax filer or their spouse did not comply with the requirement to file an income tax return and reconcile APTC for a year for which tax data would be utilized for verification of household income and family size. Based on information on the availability of data from IRS, we intend to continue pausing implementation of the FTR requirement on Exchanges on the Federal platform until data from IRS about APTC reconciliation is available to HHS, which we expect to be available for eligibility determinations for PY 2025, and we expect that State Exchanges are doing likewise. Exchanges on the Federal platform expect such information to be available, and to first take action to apply the new FTR rule, in September 2024, when batch auto re-enrollment (BAR) activities begin for PY 2025 eligibility determinations. During BAR, the Exchanges on the Federal platform will communicate with IRS to check whether enrollees have filed and reconciled for tax years 2022 and 2023 and set the appropriate FTR status code for enrollees who have not filed and reconciled APTC for tax years 2022 and 2023. Exchanges on the Federal platform will then send notices to enrollees who have either a one-year or two-year FTR status according to their 2022 and 2023 Federal income tax filings. Under the proposed change, Exchanges on the Federal platform will not deny APTC eligibility, but will continue to send notices to consumers for the first year in which they have failed to reconcile APTC to inform and educate them 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.

Enrollees in Exchanges on the Federal platform who have been notified and have been determined to have a current two-year FTR status will no longer be eligible for APTC, consistent with the Exchanges' on the Federal platform FTR process, while those enrollees who have received the first-year notice will be encouraged to file and reconcile to avoid losing APTC eligibility the following year. Given the expected timing to resume accurately and timely notifying Exchanges of FTR status by September 2024, we believe there is enough time for Medicaid unwinding to take place and to ensure alignment with IRS systems. In response to commenter concerns regarding adequate notice of when the new FTR policy may be applied to deny APTC eligibility, and to provide HHS and IRS flexibility to resume FTR operations as soon as they are able to implement the policy, HHS will provide at least 3 months' notice before Exchanges are required to deny APTC to consumers who the IRS reports to have failed to reconcile APTC for 2 consecutive years.

Comment: Two commenters expressed concern for consumers who might experience a greater tax burden or tax liability if they are unable to reconcile their APTC after two years rather than one year and suggested we find a solution to alleviate this burden. We also received a few comments that neither supported nor opposed the proposal but raised concerns about consumer protections for enrollees facing high repayment effects, especially those with household incomes above 400 percent of FPL.

Response: We agree with the commenters that this proposal could place consumers at a risk for increased tax liability. In particular, taxpayers who underestimated their annual income when they enrolled in an Exchange QHP and are ultimately determined ineligible for APTC because of their FTR status, may be required to repay large amounts of APTC when they file their Federal income taxes and reconcile past APTC received. We agree that taxpayers with incomes above 400 percent of the FPL may face the highest repayment burdens if they fail to file and reconcile for 2 consecutive tax years as APTC repayments are not capped for this group. To mitigate this concern, we intend to continue issuing FTR warning notices for enrollees in Exchanges on the Federal platform who have not filed and reconciled for one tax year. We believe that annual FTR warning notices will remind this population of the potential for a large tax liability and prompt them to comply with the requirement to file and reconcile if they have not already. We encourage State Exchanges to take similar action.

Despite the potential for a large tax liability, we believe that this proposal will have a positive impact on consumers while still ensuring program integrity as it will provide better continuity of coverage for consumers who may not be aware of the requirement to file and reconcile. We are aware that some third-party tax preparers do not properly educate consumers on the importance of filing and reconciling and, in some instances, these third-party tax preparers are unaware that consumers have to file IRS Form 8962 along with their tax return to reconcile past APTC received. In implementing the new FTR requirement, Exchanges on the Federal platform will provide additional education, outreach, and initial warning notices for those consumers who are out of compliance with the filing and reconciling requirement after one year to avoid those high tax penalties. We will continue to monitor the implementation of this new policy including whether certain populations continue to experience large tax liabilities and will consider whether additional guidance, or any additional policy changes in future rulemaking, are necessary.

Comment: Two commenters supported the proposal and suggested that more outreach is needed to both consumers and tax preparers about the FTR process, the risk of noncompliance, and the process for determining eligibility.

Response: We agree with the commenter regarding the need for education and outreach for consumers, States, tax preparers, and interested parties that assist consumers with enrollment decisions, such as Assisters, agents, and brokers. As we monitor the implementation of this provision, we will consider providing additional guidance, education, and other technical assistance to Exchanges to adequately prepare consumers, States, tax preparers, and interested parties before the implementation is completed and FTR operations are resumed.

Comment: We received various comments regarding potential program integrity implications. One commenter fully opposed the proposal of removing APTC after an enrollee has been in an FTR status for 2 consecutive years, citing the risks of increased fraud and abuse by consumers who know they can ignore an FTR status for an additional year. Similarly, a few commenters neither supported nor opposed the proposal but cautioned HHS about

potential fraud and abuse by enrollees receiving excess premium tax credits.

Response: We understand and appreciate the commenters' concern regarding the risk for fraud and abuse with respect to this proposal. We acknowledge that there is some risk that enrollees may choose to ignore the requirement to file and reconcile, but we anticipate these instances will be limited as the majority of enrollees comply with the requirement to file and reconcile. Additionally, taxpayers who choose to ignore the requirement to file and reconcile may be subject to IRS enforcement action, additional tax liability, and possibly interest and penalties. We also note that nothing in this regulation changes the requirement for enrollees to file their Federal income tax return and reconcile the previous year's APTC with the IRS. We will continue to monitor the implementation of this policy by reviewing and monitoring yearly FTR consumer data and referring any instances of suspected fraud or abuse to the appropriate Federal agencies. We will also determine whether additional guidance, or any additional policy changes in future rulemaking to combat fraud and abuse, are necessary.

Comment: A few commenters urged HHS to fully repeal the FTR process, citing the threat it presents to continuity of coverage for consumers who are facing periods of intense care, the punitive nature of the FTR process towards consumers who cannot afford coverage, and the risk that a two-year FTR process does not sufficiently mitigate the unwarranted loss of APTC.

Response: We considered many factors in our decision to shift from a one-year FTR process to a two-year FTR process. We believe that the change properly balances consumer protections and program integrity concerns, and therefore, we believe we should continue to improve the FTR process rather than repeal it entirely.

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

a. Income Inconsistencies

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78257), we proposed 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 proposed 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.[230] *See* § 155.320(c)(1)(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) through (vi). *See* section 1412(b)(2) of the ACA.

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* section 1412(b)(2) of the ACA. When an applicant or enrollee has experienced a change in circumstances as described in section 1412(b)(2) of the ACA, 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) through (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)(3)(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 proposed 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 proposed 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 because the current process is overly punitive to consumers and burdensome to Exchanges. There are many reasons for IRS not returning consumer data, aside from the consumer's failure to file tax returns, including 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 cause a consumer

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

to receive an income DMI. Additionally, the consequence of receiving an income DMI and being unable to provide sufficient documentation to verify projected household income outweighs program integrity risks as, under § 155.320(c)(3)(vi)(G), consumers are determined completely ineligible for APTC and CSRs. For 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 proposed 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 section 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.[231] It is also consistent with the flexibility under section 1411(c)(4)(B) of the ACA to modify methods for verification of the information where we determine such modifications will reduce the administrative costs and burdens on the applicant.

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 section 1411(c)(3) of the ACA, data from the IRS is required to be used to determine if income is inconsistent. Exchanges on the Federal Platform do not use any other data sources for the purpose of generating income DMIs because there are currently no reliable and accurate income data sources legally available to such Exchanges that would provide quality data for this purpose. For Exchanges using the Federal platform, income data from other electronic data sources will continue to be used to verify income to avoid setting an income DMI 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.

However, we clarify that under § 155.315(h), State Exchanges are granted flexibility to modify the methods used for income collection and verification, subject to HHS' approval, which can include the use of alternative data sources. And, per § 155.320(c)(3)(vi), these HHS approved electronic data sources must be used, where available, in instances where IRS income data is unavailable or inconsistent. Accordingly, upon approval from HHS, State Exchanges may use alternative electronic data sources to generate income DMIs when IRS is unable to return data or if the projected household annual income is more than a reasonable threshold less than the income amount returned for the household by the alternative electronic data source. In order for the alternative electronic data to be used to generate an income DMI, the alternative electronic data source must maintain the same accuracy of the IRS data in providing an income data for verification by returning income data for all members of the household who have attested to earning income. If IRS is successfully contacted for a household but does not return data, and the alternative electronic data source does not provide full income data for the household, then the State Exchange must accept the applicant's or enrollee's attestation of projected annual household income.

Lastly, we proposed to revise § 155.315 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 their household income DMI. 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 section 1411(c)(4)(B) of the ACA to modify methods for verification of the information where we determine such modifications will 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 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 previously, which requires contact from the Exchange and additional document submission, often pushing the verification timeline past 90 days. An additional 60 days would allow consumers more time to gather multiple documents from multiple sources, and would allow time for back and forth review with the Exchange. The majority of households with income DMIs are comprised of consumers who are low income and 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.

While we recognize that it raises program integrity concerns to provide APTC for an additional 60 days to consumers who may ultimately be ineligible, we believe that these concerns are outweighed by the benefits of improved health care access and health equity, a stronger risk pool, and operational efficiency. The proposed extension would provide many consumers who are eligible for APTC with the necessary time to gather and submit sufficient documentation to verify their eligibility. 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

[231] 42 U.S.C. 18081.

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, take into consideration the complicated process of obtaining and submitting income documents for these households, and provide more opportunity for Exchanges to work with consumers to submit the correct documentation to verify their projected annual household income. We believe that this extension would provide consumers with these benefits because previous extensions enabled us to determine eligibility for more consumers who, after verifying their eligibility through the DMI process, were determined eligible for financial assistance. We continue to study consumer behavior in resolving inconsistencies to continue to support accurate eligibility determination.

We have found that income DMIs have a negative impact on access and health equity. Upon a review of PY 2022 data, income DMIs disproportionately impacted households with lower attested household income. Among households with an income DMI in PY 2022, approximately 60 percent attested to a household income of less than $25,000. In households without an income DMI, 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. The proposed changes would promote access to more affordable coverage by continuing APTC for many eligible consumers.

Consumers' challenges in submitting documentation to resolve 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 have 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.

Given the information we have on the negative and disproportionate impacts of income DMIs, we proposed to adjust the household income verification requirements to treat consumers more equitably, help ensure continuous coverage, and strengthen the risk pool. Exchanges would utilize only data from the IRS for the purpose of generating an income DMI, except for State Exchanges that are approved to utilize additional data sources as outlined earlier in this proposal, and Exchanges 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 DMI generation and adjudication 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 accurate answers to application questions under penalty of perjury. We note that the program integrity risk applies to a limited group of consumers, namely those who misreport income and for whom IRS indicates that they have no income data after being contacted by HHS. Also, we do not believe that individuals for whom IRS cannot return income data 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. We will continue to engage with partners to evaluate the impact of this proposal on the amount of APTC a household receives compared to the amount of PTC the household is eligible for when filing taxes.

After reviewing the public comments, we are finalizing these provisions as proposed. We summarize and respond below to public comments received on the proposed policies to accept household income 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 and to provide an automatic 60-day extension for income DMIs.

Comment: Multiple commenters requested clarification on the usage of State data sources to resolve income inconsistencies, noting a desire to continue using those sources for that purpose.

Response: We agree that State Exchanges can continue to use the data sources that they currently use to verify income, and we have provided additional information in the preamble to explain when and how State Exchanges may use alternative data sources. Exchanges may only continue to use income data from other electronic data sources to verify income if income is not already verified by the IRS, or if IRS data is inconsistent with the projected annual household income, unless flexibility is granted and approved by HHS under § 155.315(h). This includes income sources that are available to State Exchanges that may not be available to other Exchanges, such as information maintained by State tax franchise boards or public benefit records.

Comment: Multiple commenters expressed program integrity concerns, as well as tax liability concerns for consumers, particularly for consumers who miscalculate their income.

Response: While data suggests that consumers have a high degree of ability to project their income and *HealthCare.gov* has made recent changes to further assist individuals in determining their projected income, we will continue to engage with State Exchanges, consumer advocates, and other external interested parties on how to increase the accuracy of consumer income attestation and subsequent APTC determination. Anticipated updates to promote program integrity include strengthening accurate income attestation and tax reconciliation language in existing consumer-facing materials. Although the program integrity risk applies to a limited group of consumers, namely those who misreport income and for whom IRS indicates that they have no income data after being contacted by HHS, we acknowledge the commenter's concerns on program integrity. It is our belief that the health care accessibility, health equity, risk pool, and operational efficiency benefits outlined in the preamble outweigh these concerns. Additionally, households are required to provide true answers to application questions under penalty of perjury.

Comment: Some commenters suggested asking the applicant for additional information on why an applicant projects their income a certain way, including why it has changed over time.

Response: We currently ask consumers for additional information in the application, such as the specific reason why their income may have changed with the opportunity to provide responses from a pull-down menu, including an option for additional information, and we use that information as part of our verification of a household's projected income. We have found that while sometimes the information provided is sufficient to verify household projected income, it often does not help thoroughly explain consumers' complicated income streams and household changes. Additionally, an applicant or enrollee may not know, and therefore may not be able to explain why a DMI is caused by a tax household composition change (such as birth, marriage, and divorce), name change, or other demographic updates or mismatch.

Comment: Multiple commenters stated that the 60-day extension was not necessary for all consumers and would slow down and burden the administrative process, and that the existing 90 days is sufficient. Some commenters proposed that we instead offer the 60-day extension on a case-by-case basis.

Response: We do not believe that 90 days is sufficient for many applicants. Applicants and enrollees often need to submit multiple documents to verify their projected household income, which is often difficult to do within 90 days, particularly for those in seasonal work or who are self-employed. When given extra time (as currently may be provided on a case-by-case basis under § 155.315(f)(3)), over one third of consumers resolve their income DMIs after 90 days, demonstrating that many consumers are able to provide the required information when they are given sufficient time to do so. Finally, the 90-day extension adjustment would likely not burden the administrative process as the additional time could facilitate more DMI resolutions, potentially leading to fewer appeals related to the adjustment or removal of financial assistance.

Comment: One commenter mentioned concerns about implementing the 60-day extension and requested flexibility on the implementation timeline for State Exchanges.

Response: While we acknowledge that this change will require implementation effort from the State Exchanges, we have decided not to provide flexibility on the implementation timeline for State Exchanges. As stated in the preamble, 90 days is often an insufficient amount of time for households to collect and submit documents to successfully verify their projected household income, and consumers who lose eligibility for financial assistance as a result of a failed income verification often drop coverage. We believe that this provision must be implemented in all Exchanges to account for the complicated process of submitting documentation. However, we will be available to conduct technical assistance to State Exchanges experiencing difficulty in implementing the extension.

Comment: One commenter noted that the existing income verification process is sufficient and that the existing document submission process is a small burden on consumers.

Response: We do not believe that the current income verification process is sufficient due to the negative impacts on health care access, health equity, the risk pool, and operational efficiency. Additionally, the existing document submission process is burdensome on consumers and time consuming, as they often have to obtain and submit multiple documents before their income inconsistency is resolved, particularly if they are self-employed or work seasonal jobs.

6. Annual Eligibility Redetermination (§ 155.335)

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78259), we proposed revising § 155.335(j) to allow the Exchange, beginning in PY 2024, to direct re-enrollment for enrollees who are eligible for CSRs 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, if certain conditions are met (referred to here as the ''bronze to silver crosswalk policy''). We also proposed to amend the Exchange re-enrollment hierarchy to require all Exchanges (Exchanges on the Federal platform and State Exchanges) 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.

After reviewing public comments, we are finalizing these proposals with modifications. Specifically, we are amending the proposed regulations to clarify that Exchanges implementing the bronze to silver crosswalk policy will compare net monthly silver plan premiums for the future year with net monthly bronze plan premiums for the future year, as opposed to net monthly bronze plan premiums for the current year (where net monthly premium is the enrollee's responsible amount after applying APTC). For example, when determining whether to automatically re-enroll a 2023 bronze plan enrollee who is CSR-eligible into a silver plan for 2024, an Exchange will compare the net premium the enrollee would pay for the silver plan in 2024 with the net premium that they would pay for the bronze plan into which they would otherwise be auto re-enrolled in 2024, as opposed to the net premium the enrollee paid for their bronze plan in 2023. This clarification ensures that Exchanges will make auto re-enrollment determinations based on comparable premium information.

Additionally, we changed the structure and some content of the regulation to simplify the regulatory text and to more clearly explain that enrollees whose QHP is no longer available as described in paragraphs (j)(1) and (2) must be enrolled in a plan that has the most similar network compared to their current plan, whereas enrollees subject to the bronze to silver crosswalk policy under paragraph (j)(4) must be enrolled in a plan with the same network as the bronze plan they would have been auto re-enrolled in per requirements in paragraph (j)(1) or (2). We made these changes in part based on public comments indicating confusion about when an enrollee's issuer, provider network, and covered benefits will change as a result of the bronze to silver crosswalk policy, compared to the policy regarding network continuity for enrollees whose QHP is no longer available.

The restructured regulation language shifts the provisions related to the bronze to silver crosswalk policy into a new paragraph (j)(4) to distinguish this policy from other crosswalk scenarios. We also amended this language to clarify that, under the bronze to silver crosswalk policy, an Exchange may only auto re-enroll a bronze plan enrollee into a silver plan if there is a silver plan within the same product and with the same provider network as the bronze plan into which the enrollee would otherwise have been auto re-enrolled, with a net premium that does not exceed that of the bronze plan. In other words, the bronze to silver crosswalk policy will not result in enrollment into a plan for any enrollee that is in a

different product or that has a different provider network from the one the enrollee would have had absent this bronze to silver crosswalk policy. The restructured language deviates from the proposed rule as follows. Under the proposed rule (87 FR 78260), we proposed to require, with respect to all auto re-enrollments, including those under the bronze to silver crosswalk policy now described in paragraph (j)(4), that the future year silver plan's provider network be ''the most similar network compared to'' an enrollee's *current* bronze plan network because provider networks can change year-to-year within the same plan and product. We are finalizing this proposal only with respect to auto re-enrollments under paragraphs (j)(1) and (2). Specifically, we are finalizing that where an enrollee's plan is no longer available through the Exchange under § 155.335(j)(1)(ii) through (iv) and (j)(2), the Exchange will be required to compare the future year plan's provider network to the current year plan's network and take network similarity into account when auto re-enrolling enrollees whose current plan will no longer be available. However, we are also finalizing under § 155.335(j)(4), that the Exchange is permitted to compare the *future* year silver plan's provider network against the *future* year bronze plan's provider network (as opposed to the current year bronze plan's network as proposed), which is the plan and network that the enrollee would have been auto re-enrolled into absent the bronze to silver crosswalk policy, and the Exchange can select the silver plan only if the networks are identical. For example, a bronze plan enrollee who is auto re-enrolled into the same plan as their current plan will have a similar, but not necessarily identical, network to their current plan because provider networks may change from year-to-year. If crosswalked into a silver plan under the bronze to silver crosswalk policy at § 155.335(j)(4), the enrollee's future year silver plan network would be compared to the network of the future year bronze plan into which they would have been auto re-enrolled absent the policy at paragraph (j)(4), making for a same year comparison.

Accordingly, we are finalizing the policy to require Exchanges to take into account network similarity to current year plan when re-enrolling enrollees whose current year plans are no longer available, and to permit Exchanges to re-enroll enrollees under the bronze to silver crosswalk policy only if the future year silver plan has the same network that the future year bronze plan would have absent the bronze to silver crosswalk policy.

For PY 2024, we will implement both policies in Exchanges on the Federal platform by incorporating plan network ID into the auto re-enrollment process, while continuing to take into account enrollees' current year product.[232] We believe that plan network ID will be an effective method of network comparison for Exchanges on the Federal platform because if specific providers are in-network for some of an issuer's products but not others, the issuer must establish separate network IDs to enable mapping the plans to the applicable network IDs. We will also work closely with issuers and State regulators to ensure a mutual understanding of the information we will collect to facilitate smooth network data submission and review processes during the QHP Certification process. As further discussed in our responses to comments, we will also work with issuers and State regulators to learn how we may improve methods to analyze and ensure network continuity in future years. For example, Exchanges on the Federal platform will rely on issuer submissions through the existing crosswalk process, which, per § 155.335(j)(2), already requires that the issuer propose a plan for the future year that is in the product most similar to the current year product if no plans under the same product as an enrollee's current year QHP are available for renewal.[233] Based on internal analysis, in many cases we already re-enroll consumers in plans for the future year with the same network ID as their current year plan through this approach. However, for plan years starting in 2024, we will incorporate plan network ID into our analysis of crosswalk plan information that we receive from issuers, and permit them to submit justifications to HHS for review if they believe a different network ID in the following plan year has the most similar network to the enrollee's current QHP.[234]

We believe that these changes in the final rule will help distinguish between the enrollment procedures under the bronze to silver crosswalk policy and the procedures for when an enrollee's current QHP is no longer available.

Finally, we also made additional revisions for clarity and readability that do not substantively change the policy. For example, in certain instances we amended passive language to active language to specify that ''the Exchange will'' auto re-enroll current enrollees as opposed to stating that a consumer ''will be auto re-enrolled.'' We also updated rule language to include gender-neutral terms: specifically, changing instances of ''he or she'' to ''the enrollee.''

We summarize and respond below to public comments received on the automatic re-enrollment proposals in § 155.335(j).

Comment: Many commenters supported the bronze to silver crosswalk policy proposal, agreeing that it would help limit CSR forfeiture and increase the likelihood that more consumers would be enrolled in more generous coverage without additional cost. A number of commenters added that low-income consumers would be able to use the money that they saved for other crucial household expenses such as food and housing, and would have improved access to care at the same monthly premium. Commenters added that automatically re-enrolling low-income consumers into more generous plans for the same or lower monthly premium could be especially helpful for individuals and families who do not understand the need to actively re-enroll in coverage for a new plan year, those who find the plan compare and selection process especially burdensome, and those who originally enrolled in coverage prior to availability of more generous subsidies provided for in the American Rescue Plan Act of 2021 (ARP) and extended by the Inflation Reduction Act of 2022 (IRA).[235]

Commenters cited examples of similar auto re-enrollment practices that State Exchanges have implemented successfully, including the Massachusetts Health Connector's auto re-enrollment of about 2,000 enrollees into a silver plan for the 2023 plan year, and Covered California's auto re-enrollment of bronze enrollees with a household income no greater than 150 percent of the FPL into silver QHPs for PY 2022 and PY 2023. One commenter expressed support but suggested that the policy could be limited in its impact for individuals and families with household incomes above 150 percent FPL because of the difference in bronze and silver plans' monthly premiums.

[232] As discussed in the proposed rule (87 FR 78262), in situations where a non-CSR eligible enrollee would not be auto re-enrolled into their current QHP because it is no longer available, the existing auto re-enrollment process places them into a plan with the same product ID as their current QHP, if possible.

[233] *See* § 155.335(j)(2), and *see* ''Plan Crosswalk'' on the QHP Certification Information and Guidance website: *https://www.qhpcertification.cms.gov/s/Plan%20Crosswalk for more information on the Crosswalk Template.*

[234] *See* 87 FR 78261 through 78263.

[235] ARP, Public Law 117–2 (2021); IRA, Public Law 117–169 (2022).

Commenters generally agreed with the policy's prioritization of network and benefit continuity for consumers who are auto re-enrolled in a QHP that is different from their current QHP. One commenter appreciated that the proposal incorporated network into the bronze to silver crosswalk policy specifically because in their experience, enrollees who forgo a $0 net monthly premium silver plan with CSRs in favor of a $0 net monthly premium bronze plan (without the ability to use CSRs) do so in order to access a specific provider when they cannot afford the premiums for the silver plan(s) with networks that include the provider. One commenter asked that we clarify the re-enrollment hierarchy for consumers who are auto re-enrolled in a silver plan with CSRs but become ineligible for CSRs the following year.

Response: We agree that finalizing this proposal will help to ensure that additional enrollees are able to benefit from more generous coverage at a lower cost that provides the same benefits and provider network. We also agree that this may be especially beneficial for those who find the re-enrollment process confusing or who are unaware of the benefits of actively re-enrolling in coverage, though we will continue to help such consumers understand the plan comparison and selection processes. We appreciate evidence from State Exchanges of the success of similar practices, and will work with States to understand the impact of the policy moving forward. Because bronze plan premiums are generally lower than silver plan premiums, we agree with the comment that many enrollees who can benefit from the bronze to silver crosswalk policy under paragraph (j)(4) will be eligible for a silver plan with a $0 net monthly premium because their household income does not exceed 150 percent of FPL.[236] However, some enrollees with a household income greater than 150 percent of FPL may also qualify for a silver plan with a $0 net monthly premium, depending on the premiums of bronze and silver plans available to them, and so we will not limit this policy based on household income. We strongly agree with the importance of ensuring network continuity for re-enrollees as much as possible. The policy at § 155.335(j)(4) clarifies that those who are auto re-enrolled from a bronze to a silver plan will not experience network changes that they would not have experienced had they been auto re-enrolled into a bronze plan.

Finally, in response to the comment requesting clarity on the auto re-enrollment hierarchy for consumers who are auto re-enrolled in a silver plan with CSRs but become ineligible for CSRs the following year, we clarify that Exchanges will not be required to take into consideration when applying auto re-enrollment rules under § 155.335(j) whether an enrollee had previously been re-enrolled under the new rule at § 155.335(j)(4). That is, a CSR-eligible individual who is auto re-enrolled from a bronze to a silver plan for PY 2024 in accordance with paragraph (j)(4) and who does not return to select a plan for PY 2025, will be auto re-enrolled as otherwise provided for under § 155.335(j). However, we also note that we encourage all enrollees to return to the Exchange to update their application if they experience changes during the plan year, and an enrollee in a silver plan with CSRs who updates their application such that they are no longer CSR-eligible may qualify for a SEP to change to a plan that is one metal higher or lower.[237]

Comment: Some opposing commenters voiced concerns that the bronze to silver crosswalk proposal would cause consumer confusion, and they cautioned against interpreting consumer inaction as indifference. In particular, these commenters noted that consumers sometimes research their options and make a decision to allow themselves to be auto re-enrolled, without taking action on *HealthCare.gov.* These commenters also advocated for HHS to improve decision-making tools on *HealthCare.gov* instead of changing consumers' default plan selections. Opposing commenters also noted that consumers select plans for many reasons other than monthly premium amount, including provider network, benefit structure, and health savings account (HSA) eligibility, and raised the concern that auto re-enrolling some consumers from a bronze plan to a silver plan would disregard these consumer priorities.

Some commenters expressed concern that consumers who are auto re-enrolled into a silver plan could incur unexpected tax liability, including consumers aware of their auto re-enrollment, if their APTC amount was determined based on inaccurate household income for the future year, which is a particular risk for hourly workers. One commenter noted that bronze enrollees not using the entire amount of the APTC for which they qualify towards their premiums during the year have some protection against tax liability in the event of an unexpected increase in household income, and that they could lose this protection if an Exchange auto reenrolls them into a silver plan because the consumer would be likely to use more APTC to cover the higher monthly premium.[238] That is, an enrollee who experiences a household increase mid-year that they do not report to the Exchange, which results in eligibility for less PTC, may have a larger tax liability upon tax filing if they apply more APTC to a monthly silver plan premium than to a monthly bronze plan premium to off-set the higher premium.

Some opposing commenters asked that we delay this policy, if implemented, to conduct further research to ensure it honors consumer preferences and to provide interested parties with additional time to develop appropriate consumer messaging. A few commenters raised the concern that auto re-enrolling consumers into an alternate plan when their current plan remains available violates the guaranteed renewability requirements with which issuers must comply, and that the limited exceptions to these requirements do not include availability of a different plan with lower premiums or cost-sharing.

Response: We acknowledge that some consumers may choose not to take action during an open enrollment period with the expectation that they will be auto re-enrolled in their current

[236] Section 9661 of the ARP amended section 36B(b)(3)(A) of the Internal Revenue Code for tax years 2021 and 2022 to decrease the applicable percentages used to calculate the amount of household income a taxpayer is required to contribute to their second lowest cost silver plan, which generally result in increased PTC for PTC-eligible taxpayers. For those with household incomes no greater than 150 percent of the FPL, the new applicable percentage is zero, resulting in availability of one or more available silver-level plans with a net premium of $0, if the lowest or second-lowest cost silver plan covers only EHBs. The Inflation Reduction Act of 2022 extended these changes through tax year 2025.

[237] *See* § 155.420(a)(4)(ii)(B) and (d)(6)(i) and (ii)

[238] For example, assume an individual enrolls in a bronze plan and the enrollee's APTC covers the entire monthly premium for the plan based on projected household income at 150 percent of the FPL. Also assume, based on the enrollee's projected income, that APTC would have covered the entire amount of the enrollee's premium for a silver plan in the same product. If the enrollee's income as a percent of FPL ends up higher than projected, it is possible that the enrollee's benchmark plan premium minus the enrollee's contribution amount (that is, the maximum available premium assistance) would still be more than the bronze premium but less than the relevant silver plan premium. This would result in a tax liability with the silver plan, but not the bronze plan selection, in this case. (Note: ''contribution amount'' means the amount of a taxpayer's household income that the taxpayer would be responsible for paying as their share of premiums each month if they enrolled in the applicable second lowest-cost silver plan. *See* ''Terms You May Need To Know'' in Instructions for Form 8962: *https://www.irs.gov/pub/irs-pdf/i8962.pdf.*)

plan, and we anticipate updating current outreach on *HealthCare.gov* and elsewhere and providing technical assistance to promote understanding of these changes, and encourage State Exchanges to similarly educate their enrollees. Also, as discussed in the proposed rule,[239] income-based CSR-eligible enrollees in Exchanges on the Federal platform who may be auto re-enrolled under the bronze to silver crosswalk policy described in paragraph (j)(4) will 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. These enrollees would also see the silver plan highlighted in the online shopping experience if they return on or before December 15th to review their options.[240] Also, we agree that we should continue to work to improve decision-making tools on *HealthCare.gov;* however, we do not believe that that work is a substitute for auto re-enrolling certain consumers in a plan that will provide them with more generous coverage for a lower or equal premium.

In response to concerns that enrollees subject to the bronze to silver plan crosswalk policy will be auto re-enrolled into a plan with a different benefit structure and provider network, we note that the policy only applies for consumers who have access to a silver plan in their same product with a Network ID that matches that of their future year bronze plan, and therefore consumers will not experience network changes or benefit changes that they would not otherwise experience had they been auto re-enrolled into their bronze plan.

Also, we will perform additional research to ensure that we are able to provide appropriate support and technical assistance to enrollees who may have chosen a plan for its HSA eligibility. We also encourage State Exchanges, agents and brokers, and Assisters to work with these enrollees to ensure they can make informed decisions on this matter.

In terms of potential tax liability for repayment of APTC, we agree that it is important for Exchanges to take steps to ensure enrollees understand this possibility when applying APTC to premium payments in advance. We believe that consumer notices can help to ensure they do, and we already convey this information, because the existing auto re-enrollment process can re-enroll enrollees in a plan with a higher monthly premium than their current year plan due to annual increases in the cost of coverage, which can increase tax liability. For example, the current *HealthCare.gov* notice for consumers who were auto re-enrolled in coverage with financial assistance instructs enrollees to ''Keep your Marketplace application up to date,'' and explains that consumers must report changes in circumstance, including changes in household income, within 30 days to ''help make sure you get the right amount of financial help and don't owe money on your tax return because you got the wrong amount.'' This notice also explains that ''The full amount of tax credit that you qualify for is now being applied to your monthly premium,'' and provides instructions for enrollees who do not want to apply the full amount of APTC for which they qualify to their monthly premium payments.[241] State Exchanges should ensure their notices are similarly educational. These State Exchange notices will be reviewed and approved as part of HHS' annual review of State Exchanges alternative eligibility redetermination plans, as specified in § 155.335(a)(2)(iii).

Additionally, when calculating the difference in net premium between enrollees' bronze and silver plan options for the future year, for the auto re-enrollment process for Exchanges on the Federal platform, we will generally take into account the full amount of APTC for which enrollees may qualify. However, in cases where a consumer opted not to use any of their PTC in advance during the current plan year, in keeping with our existing auto re-enrollment practice for Exchanges on the Federal platform, we will maintain the enrollee's preference not to apply any APTC towards monthly premiums by not taking APTC into account when determining the difference between their monthly bronze and monthly silver premiums for the future year, and not automatically applying APTC to their future year monthly premiums.[242]

We also note that enrollees whose expected household income changes mid-year such that they no longer qualify for APTC or CSRs may be eligible for a SEP that allows them to change to a plan of a different metal level. For example, an enrollee whose household income increases such that they no longer qualify for CSRs can change from a silver plan to a bronze or gold plan, per § 155.420(d)(6)(i) or (ii). We believe that this SEP will help protect enrollees who experience changes in household income during the year from applying APTC in an amount that exceeds the PTC they are ultimately eligible to receive. Nevertheless, we will work closely with interested parties to promote understanding of potential tax liability for enrollees who are auto re-enrolled from a bronze to a silver plan under paragraph (j)(4). We will also work closely with State Exchanges that implement this policy to share best practices for doing so.

Given the benefits that this policy will provide to consumers who are enrolled in more generous coverage for no greater cost, we will not delay its effectuation. We will work closely with all interested parties to promote smooth implementation and mitigate consumer confusion.

Finally, as discussed in the proposed rule (87 FR 78262 through 78263), this proposal is consistent with the explanation of the guaranteed renewability provisions at § 147.106 provided 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.[243] 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 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

[239] See 87 FR 78262.

[240] Enrollees who return to their *HealthCare.gov* account after December 15 will see the plan as their enrolled plan, and could choose a different plan until January 15 for coverage starting February 1.

[241] See Marketplace Automatic Enrollment Confirmation Messages (December 2022); automatic-enrollment-with-financial-help.pdf, at *https://marketplace.cms.gov/applications-and-forms/notices.*

[242] This operational practice is not an Exchange requirement. We share this information here as an example of how we plan to implement this policy to reflect enrollees' likely intentions. We also note that in cases where an enrollee who is auto re-enrolled opted to apply some, but not all, of their APTC toward monthly premiums during the current year, our current practice is to apply any additional APTC for which the enrollee qualifies to cover as much of the future year monthly premium as possible. We will continue this practice, including for enrollees who qualify for the bronze to silver crosswalk.

[243] See 87 FR 78262–78263 for this discussion.

under a product offered by the same QHP issuer through the Exchange that is different than the enrollee's current plan. Auto re-enrolling consumers under § 155.335(j)(4) will not result in the issuer violating the guaranteed renewability provisions at § 147.106 as long as the issuer gives the enrollee the option to renew coverage within their current product, including permitting the enrollee to actively re-enroll in their current year plan for the coming year if it remains available for renewal.

Comment: Some commenters supported the proposal to give States that operate their own Exchange platforms flexibility with whether to implement the policy described in final paragraph (j)(4), and requested confirmation that the final policy would provide such flexibility.

Response: We confirm that, as proposed, Exchanges have the option to implement the policy at § 155.335(j)(4). For example, an Exchange might choose not to implement this policy, or might choose to implement it for PY 2025 or a future plan year, instead of PY 2024. However, the rule requires all Exchanges to implement changes to the requirements under paragraphs (j)(1) and (2) for PY 2024.[244] We will work closely with Exchanges that request any related technical assistance regarding implementation of the auto re-enrollment hierarchy.

Additionally, we clarify that State regulatory authorities and Exchanges have the option to apply the bronze to silver crosswalk policy per § 155.335(j)(4) to the approach that they use for cross-issuer enrollments per § 155.335(j)(3)(i) and (ii). As noted in ''Section 5. Plan ID Crosswalk'' of Chapter 1 of the PY 2024 Draft Letter to Issuers, if this policy was finalized, we would modify the 2024 cross-issuer auto re-enrollment policy to take into account the other changes at § 155.335(j).[245] Specifically, in Exchanges on the Federal platform, when § 155.335(j)(3)(ii) is applicable, we will crosswalk enrollees in a bronze plan who are eligible for CSR in accordance with § 155.305(g), and who would otherwise be auto re-enrolled in a bronze plan, to a silver level QHP within the same product, with the same provider network, and with a net premium lower than or equivalent to that of the bronze level QHP into which the Exchange would otherwise re-enroll the enrollee under paragraph (j)(3). When § 155.335(j)(3)(i) is applicable, we will defer to the applicable State regulatory authority with regard to whether to incorporate the bronze to silver crosswalk policy into cross-issuer auto re-enrollment.

Comment: Some commenters supported using network ID to determine the most similar network for purposes of auto re-enrolling consumers, and one commenter noted that the Washington State Exchange already uses the network ID as a consideration when cross-walking enrollees from one plan to another. Several commenters urged that we work closely with States to better understand how networks differ based on ID, because States may use different practices for the assignment of network IDs. These commenters expressed concerns that overriding an enrollee's prior choice of plan level may create disruptions when networks are similar but not identical, and they asked that we be transparent in the reasons behind auto re-enrolling a consumer into a particular plan.

One commenter had concerns with using network ID as part of the plan crosswalk process because issuers are not required to use a distinct ID for each health maintenance organization (HMO), preferred provider organization (PPO), and exclusive provider organization (EPO) network type, which would make such comparisons incomplete, and added that network IDs would not fully explain potential differences in delivery systems or providers offered within the same issuer's products. Several commenters shared the concerns about preserving plan benefit structure for consumers who are not auto re-enrolled into their current plan. One commenter stated they supported the proposed policy only if enrollees were not moved to a different product.

Response: We appreciate the additional insight that commenters provided about how States and issuers currently use network IDs. Also, we note that, all changes to § 155.335(j) require Exchanges to continue to account for characteristics of enrollees' current product. As noted earlier, Exchanges on the Federal platform will implement the similar network policy and the bronze to silver crosswalk policy by incorporating network ID into existing requirements for issuer submissions through the crosswalk process, which, per existing rules at § 155.335(j)(2), already requires that if no plans under the same product as an enrollee's current QHP are available for renewal, the Exchange will auto re-enroll the enrollee in the product most similar to their current product with the same issuer.[246] As noted earlier in preamble for this section, we believe that plan network ID will be an effective method of network comparison for Exchanges on the Federal platform because QHP Certification Instructions specify that if specific providers are available for some of an issuer's products but not others, the issuer must establish separate Network IDs to enable mapping the plans to the applicable Network IDs. However, reiterating what we stated in the proposed rule, we will permit issuers to submit justifications for our review if they believe a different network ID in the following plan year is better suited as a crosswalk option for enrollees in a particular plan.[247] Further, we will collaborate with State regulators in States with FFEs and with SBE–FPs through regularly scheduled meetings and other methods to ensure clear and appropriate incorporation of network ID into the auto re-enrollment process. We will also work closely with State Exchanges to share best practices for implementing this policy. Finally, based on experience from past years, a majority of enrollees who were crosswalked into a different product with the same issuer had the same network ID and product type (for example, HMO, PPO), and so we anticipate that this policy will reinforce and not disrupt current auto re-enrollment processes.[248]

Comment: Some commenters raised concerns about how consumers who are auto re-enrolled from a bronze to a silver plan under paragraph (j)(4) would be notified by the Exchange and issuers. Commenters urged that we ensure that, if finalized, the new auto re-enrollment rule would require Exchanges and issuers to send notification of the plan change in time for consumers to make a plan selection if they choose, and that the notification include information about key characteristics of their new plan and the reasons they were auto re-enrolled into it. Some commenters raised concerns that consumers would be confused by content in the Federal Standard Renewal and Product Discontinuation Notices, which are required to include information about availability of the product in which a consumer is currently enrolled and could not include targeted information

[244] See § 155.335(j)(1)(ii) through (iv) and (j)(2).

[245] See *https://www.cms.gov/files/document/2024-draft-letter-issuers-508.pdf.*

[246] See § 155.335(j)(2), and *see* ''Plan Crosswalk'' on the QHP Certification Information and Guidance website: *https://www.qhpcertification.cms.gov/s/Plan%20Crosswalk* for more information on the Crosswalk Template.

[247] See 87 FR 78261 through 78263.

[248] Based on internal CMS analysis, for PY2023 86 percent of crosswalks to a different product with the same issuer had the same network ID and the same network type (that is, HMO, PPO, EPO).

about potential auto re-enrollment from bronze into a silver plan because issuers do not have access to enrollees' CSR eligibility.[249] One commenter asked whether issuers would be allowed more flexibility in terms of the content or the timing for mailing the Federal Standard Renewal and Product Discontinuation Notices to account for proposed re-enrollment changes. Multiple commenters asked that we provide consumers who are auto re-enrolled from a bronze to a silver plan under paragraph (j)(4) with a SEP to allow them time after their coverage takes effect to change plans if they find that the plan's network does not include a provider that they need or the coverage does not work well for them in some other way.

Response: As discussed in this rule and in the proposed rule,[250] income-based CSR-eligible enrollees in Exchanges on the Federal platform who may be auto re-enrolled from a bronze to a silver plan under paragraph (j)(4) will receive messaging 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 that they can see the silver plan highlighted in the online shopping experience on *HealthCare.gov* until December 15th. Further, enrollees in Exchanges on the Federal platform who do not make an active selection on or before December 15th will receive an additional communication from the Exchange after December 15th reminding them of their new plan enrollment for January 1st, and that they can select a different plan by January 15th that would be effective starting February 1st. We believe that State Exchanges also have practices in place to notify consumers of important changes to their enrollment, and that State Exchanges' flexibility in terms of whether or not to implement the bronze to silver crosswalk policy, or to implement it in a future plan year, allows State Exchanges additional time to further develop consumer noticing timing and content in advance of implementation.

In response to comments on the Federal Standard Renewal and Product Discontinuation Notices, we note that issuers are required to use the Federal standard notices developed by HHS, unless a State develops and requires the use of a different form consistent with HHS guidance, in which case issuers in that State are required to use notices in the form and manner specified by the State. Because issuers are not permitted to make modifications to the Federal standard notices, we do not believe it is necessary to provide additional flexibility regarding timing of the notices.[251] We are updating the Federal standard notices currently approved under OMB control number 0938–1254 (Annual Eligibility Redetermination, Product Discontinuation and Renewal Notices) and we intend to include language related to the re-enrollment hierarchy finalized in this rule in the Federal standard notices as part of that process.

In addition, nothing under Federal law prevents an issuer from providing additional information, outside of the standard notices, to an enrollee about their re-enrollment options. Also, we will work closely with issuers in Exchanges on the Federal platform to coordinate and develop strategies to mitigate potential consumer confusion. We will also work with State Exchanges that choose to implement the bronze to silver crosswalk policy in plan year 2024 or in future years to share information on best practices to help ensure smooth transitions for impacted consumers.

Finally, as discussed in the proposed rule,[252] we did not propose, and therefore are not finalizing, any changes to SEP eligibility or duration in connection with the proposed changes at § 155.335(j). As the proposed rule[253] also explained, enrollees qualify for a loss of MEC SEP under § 155.420(d)(1)(i) when their current product is no longer available for renewal, but not when their current product is still available, even if they are auto re-enrolled from a bronze QHP to a silver QHP within the same product. Therefore, enrollees who are auto re-enrolled under § 155.335(j)(2), which applies when an enrollee's product is no longer available, may qualify for a loss of MEC SEP, but enrollees auto re-enrolled under § 155.335(j)(1) or (4) will not. Finally, while we agree that a SEP plays an important role in ensuring that consumers with a change in circumstance can update their coverage accordingly, we do not believe that a SEP is necessary in this case because consumers who are auto re-enrolled into a silver plan will have the same network as if they had instead been auto re-enrolled into a bronze plan absent the bronze to silver crosswalk policy. Further, notifications before and after auto re-enrollment provide them with the information that they need to choose a different plan during open enrollment if desired.

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78263–78264), HHS requested information on potential future changes to the auto re-enrollment hierarchy. We thank commenters for their feedback and will take comments into consideration in future rulemaking.

7. Special Enrollment Periods (§ 155.420)

a. Use of Special Enrollment Periods by Enrollees

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78264), we proposed 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 clarified that only one person in a tax household applying for coverage or financial assistance through the Exchange must qualify for a SEP under paragraphs (d)(6)(i) and (ii) for the entire household to qualify for the SEP.

After reviewing the public comments, we are finalizing this provision as proposed, with a modification to use gender neutral language. We also note a correction, that any member of a household, rather than any member of a *tax* household as previously stated in preamble, can trigger this SEP for the household. We summarize and respond to public comments received on the proposed technical corrections below.

Comment: All commenters strongly supported the proposed technical corrections. Commenters noted that this change supports the inclusion of households with different family structures and/or access to affordable insurance options, which is especially important for consumers moving from Medicaid or CHIP to Exchange coverage. Commenters also stated that the proposal will reduce administrative burden and potential confusion for households applying for coverage or financial assistance with a SEP. One

[249] See Updated Federal Standard Renewal and Product Discontinuation Notices in the Individual Market (Required For Notices Provided In Connection With Coverage Beginning In The 2021 Plan Year) OMB Control No.: 0938–1254, *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updated-Federal-Standard-Notices-for-coverage-beginning-in-the-2021-plan-year.pdf.*

[250] See 87 FR 78262.

[251] Non-grandfathered, non-transitional plans must provide renewal notices before the first day of the next annual open enrollment period. In prior years, HHS has provided an enforcement safe harbor under which the agency will not take enforcement action against an issuer for failing to provide a product discontinuation notice with respect to individual market coverage at least 90 days prior to the discontinuation, as long as the issuer provides such notice consistent with the timeframes applicable to renewal notices. We anticipate providing similar relief for PY 2024.

[252] See 87 FR 78263.

[253] 87 FR 78263.

commenter also asked that we clarify that any member of a household, rather than any member of a tax household as stated in preamble to the proposed rule (87 FR 78264 through 78265), must qualify for a SEP under paragraphs (d)(6)(i) and (ii) for the entire household to qualify for the SEP.

Response: We agree that the proposed technical corrections support different types of household compositions and that it will reduce both administrative burden and confusion for consumers, which is especially important during Medicaid unwinding. We also wish to clarify that any member of a household (as opposed to a tax household) must qualify for a SEP under paragraphs (d)(6)(i) and (ii) for the entire household to qualify for the SEP.

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

We proposed 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 under paragraph (d)(1), and also the SEPs at paragraphs (d)(6)(iii) and (d)(15), as the eligibility for these SEPs also require that the loss of coverage be considered 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 were 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 under the loss of MEC SEP is the first day of the month following the date of loss of MEC. We were aware in the proposed rule (87 FR 78265) that in some States, Medicaid or CHIP is regularly terminated mid-month, so we solicited input on whether the proposed change would help consumers, especially those impacted by Medicaid 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 SEP under § 155.420(d)(1), (d)(6)(iii), and (d)(15) 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 SEP 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), 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, under § 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 2 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) [254] 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)(iv). 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. This option has been selected for Exchanges on the Federal platform. *See* § 155.420(b)(3)(i).

Because current regulation at § 155.420(b)(2)(iv) does not allow for retroactive or mid-month coverage effective dates, consumers who lose MEC mid-month, including consumers who live in States that allow mid-month terminations of Medicaid or CHIP coverage, may experience a gap in coverage when transitioning to coverage through the Exchange. During Medicaid unwinding, we expect to see a higher than usual volume of individuals transitioning from Medicaid and CHIP coverage to the Exchange from April 1, 2023, through May 31, 2024, as States resume Medicaid and CHIP terminations that have been paused due to the Medicaid continuous enrollment condition. Consumers who become ineligible for Medicaid or CHIP 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 their prior coverage to Exchange coverage as quickly as possible with no coverage gaps, we proposed revisions to paragraph (b)(2)(iv). Specifically, we proposed to add additional language to paragraph (b)(2)(iv) stating 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 first 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 day 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 loss of MEC), or at the option of the Exchange, on July 1st (the first day of the month in which the triggering event occurs).

We acknowledged in the proposed rule (87 FR 78265 through 78266) that this proposed change may have a limited impact because many types of coverage typically do not 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

[254] 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.

proactive and attested to a coverage loss as soon as they became aware. We noted in the proposed rule (87 FR 78265 through 78266) that we did not believe that this proposed change introduces program integrity concerns because these concerns would apply to only a very narrow group of consumers, specifically: those who report a future loss of MEC within their 60-day reporting window, have been determined eligible for a SEP and found eligible for an Exchange QHP, and select a plan on or before the last day of the month preceding the loss of MEC.

We stated in the proposed rule (87 FR 78266) that we believed this proposal would provide additional flexibilities for Exchanges, as Exchanges would have the option to use the current coverage effective dates available under current paragraph (b)(2)(iv) and provide earlier coverage effective dates for consumers who attest to a future mid-month loss of MEC. We also acknowledged that if Exchanges do elect an earlier coverage effective date as we proposed, this would result in some consumers paying for both an Exchange QHP and their other MEC for a short period of dual enrollment.

We also stated in the proposed rule that the partial-month period of dual enrollment would not bar an enrollee from eligibility for APTC or CSRs, if otherwise eligible, because PTC would be allowed for such month under 26 CFR 1.36B–3(a).[255] Under this provision, PTC is the sum of the premium assistance amounts for each coverage month, and a month in which an individual is eligible for MEC for only a portion of the month may be a coverage month for the individual. We sought comment on whether Exchange regulations at § 155.305(f) should be revised to reference the IRS's definition of a coverage month to clarify that a consumer who is eligible and enrolled in non-Exchange MEC for only a portion of the month is not prohibited from receiving APTC.

We also stated in the proposed rule (87 FR 78266) that we believed consumers in States that permit mid-month terminations of Medicaid or CHIP coverage would be most impacted by the proposed change. We sought comment from interested parties on the frequency of mid-month coverage end dates, potential program integrity issues associated with earlier effective dates, and 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 enrollment periods and SEPs described in § 147.104(b)(2) and (3) must become effective consistent with the dates described in § 155.420(b).[256] Therefore, with the exception of the triggering event in § 155.420(d)(6), which is limited to coverage purchased through an Exchange, the 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. For individual market coverage offered outside of an Exchange, the proposed option of the Exchange to specify the effective date would refer to an option of the applicable State authority.

While we also considered proposing retroactive coverage effective dates for consumers reporting past loss of MEC, we decided in the proposed rule (87 FR 78266) 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 noted that we believed 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 limited the affordability of coverage given that IRS regulations at 26 CFR 1.36B–3 generally provide that PTC is only allowed for a month when, as of the first day of the month, the individual is enrolled in a QHP. We sought 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 sought comment on these proposals.

After reviewing the public comments, we are finalizing this provision as proposed, with a modification to section § 155.305(f)(1)(ii)(B) to state that a tax filer must be determined eligible for APTC if the tax filer (or a member of their tax household) is not eligible for a full calendar month of MEC (and other criteria are met). We summarize and respond to public comments received on the proposed policy to permit Exchanges the option to provide earlier coverage effective dates for consumers attesting to a future loss of coverage below.

Comment: The majority of commenters expressed their support for the proposal, explaining that the proposal would help ensure consumers, especially those with HIV or cancer, continue to have access to medical care without interruption. Commenters stated that the proposal would help consumers maintain adherence to treatment, including access to certain prescription drugs, which are a critical component of most cancer treatment plans. Several commenters also explained that it is important to align Exchange QHP coverage effective dates with Medicaid or CHIP termination dates, and that the immediate enactment of the proposal is especially important as it will help with coverage transitions from Medicaid or CHIP into other forms of coverage, such as Exchange coverage, during the Medicaid unwinding period. Other commenters said that they supported the flexibility provided to the State Exchanges to implement this proposal and urged HHS to keep this proposal at the option of Exchanges.

Response: We agree that this proposal will have a positive impact by preventing some consumers losing MEC from experiencing gaps in coverage or an inability to access treatment or prescription drugs. We agree with the commenter of the importance of aligning Medicaid or CHIP coverage mid-month terminations with Exchange QHP effective dates; however, we wish to clarify that the intent of this policy is not to align Exchange coverage effective dates with Medicaid of CHIP mid-month terminations, but rather to provide consumers reporting a future loss of MEC with earlier coverage effective dates to ensure continuity of coverage. We also agree that the proposal will help further ensure during Medicaid unwinding that consumers transitioning from Medicaid or CHIP into individual coverage on or off the Exchange are able to maintain continuity of coverage. Finally, we agree that State Exchanges should have flexibility to implement the proposed changes or not, based on their specific enrolled populations.

Comment: Some commenters supported the proposal, but had various

[255] Under section 1412(c)(2) of the ACA, APTC cannot be paid for a month if PTC is not allowed for such month under the Code section 36B.

[256] With the exception that, under § 147.104(b)(2), a health insurance issuer in the individual market is not required to allow enrollment for certain SEPs, including § 155.420(d)(6), with respect to coverage offered outside of an Exchange.

concerns and recommendations for HHS regarding coverage effective dates and adverse selection. One commenter urged HHS to make this proposal mandatory for all Exchanges, while another commenter recommended that HHS modify the proposal so that Exchanges give the consumer the option to choose an earlier or later Exchange coverage effective date to mitigate any complexities related to overlapping coverage. Also due to adverse selection risk, some commenters recommended that HHS should finalize this policy only in States that allow mid-month terminations of Medicaid or CHIP coverage or put into place guardrails for when consumers can select these coverage effective dates in cases of retroactive enrollments. One commenter supported the policy but shared a concern that the proposal may still result in continuity of care issues and that HHS should allow coverage effective dates to be closer to the loss of MEC date, such as through mid-month coverage effective dates. A few commenters also said that HHS should not make any changes to allow mid-month or retroactive coverage effective dates due to adverse selection risks.

Response: We appreciate the concerns raised by commenters regarding the proposed changes. We considered making this proposal required for all Exchanges, however, we believe that Exchanges should continue to have flexibility and authority to determine if allowing earlier coverage effective dates would benefit their enrolled populations. If an Exchange operates in a State that allows mid-month terminations of Medicaid or CHIP coverage, that Exchange may want to allow earlier coverage effective dates for consumers attesting to a future loss of MEC, whereas this change may not be necessary for an Exchange that operates in a State that does not allow mid-month terminations of Medicaid or CHIP. We rejected the idea to implement this policy only in States that allow mid-month terminations of Medicaid or CHIP because, due to the demands that both Exchanges and States will face during Medicaid unwinding, we believe that States should have the option whether or not to devote resources to implement earlier coverage effective dates for consumers attesting to a future loss of coverage in PY 2023 or 2024. Additionally, we wish to note that there is still the possibility that consumers lose non-Medicaid or CHIP coverage mid-month, such as COBRA coverage. Therefore, limiting this policy only to States that have mid-month Medicaid or CHIP termination dates would be too restrictive.

We also considered whether consumers should be able to select their own coverage effective dates when selecting a plan but determined this would be operationally complex for Exchanges and issuers to implement. Exchanges would have to implement application and logic changes to permit consumers to select their own coverage effective date through new application questions, as well as a way for consumers to reverse their decision in cases of error. Nonetheless, we are preserving in the final rule some element of consumer choice, as a consumer who knows they will be losing MEC in the future still has the option to select a plan after the last day of the month preceding the triggering event to be subject to the existing coverage effective date rules.

We also took into consideration operational complexities for both Exchanges and issuers of allowing coverage to start retroactively. Retroactive coverage would also require application and logic changes, and could impact QHP pricing across all Exchanges. Given these considerations and the complexities around offering retroactivity, we are not finalizing any changes to allow retroactivity for the loss of MEC SEP.

Regarding the comment that we allow QHP coverage to start as close as possible to the last day of coverage, we currently lack the authority to permit APTC and CSRs to start mid-month and elected not to allow consumers to enroll in a QHP mid-month if they could not be eligible for APTC or CSRs. IRS regulation at 26 CFR 1.36B–3(c) provides that a consumer may only qualify for PTC during a given month if they are enrolled in QHP ''as of the first day of the month'' (providing an exception only for births and adoptions, and certain other circumstances at 26 CFR 1.36B 3(c)(2)). If we were to begin QHP coverage mid-month without APTC and CSR, enrolling in Exchange coverage might be cost prohibitive for some consumers which may dissuade them from enrolling in Exchange coverage at all. Additionally, in the Exchanges on the Federal platform, a consumer who did enroll in a QHP (without APTC or CSRs) mid-month would need to update their Exchange application after the beginning of the month following their loss of MEC to be determined eligible for APTC and CSRs going forward (if otherwise eligible). This process would be difficult to message and burdensome for consumers.

Finally, we acknowledge the concerns raised by commenters regarding the potential risk for adverse selection, however, we believe the risk to be low because we are not proposing that coverage may start retroactively or that consumers have the option to select their preferred coverage start date. Given these concerns and our belief that Exchanges should retain flexibility in whether to offer the option for earlier coverage effective dates for consumers attesting to a future coverage loss, we are finalizing as proposed.

Comment: A commenter supported the proposal but stated that the proposed policy only provides seamless coverage transitions for consumers who proactively come to an Exchange to report their future loss of Medicaid or CHIP the month before their termination. The commenter requested that we consider additional improvements to notices to ensure that Medicaid and CHIP beneficiaries receive clear instructions about coverage transitions.

Response: We agree with the need for clear and effective communications with Medicaid and CHIP beneficiaries and wish to share some of the work we have done. In partnership with States and other interested parties, we have developed toolkits and strategies that States can implement to support Medicaid unwinding activities to inform consumers about renewing their coverage and exploring other available health insurance options if they no longer qualify for Medicaid or CHIP. The resources emphasize the need for consumers to act quickly to enroll in Exchange coverage so they are able to minimize gaps in coverage, where possible.[257]

Comment: One commenter supported the proposal, but also requested that HHS maintain the existing special enrollment flexibilities that were introduced after COVID–19 was declared a PHE by the President on March 13, 2020, including the Exceptional Circumstances SEP for consumers who lost qualifying health coverage on or after January 1, 2020, but missed their 60-day window after their loss of coverage to enroll in an Exchange plan due to the COVID–19 PHE. Other commenters supported the proposal and HHS' recent announcement of the Unwinding SEP,[258] which temporarily

[257] More information about these efforts is available at *https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/ffm-transfer-message-lc-presentation-deck.pdf.*

[258] See CMS. (2023, January 27). *Temporary Special Enrollment Period (SEP) for Consumers*

Continued

provides more time for consumers to report losing Medicaid or CHIP coverage during Medicaid unwinding, but recommended HHS also require this Unwinding SEP for issuers offering plans in the individual and group health insurance markets off-Exchange.

Response: In 2018, we clarified through guidance that an Exceptional Circumstances SEP pursuant to 45 CFR 155.420(d)(9) is available for individuals seeking coverage on Exchanges on the Federal platform and who were prevented from enrolling in Exchange coverage during another SEP or during an Open Enrollment period (OEP) by an event that Federal Emergency Management Agency (FEMA) declared a national emergency or major disaster (FEMA SEP).[259] This guidance also clarified that we would make a FEMA SEP available for only 60 days after the date in which a national emergency or major disaster officially ends.[260] Given the recent end of the COVID national emergency on April 10, 2023, the current SEP flexibilities due to the COVID–19 FEMA national emergency will only be in place until June 9, 2023.

We appreciate the recommendation that the Unwinding SEP be available off-Exchange. However, as specified in 45 CFR 147.104(b)(2)(i)(D), issuers in the individual market off-Exchange are not required to provide Exceptional Circumstances SEPs under § 155.420(d)(9).[261] In addition, the Exceptional Circumstances SEP does not extend to issuers offering group health insurance coverage outside of the Exchange.[262] As such, issuers in the individual and group market off-Exchange are not required to offer an Exceptional Circumstances SEP to help with coverage transitions due to Medicaid unwinding. Finally, while the Unwinding SEP does not apply to issuers in the individual and group health markets off-Exchange, employers may still work with their plan or issuer to extend the SEP available to consumers losing Medicaid or CHIP for those who need to enroll in employer sponsored coverage after the end of the 60-day loss of MEC SEP available under applicable law.

Comment: A few commenters neither fully supported or opposed the proposed policy but provided some considerations for HHS, specifically that the proposal could result in consumers enrolling in a new plan earlier than they intended to or were aware of. Commenters also recommended that HHS consider whether it could result in confusion or misunderstandings among consumers as to when coverage would begin, which could have financial implications or lead to issues with billing and premium payments. Another commenter noted that the proposed change could result in short periods of dual enrollment for consumers, which may introduce coordination of benefits issues for consumers.

Response: We agree that both consumers and issuers will require additional guidance to ensure that the policy is implemented as intended and that all interested parties assisting consumers with enrollment decisions receive education and guidance, especially regarding coordination of benefits and potential periods of overlapping coverage. Because the earlier coverage effective date will only be available when consumers select a QHP in advance of the month in which they are losing MEC, consumers who do not want any overlap in coverage could choose to wait until the month they lose MEC (and up to 60 days after the loss of MEC) before selecting a plan. We encourage any Exchanges choosing to implement earlier effective dates to provide clear explanations to consumers regarding this option. We will continue to monitor the implementation of this policy, including whether additional guidance, or any additional policy changes in future rulemaking, are necessary.

Comment: One commenter fully opposed the proposed policy, stating that it could further complicate the Medicaid unwinding process, especially in light of recent guidance published by HHS on January 27, 2023, announcing flexibilities for consumers losing Medicaid or CHIP due to Medicaid unwinding.[263] The commenter stated that a more narrowly tailored approach, such as allowing mid-month enrollments in Exchange QHPs and proration of APTC and premium amounts, similar to the SEPs for adoption or birth of a child, is the better solution.

Response: We appreciate and understand the concern that this policy could further complicate the Medicaid unwinding process given that there is variability amongst States' unwinding plans and activities. However, we do believe that the policy still has value given that it would facilitate timely coverage transitions, which will be critical throughout the entire Medicaid unwinding period. For example, consumers who reside in States that allow mid-month terminations of Medicaid or CHIP risk gaps in coverage during Medicaid unwinding. A rule that allows for earlier QHP effective dates could mitigate these gaps in coverage, even more so if consumers do not have access to the flexibilities we announced on January 27, 2023, because their State Exchange opted to not provide the Unwinding SEP or something similar. Regarding the suggestion to allow Exchange QHP coverage to start mid-month, we also considered and rejected this option for the reasons described earlier in this final rule.

Comment: A commenter supported a review of the regulations to ensure that consumers with MEC ending mid-month can be found eligible for an earlier coverage effective date not just for QHP, but also for APTC and CSR to help pay for their coverage.

Response: We reiterate that a consumer who is not eligible for or enrolled in non-Exchange MEC for a full month, and who is enrolled in a QHP on the first day of such month, may be allowed PTC under 26 CFR 1.36B–3(c)(1). To clarify that such a consumer may be eligible for APTC and CSRs, we are adding language to the APTC eligibility regulation at § 155.305(f)(1)(ii)(B) to state that a tax filer must be determined eligible for APTC if the tax filer (or a member of their tax household) is not eligible for a full calendar month of minimum essential coverage (and other criteria are met).

Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition—Frequently Asked Questions (FAQ). https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf.

[259] See Pate, R. (2018, August 9). *Emergency and Major Disaster Declarations by the Federal Emergency Management Agency (FEMA)—Special Enrollment Periods (SEPs), Termination of Coverage, and Payment Deadline Flexibilities, Effective August 9, 2018. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/8-9-natural-disaster-SEP.pdf.*

[260] *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/8-9-natural-disaster-SEP.pdf.*

[261] See CMS. (2023, January 27). *Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition—Frequently Asked Questions (FAQ). https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf.*

[262] QHP issuers offering a QHP through a Small Business Health Options Program (SHOP) are required to provide the exceptional circumstances special enrollment period. 45 CFR 156.286.

[263] See CMS. (2023, January 27). *Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition—Frequently Asked Questions (FAQ). https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf.*

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

To mitigate coverage gaps when consumers lose Medicaid or CHIP coverage and to allow for a more seamless transition into Exchange coverage, we are finalizing the proposed 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 SEP 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 SEP 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. *See* 45 CFR 155.420(c)(2). When these qualified individuals or their dependents are not renewed into Medicaid or CHIP based on modified adjusted gross income following an eligibility redetermination, 42 CFR 435.916 requires that the State Medicaid agency provide a 90-day reconsideration window, or a longer period elected by the State, 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 (or longer period elected by the State) following a Medicaid or CHIP non-renewal, 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 SEP 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 renew coverage through Medicaid or CHIP (which they must do within 90 days or the longer period elected by a State of the consumer's loss of Medicaid or CHIP), they may have missed their window to enroll in Exchange coverage through a SEP based on loss of MEC (60 days after loss of Medicaid or CHIP).

In further support of this proposal, we explained in the proposed rule (87 FR 78266 through 78267) that we are aware that most consumers losing Medicaid or CHIP and who are also eligible for Exchange coverage may not transition to Exchange coverage in a timely manner. A recent report published by the Medicaid and CHIP Payment and Access Commission (MACPAC) [264] 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.[265] 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 while minimizing 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 and to mitigate the risk of coverage gaps, we proposed to create new paragraph (c)(6) stating that, effective January 1, 2024, at the option of the Exchange, consumers eligible for a SEP under § 155.420(d)(1)(i) due to loss of Medicaid or CHIP coverage that is considered MEC would have up to 90 days (or the longer period elected by a State) after their loss of Medicaid or CHIP coverage to enroll in an Exchange QHP. This proposal would align the SEP window following loss of Medicaid or CHIP with the reconsideration period available under 42 CFR 435.916(a). We also proposed adding language to paragraph (c)(2) to clarify that a qualified individual or their dependent(s) 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 believed in the proposed rule (87 FR 78267) that these proposed changes would have a positive impact on consumers while providing flexibility for Exchanges with different enrollment trends.

We sought comment on this proposal.

After reviewing the public comments, we are finalizing this provision as proposed, with two modifications to permit State Exchanges some additional flexibilities. As finalized, State Exchanges are permitted to provide a qualified individual or their dependent(s) who are losing Medicaid or CHIP coverage with more time to select a QHP, up to the number of days provided for the applicable Medicaid or CHIP reconsideration period if the State Medicaid Agency allows or provides a longer Medicaid or CHIP reconsideration period. State Exchanges will also have the option to implement this special rule as soon as this final rule takes effect, instead of on January 1, 2024, as proposed. We summarize and respond to public comments received on the proposed special rule for consumers losing Medicaid or CHIP coverage below.

Comment: Multiple commenters supported the proposal stating that, even before the COVID–19 PHE, many Medicaid beneficiaries experienced churn due to administrative errors, lost paperwork, and address changes. Commenters noted that despite States' best efforts during Medicaid unwinding, notices may still not reach consumers in time. Commenters also supported the proposal because it would promote continuity of care, which helps consumers achieve healthier outcomes, helps support the emergency care safety net, and minimizes care disruptions, especially for those with serious, chronic medical conditions. Commenters also were supportive of the flexibility for State Exchanges to determine whether they will adopt the special rule or not.

Response: We agree that the new special rule will have a significant impact and will be beneficial for consumers losing Medicaid or CHIP coverage, especially those with chronic health conditions, and will help ease transitions into Exchange coverage. We also agree that State Exchanges should have flexibility to decide whether to offer this special rule or not.

Comment: A few commenters supported the proposal but made recommendations for HHS to consider. A few commenters requested that HHS make this special rule mandatory instead of at the option of Exchanges. A few commenters requested that HHS not delay implementation to January 1, 2024, and requested that this special rule go into effect immediately or that Exchanges be given explicit authority to offer this special rule before January 1, 2024, if desired. Other commenters asked that HHS consider extending the window to 120 days or to permit Exchanges to extend the attestation window in States where the Medicaid or CHIP reconsideration period is longer than 90 days. Finally, a few commenters said that HHS should clarify that, under 45 CFR 155.420(d)(9), Exchanges already have flexibility to offer Exceptional Circumstance SEPs, can

[264] Medicaid and CHIP Payment Access Commission. (2022, July). *Transitions Between Medicaid, CHIP, and Exchange Coverage. https://www.macpac.gov/wp-content/uploads/2022/07/Coverage-transitions-issue-brief.pdf.*

[265] Ibid.

establish Exceptional Circumstance SEPs at any time and/or length, and that these lengths can be greater than the 60 or 90-day timeframes as discussed in preamble.

Response: We continue to believe that all Exchanges should have flexibility to adopt this special rule or not, based on their experiences with their eligible and enrolled populations. Therefore, we are not requiring that all Exchanges offer this special rule but we may consider this in future rulemaking. We believe that delaying implementation until January 1, 2024, will give Exchanges time to prepare any system changes for implementation, and update guidance and educational materials, which may not be feasible when States are also engaged in Medicaid unwinding activities. However, we understand that some Exchanges may be ready to implement this special rule earlier than January 1, 2024, and therefore, we are modifying our proposal to provide State Exchanges the flexibility to implement this policy as soon as this rule is finalized. Finally, we understand and appreciate States' concerns that the proposed 90-day window for consumers to report a past loss of Medicaid or CHIP is not enough time in States whose State Medicaid agency allow or provide for a Medicaid or CHIP reconsideration window that is 90 days or greater. Given these concerns, we are modifying our proposal to permit Exchanges to offer an attestation window (for consumers eligible for a SEP under § 155.420(d)(1)(i) due to loss of Medicaid or CHIP coverage that is considered MEC) up to the number of days provided for the applicable Medicaid or CHIP reconsideration period, if the State Medicaid agency allows or provides for a Medicaid or CHIP reconsideration period greater than 90 days.

Regarding the comment that Exchanges already have flexibility and authority under paragraph (d)(9) to set the length of a SEP, we remind Exchanges that the exceptional circumstances authority is subject to each Exchange's reasonable interpretation of what is ''exceptional.'' A misalignment between the Exchange attestation window for consumers losing Medicaid or CHIP coverage with the Medicaid or CHIP reconsideration period alone does not alone constitute an exceptional circumstance. If an Exchange chooses not to adopt this special rule for consumers losing Medicaid or CHIP coverage, or if an Exchange receives a request from an applicant to enroll in Exchange coverage more than 90 days after losing Medicaid or CHIP coverage, an Exchange could consider that applicant's claim that they experienced an exceptional circumstance that prevented them from enrolling in Exchange coverage in a timely manner on a case-by-case basis only. We also remind commenters that while Exchanges have broad authority to establish a SEP due to an exceptional circumstance, the Exceptional Circumstance SEP may not last more than 60 days, consistent with 45 CFR 155.420(c)(1). Therefore, we are finalizing as proposed.

Comment: One commenter supported the proposed special rule but also recommended that HHS continue to implement other changes to enrollment rules to reduce burden on consumers looking to enroll in Exchanges to make it more likely that they enroll. For example, the commenter suggested offering a SEP to consumers who owe a monthly premium after application of APTC, so that they can enroll in Exchange coverage throughout the year, similar to the SEP at § 155.420(d)(16) for consumers with attested household incomes at or below 150 percent of the FPL. The commenter also recommended that HHS consider other SEPs once the 150 percent FPL SEP expires at the end of coverage year 2025. Finally, one commenter supported automatic coverage transitions for consumers needing to transition from Medicaid or CHIP into Exchange coverage.

Response: We appreciate the commenters' concerns regarding consumers who have low incomes but are ineligible for the SEP at paragraph (d)(16). While any changes to the existing SEP at paragraph (d)(16) are out-of-scope for this rule, we will continue to explore potential ways to help lower income consumers access and enroll in Exchange coverage. We also appreciate the concerns regarding the need for automatic coverage transitions and will continue work with internal and external interested parties to find ways to improve transitions for consumers.

Comment: Some commenters also expressed concern about the recently announced Unwinding SEP available for consumers who submit a new application or update an existing application between March 31, 2023, and July 31, 2024, and attest to a last date of Medicaid or CHIP coverage within the same time period.[266] Commenters were concerned that the Unwinding SEP could invite adverse selection, as impacted consumers may delay enrolling into Exchange coverage until they have a medical need for health insurance, and because the Unwinding SEP is not subject to SEP verification. Commenters also said that they did not anticipate the announcement of the Unwinding SEP so that they could determine how the Unwinding SEP will impact their 2024 pricing.

Response: The recently announced Unwinding SEP[267] is out of scope for this rulemaking, but we acknowledge and appreciate the concerns raised by commenters related to potential adverse selection and impact on pricing of premiums.

Comment: A few commenters opposed the proposed special rule. One commenter contended that it was unnecessary given that the Consolidated Appropriations Act, 2023[268] delinked the Medicaid unwinding from the end of the COVID–19 PHE. Specifically, the commenter said that ''beginning April 1, 2023, States can begin Medicaid redeterminations'' and because of this, the commenter expects that ''many individuals impacted by this will have been redirected to coverage on the Exchange by the end of 2023.'' Another commenter stated that the existing SEP at § 155.420(d)(1) adequately addresses the situation, and expressed concern that HHS is introducing too many new SEPs, which can cause too much variation amongst Exchanges and may create more confusion within and across markets. The commenter also stated that enrollment data shows that consumers submit their applications early during their 60-day SEP window, and that lengthy, overlapping SEPs create more administrative burden for Exchanges and may cause delays or prevent consumers from enrolling into coverage.

Response: While there may not be a need for this special rule during Medicaid unwinding due to our recent announcement of the Unwinding SEP, the Unwinding SEP is only temporary and will not address the misalignment of the loss of MEC SEP eligibility period and Medicaid and CHIP reconsideration periods outside of the exceptional circumstances of Medicaid unwinding. We proposed this change due to

[266] See CMS. (2023, January 27). *Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition—Frequently Asked Questions (FAQ). https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf.*

[267] See CMS. (2023, January 27). *Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition—Frequently Asked Questions (FAQ). https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf.*

[268] Public Law 117–328.

continued concerns from interested parties that consumers transitioning from Medicaid or CHIP coverage and into other coverage, like Exchange coverage, continue to experience gaps in coverage, which can be detrimental to health outcomes. We also appreciate the concern that different rules for SEPs may be confusing, and therefore, Exchanges have the option of whether or not to offer this special rule.

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

We are finalizing our proposal to amend § 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 proposed amending paragraph (d)(12) by changing the subject of the regulation to focus on the affected enrollment, not the affected qualified individual, enrollee, or their dependents.[269]

In accordance with § 155.420, SEPs allow a qualified individual, enrollee, and/or their dependents who experiences certain qualifying events to enroll in, or change enrollment in, a QHP through the Exchange outside of the annual OEP. In 2016, we added warnings on *HealthCare.gov* about inappropriate use of SEPs, and tightened certain eligibility rules.[270] 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), we codified the plan display error SEP at § 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, we 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 SEP 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 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, or their dependent's, decision to purchase a QHP through the Exchange. However, we have found that consumers may benefit when other interested parties 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, at which point the issuer or State regulator is in the best position first to identify the display error. For example, a plan display error that influenced a consumer's enrollment can be discovered when a consumer enrolls in a QHP, pays the premium amount that was submitted by the issuer to be displayed on *HealthCare.gov,* and the enrollment is cancelled by the issuer for non-payment of premiums because the premium was incorrectly displayed on *HealthCare.gov.* 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 and notify the Exchange that the error was caused by incorrect premium amounts between the issuer's records and data submitted to *HealthCare.gov.* We can then work with the issuer to implement the data correction processes to make the necessary corrections to the *HealthCare.gov* and investigate the error to determine if the error was material because it was likely to have influenced the consumer's enrollment. In this example, we would likely determine that the error impacted the consumer's enrollment if the difference between the displayed premium and the actual premium was material. 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 proposed revising paragraph (d)(12) to remove the burden solely from the qualified individual, enrollee, and their dependents. We also proposed adding cost-sharing to the list of plan display errors, alongside plan benefits, service area, and premiums, as a plan display error with respect to cost-sharing could equally influence a consumer's enrollment decision. Specifically, we proposed revising § 155.420(d)(12) to reflect that a 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 proposed to consider a material error to be an error that is likely to have influenced a qualified individual's, enrollee's, or their dependent's enrollment in a QHP.

We note that an error related to plan benefits, service area, cost-sharing or premium does not trigger a SEP when the error is not material, which may occur if an error is honored as displayed. Errors related to plan

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

[270] February 25, 2016. Fact Sheet: Special Enrollment Confirmation Process. Available online at *https://www.cms.gov/newsroom/fact-sheets/fact-sheet-special-enrollment-confirmation-process.*

benefits, service area, cost-sharing or premium include situations where coding on *HealthCare.gov* causes benefits to display incorrectly, or where we identified incorrect QHP data submission or discrepancy between an issuer's QHP data and its State-approved form filings.[271] If the error involves information that displays on *HealthCare.gov,* we work 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, we will not typically provide the consumers with a SEP. The proposed revision to the regulation will be consistent with this approach.

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. We currently engage with partners and interested parties throughout the plan display error SEP process to ensure that issuers and States are notified of our 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 SEP if their plan data had a significant, material error. We expected that this experience is similar on all Exchanges, and therefore are proposing that this amendment to the description of the SEP will apply for all Exchanges.

We requested comment on this proposal.

After reviewing the public comments, we are finalizing this provision as proposed. All comments supported the proposed policy. We summarize and respond to public comments received on the proposed plan display error SEP below.

Comment: Multiple commenters supported a SEP for consumers affected by a material plan display error related to plan benefits, service area, or premium. Specifically, commenters mentioned their support for the SEP for consumers whose enrollment in a plan was adversely affected by the material plan display error. Additionally, multiple commenters supported the proposal to add ''cost-sharing'' to the list of plan display error that includes material error related to plan benefits, service area, and premiums.

Response: We agree that this revised plan display error SEP will support consumers whose enrollment in a plan was influenced by a material plan display error related to plan benefits, service area, or premium. We also agree with adding cost-sharing to the list of errors that may constitute a plan display, and we are finalizing this as proposed.

Comment: Several commenters supported our proposal to lift the burden of proof to additionally allow regulators and other interested third parties to demonstrate that a plan display error affected a consumer's plan selection. One comment supported expanding the ways in which people can prove they have been affected by plan display errors. Commenters stated this proposed change encourages the efficient operations of the Exchanges while reducing the burden on consumers to prove an error occurred. Another commenter supported the proposal as it allows consumers to benefit from other interested parties recognizing a plan display error including issuers, State regulators, and others.

Response: We agree that the proposal will remove the burden from consumers to solely demonstrate to the Exchange that their enrollment was influenced by a material error. We agree that this change will lift the burden of proof to allow regulators and other interested parties to demonstrate plan display errors. As such, we will finalize this proposal to allow plan display errors to be efficiently identified and resolved.

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78268), HHS requested information on whether consumers affected by a significant change in their plan's provider network should be eligible for a SEP, and 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. We thank commenters for their feedback and will take this into consideration in future rulemaking.

Comment: One commenter recommended that the plan display error SEP should also include provider directory inaccuracies.

Response: In the *Federally-facilitated Exchange (FFE) and Federally-facilitated Small Business Health Options Program (FF–SHOP) Enrollment Manual,* we state that plan display errors or changes that are made to external websites will not be considered triggering events for plan display error SEPs.[272] Since provider directories are displayed and maintained outside the Exchange, we did not propose in this rulemaking to include provider network inaccuracies as potential plan display error triggers under § 155.420(d)(12). Nonetheless, we will consider provider directory inaccuracies for future rulemaking.

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

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78268), we proposed 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 added PHS Act section 2714 (implemented at § 147.120) to require that group health plans and health insurance issuers offering group or individual health insurance coverage that offer dependent child coverage make such coverage available for an adult child until age 26. The ACA also added section 9815(a)(1) to the Code and section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) to incorporate the provisions of part A of title XXVII of the PHS Act (including

[271] 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.*

[272] 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.*

section 2714) and make them applicable under ERISA and the Code to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. This proposed amendment to § 155.430 would not change the requirements under § 147.120 nor would it affect parallel provisions in 26 CFR 54.9815–2714 and 2590.715–2714. Some States have established requirements under which issuers must maintain coverage for dependent children beyond age 26, and some issuers adopt higher than legally required age limits as a business decision.

In operationalizing § 155.430 on the Federal eligibility and enrollment platform, HHS has required QHP issuers that cover dependent children to provide coverage to dependent children until the end of the plan year in which they turn 26 (or, if higher, the maximum age under State law or the plan's business rules), although this is not required under § 147.120. Nevertheless, interested parties requested that HHS' policy be codified in regulation for clarity. Doing so by amending § 155.430 would reduce uncertainty for issuers on the Exchanges on the Federal platform regarding their obligation under § 155.430 to maintain coverage for a dependent child who has turned 26 (or, if higher, the maximum age under State law or the plan's business rules) 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, if higher, the maximum age under State law or the plan's business rules). This policy would codify the current policy on 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, if higher, the maximum age under State law or the plan's business rules). This is especially true when comparing individual market Exchange coverage to the employer market. In the employer market, the employer typically contributes toward the cost of child dependent coverage, but only until the child dependent attains the maximum dependent age under the group health plan (at which point the child dependent's coverage would typically be terminated). Whereas in the Exchange, APTC is allowed for the coverage of a 26-year-old child who is a tax dependent for the entire plan year because attaining age 26 may not, by itself, change tax dependent status. 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 non-tax relationships between applicants. Additionally, Exchange eligibility criteria do not prohibit allocation of APTC to dependent children enrollees based on age. Every family member who is part of the tax household must be listed on the Exchange application for coverage, and there is 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, if higher, through the end of the plan year in which the dependent reaches the maximum age required under State law or the plan's business rules.

In developing the Federal eligibility and enrollment platform, we 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, if higher, the maximum age under State law or the plan's business rules).

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, if higher, the maximum age under State law or the plan's business rules) 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. We proposed 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 proposed to make implementation optional for State Exchanges.

We requested comments on this proposal.

After reviewing the public comments, we are finalizing this provision as proposed, with the additional clarification that issuers who have adopted a higher maximum age than required by State or Federal law, as described in their business rules, also must maintain coverage for dependent children until the end of the plan year in which they reach the maximum age. We summarize and respond to public comments received on the proposal below.

Comment: Multiple commenters supported the proposal, and none opposed it. Several commenters stated that this proposal would support continuity of coverage and avoid interruptions in coverage for dependent children who turn 26 during the plan year (or the maximum age under State law). A few commenters noted that this proposal was particularly important given health concerns faced by young people, such as reproductive health, and given the tendency of young adults to have lower rates of health insurance coverage. A few commenters agreed that the proposal would help provide clarity to issuers regarding their obligation to maintain coverage for dependent children until the end of the plan year in which the child turns 26 (or the maximum age under State law), and would clarify for dependent child enrollees their ability to remain enrolled until the end of the plan year in which they turn 26 (or the maximum age under State law). Three commenters, two of whom represented State Exchanges, indicated that their State has a similar requirement in place. One commenter noted that this proposal would align

with the insurance industry standard of enrollments taking place during the annual Open Enrollment Period. Lastly, two commenters stated that the proposal would ensure accumulators were not reset mid-plan year for enrollees who turn 26.

Response: We agree that these changes will help provide clarity to consumers and issuers regarding the obligation of issuers on Exchanges on the Federal platform to maintain coverage for dependent children until the end of the plan year in which they turn 26 (or, if higher, reach the maximum allowable age under State law or the plan's business rules). Although this policy has already been in place on these Exchanges, we agree that this requirement promotes continuity of coverage, ensures consumers maintain access to needed health services, and avoids the reset of accumulators that may occur if their coverage was terminated in the middle of the plan year.

Comment: One commenter supporting the proposal noted that implementation would be optional for State Exchanges and requested that we encourage States to adopt a policy of prohibiting mid-year plan terminations for dependent children who reach the applicable maximum age.

Response: This proposal provides State Exchanges with the option to adopt a similar policy, but we do not believe it is appropriate to explicitly encourage State Exchanges to do so. We note that this requirement applies to all issuers on Exchanges on the Federal platform, and as noted in a previous comment, some State Exchanges have also indicated they currently have a similar requirement. However, as noted in the preamble of this proposal, this policy for the Exchanges on the Federal platform is based on Exchange operations and the fact that APTC eligibility determinations are made for the entire plan year based on tax household, unless replaced by a new determination of eligibility. Because State Exchanges may establish their own operational practices regarding the maximum age for dependent enrollees, including ones that differ from those on the Exchanges on the Federal platform, we believe it is appropriate to allow State Exchanges to determine whether or not to adopt this proposal.

Comment: One commenter expressing support for the proposal stated that consumers should be informed that some States have higher maximum ages for dependent child enrollees, and that Federal law requires that individuals with developmental disabilities must be covered as insurance dependents regardless of age.

Response: We agree that it is important for consumers to be aware of the maximum age for dependent children required under State law and therefore will explore ways in which we can convey this information. With respect to plans with business rules that provide a maximum age higher than what is required under State or Federal law, we note that HHS publishes Public Use Files for the Federally-facilitated Exchange which contain information on issuers' business rules, including the maximum dependent age.[273] States, including State Departments of Insurance and State Exchanges, may also have resources available to inform consumers of the applicable laws regarding maximum age. Finally, we note that Federal law requires coverage of dependent children until age 26, though States may have higher maximum dependent ages based on disability status. The application for Exchanges on the Federal platform allows consumers to designate an enrollee with a disability, which allows that enrollee to remain enrolled as a dependent past age 26 if required by applicable State law.

Comment: Two commenters expressing support for the proposal noted that it was important for enrollees to retain APTC for the full plan year. One commenter stated that dependents may be eligible for more generous APTC while on their family's coverage than in coverage alone.

Response: We agree that it is important for Exchange enrollees to retain the APTC to which they are entitled for the full plan year. However, we note that even if a dependent enrollee enrolls in a separate plan prior to the end of the year in which the dependent turns 26, they are still entitled to the portion of APTC paid on their behalf for the tax household in which they are a tax dependent. Enrolling in a separate plan does not, in and of itself, reduce the amount of APTC to which an enrollee is entitled.

Comment: One commenter expressed neither support for nor opposition to the proposal and stated that enrollees who turn 26 during the plan year should not be automatically re-enrolled into their own plan at the end of the plan year.

Response: Although this comment is not within the scope of our proposal, we believe it is appropriate for such enrollees to be re-enrolled into their own plan at the end of the year in which they turn 26 (or, if higher, reach the maximum age under State law or the plan's business rules). This practice avoids disruptions of coverage for enrollees transitioning off their parents' plans, and is in line with the general Exchange practice of automatically re-enrolling enrollees at the end of each plan year.

9. General Eligibility Appeals Requirements (§ 155.505)

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78269), we proposed 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 proposed revising this regulation to acknowledge the ability of the CMS Administrator to review Exchange eligibility appeals decisions prior to judicial review.

This change would ensure that accountability for the decisions of the HHS appeals entity is vested in a principal officer, as well as bring § 155.505(g) of the appeals process to a more similar posture as other CMS appeals entities that provide Administrator review.[274] Revising the regulation would also provide appellants and other parties with accurate information about the availability of administrative review by

[273] CMS. (n.d.). *Health Insurance Exchange Public Use Files (Exchange PUFs). https://www.cms.gov/cciio/resources/data-resources/marketplace-puf.*

[274] Examples include: 42 CFR part 405, subpart R (Provider Reimbursement Review Board); 42 CFR part 412, subpart L (Medicare Geographic Classification Review Board); 42 CFR 430.60 through 430.104 (Medicaid State Plan Materials/Compliance Determinations); 42 CFR 423.890 (Retiree Drug Subsidy (RDS) Appeals); 42 CFR 411.120 through 411.124 (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).

the CMS Administrator if they are dissatisfied with their Exchange eligibility appeal decision.

We sought comment on this proposal.

After reviewing the public comments, we are finalizing this provision as proposed, with the following technical corrections to improve understanding of the review process, and with a modified effective date. The first technical correction is to the proposed language at § 155.505(g). We are modifying the sentence at § 155.505(g) including its citation to paragraph (b) to clarify that review is available for Exchange eligibility appeals decisions issued by an impartial official under § 155.535(c)(4). The second technical correction is to change the reference found in § 155.505(g)(1)(i)(A) from paragraph (g)(1)(ii)(B) to paragraph (g)(1)(ii)(B)(*1*) to add specificity regarding voiding the Administrator's declination. The third technical correction is to § 155.505(g)(1)(i)(C), which should cross reference the 30-day period described in paragraphs (g)(1)(i)(B)(*1*) and (*3*). The fourth is to § 155.505(g)(1)(ii)(C), which should cross reference the 30-day period described in paragraphs (g)(1)(ii)(B)(*1*) and (*3*). The fifth technical correction is to § 155.505(g)(1)(iii)(A), which should cross-reference Exchange eligibility appeal decisions final pursuant to paragraphs (g)(1)(i)(C) and (g)(1)(ii)(C) in this section.

With respect to the effective date, under the proposed rule, any finalized changes to § 155.505 would be effective 60 days after the date of display of the final rule in the **Federal Register**. While this rule acknowledges the ability of the CMS Administrator to review Exchange eligibility appeals decisions prior to judicial review, we anticipate implementation of the proposed process to apply this authority will take some time. Therefore, we are finalizing this rule with the new process becoming available for eligibility appeal decisions issued on or after January 1, 2024.

We summarize and respond to public comments received on the proposed changes acknowledging the ability of the CMS Administrator to review Exchange appeals decisions below.

Comment: Some commenters expressed support for the proposed changes, acknowledging the ability of the CMS Administrator to review Exchange eligibility appeals decisions prior to judicial review. One commenter cautioned that we should work to make sure that the correct decision is made at the lowest level of review.

Response: We will continue to make every effort to ensure the correctness of the initial decision.

Comment: Two commenters sought clarity around how the proposed administrative review process would interact with the State Exchange second-tier eligibility appeal process, with one commenter expressing concern that the additional level of review may be duplicative and burdensome, adding further time before a decision can be implemented.

Response: We acknowledge the concerns around an additional level of review, but reiterate the existing ability of the CMS Administrator to review Exchange eligibility appeals decisions prior to judicial review. The proposed regulation also describes timeframes for the CMS Administrator to review, and for parties to the appeal to request the CMS Administrator review, an Exchange eligibility appeal decision, which is intended to balance the right of CMS Administrator to review a decision with the appellant's desire for finality of an Exchange eligibility appeal. We recognize that the Exchange should implement the correct decision as expeditiously as feasible and set the timeframes in the regulation to achieve that goal. We also clarify that the CMS Administrator may review the HHS appeals entity's decision with respect to a second-tier appeal of a State Exchange appeals entity's decision, but cannot review a decision of a State Exchange appeals entity.

Comment: A commenter sought clarity around the interaction between the administrative review process and the timeliness standards prescribed under § 155.545(b).

Response: The administrative review process will not affect the requirement under § 155.545(b) that the HHS appeals entity must issue written notice of the appeal decision to the appellant within 90 days of the date an appeal request is received, as administratively feasible. Parties have 14 days to request, and the CMS Administrator has 14 days to determine whether to conduct, an administrative review. Once either of these actions occurs, the CMS Administrator's review will occur within 30 days of the date a party requests review or the CMS Administrator determines to review a case. The total additional time for administrative review may add up to 44 days before the eligibility appeal decision becomes final.

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

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78270–72), we proposed to establish the IPPTA, an improper payment measurement program of APTC, that would include State Exchanges. As proposed, the IPPTA would prepare State Exchanges for the planned measurement of improper payments of APTC, test processes and procedures that support our review of determinations of APTC made by State Exchanges, and provide a mechanism for us and State Exchanges to share information that will aid in developing an efficient measurement process. We proposed to codify the IPPTA requirements in a new subpart P under 45 CFR part 155.

The Payment Integrity Information Act of 2019 (PIIA) [275] requires Federal agencies to annually identify, review, measure, and report on the programs they administer that are considered susceptible to significant improper payments. We 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 FFE and SBE–FPs were measured and reported in the FY22 Annual Financial Report (AFR) as part of the Exchange Improper Payment Measurement (EIPM) program. We stated in the 2023 Payment Notice proposed rule (87 FR 654, 654–655) that we were in the planning phase of establishing a State-based Exchange Improper Payment Measurement (SEIPM) program. We also stated in the 2023 Payment Notice proposed rule that we had intended to implement the proposed SEIPM program beginning with the 2023 benefit year. In response to that proposed rule, we received several comments 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 needed more time and information from us 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). In the 2024 Payment Notice proposed rule (87 FR 78206, 78270), we proposed IPPTA to provide State Exchanges with more time to prepare for the planned measurement of improper

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

payments of APTC, to test processes and procedures that support our review of determinations of APTC made by State Exchanges, and to provide a mechanism for HHS and State Exchanges to share information that will aid in developing an efficient measurement process (87 FR 28270).

In 2019, we developed an initiative to provide the State Exchanges with an opportunity to voluntarily engage with us to prepare for future measurement of improper payments of APTC. We 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 voluntary State engagement, and of those, 2 have participated in the piloting option.

We stated in the proposed rule that IPPTA would replace the voluntary State engagement. We explained that, if finalized, activities already completed by State Exchanges as part of the voluntary State engagement may be used to satisfy elements of IPPTA. We have determined that participation from all State Exchanges is required to test processes and procedures to prepare the State Exchanges for the planned measurement of improper payments of APTC.

We proposed to establish a new subpart P under 45 CFR part 155 (containing §§ 155.1500 through 155.1515) to codify the proposed IPPTA requirements. We explained that 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.

After reviewing public comments, we are finalizing our proposals relating to the establishment of the IPPTA with the following modifications: (1) the final regulations at subpart P will be applicable beginning in 2024 with a modification to the definition in § 155.1505 that extends the pre-testing and assessment period from one calendar year to 2 calendar years; and (2) with a modification to § 155.1515(a)(1) that reflects the extension of the pre-testing and assessment period such that each State Exchange will be selected to participate in the IPPTA for a pre-testing and assessment period of 2 calendar years, which will begin in either 2024 or 2025. We note that, in response to comments regarding burden and resources, we are extending the pre-testing and assessment period from one calendar year to 2 calendar years without increasing or changing any of the IPPTA requirements in order to provide State Exchanges with more time to perform and complete all of the IPPTA requirements. The extended pre-testing and assessment period will also reduce burden to the State Exchanges by allowing more time to focus on other Exchange priorities instead of meeting the IPPTA requirements in one year. Additionally, the burden per State Exchange in estimated hours per year was reduced from 530 to 265, and the burden in estimated costs per year was reduced from $56,986 to $28,493 by allowing State Exchanges to spread their costs over a two-year period. The estimated annualized cost across all State Exchanges by extending the pre-testing and assessment period by one calendar year to 2 calendar years without changing any of the IPPTA requirements was reduced from $1,025,756 to $512,878, saving State Exchanges half of their estimated outlays on an annualized basis. We will also work with each State Exchange during the IPPTA orientation and planning process to address a State Exchange's time and resource constraints to allow completion of all review processes and procedures. We summarize and respond to public comments received on the proposed IPPTA below.

Comment: Some commenters recommended that prior to the implementation of IPPTA or an improper payment measurement program, HHS complete the SEIPM voluntary State engagement piloting to incorporate lessons learned and best practices into the design of IPPTA and/or a future improper payment measurement program. One commenter supported IPPTA but was opposed to the mandatory nature of the initiative.

Response: Throughout the course of the voluntary State engagement, we sought State Exchange feedback to improve the structure of the planned program and to improve the tools that will be used in IPPTA in support of reviewing payments of APTC. We applied the feedback and lessons learned to gain a better understanding of State Exchange operations, policies, and procedures. Additionally, we were able to define necessary data specifications for conducting improper payment measurement and to determine data transfer and access mechanisms between HHS and State Exchanges.

We appreciate the voluntary participation of the 10 State Exchanges and acknowledge the benefits such participation has provided in our development of the planned measurement program. We have determined that participation in IPPTA by all the State Exchanges is necessary to help State Exchanges prepare for the planned measurement of improper payments. In addition, requiring participation in IPPTA will provide us with feedback from all 18 State Exchanges on the processes and procedures that support our review of APTC determinations made by State Exchanges, and therefore will help us maximize the efficiency of the measurement process. To achieve that, we have determined that all State Exchanges will need to complete the processes described for IPPTA with the goal of testing our IPPTA review methodology for each State Exchange. In this way, all State Exchanges will have the opportunity to collaborate with us and receive feedback on their current processes without our IPPTA review contributing to an estimated improper payment rate.

Comment: One commenter said they supported allowing State Exchanges to satisfy IPPTA requirements through activities undertaken during voluntary State engagements.

Response: Our general position is that activities that were performed by the 10 State Exchanges that participated in voluntary State engagement will not be duplicated as part of IPPTA. To achieve that, we will evaluate the activities performed by State Exchanges during the voluntary State engagements and determine which of those satisfy IPPTA requirements. We will also utilize voluntary State engagement information as a substitute, thereby, saving time and resources needed for the completion of IPPTA. We will accomplish this by using the pre-testing and assessment checklist, which will identify the IPPTA requirements that have already been fulfilled. The pretesting and assessment plan will include the pre-testing and assessment checklist that will identify which State Exchange's activities satisfied the requirements. We will work with State Exchanges during the orientation and planning process to review the checklist and to confirm the State Exchange's completed activities. Additional information about the process for satisfying certain IPPTA requirements as a result of participation in the voluntary State engagements will be provided in guidance issued after this rule is finalized. State Exchanges that did not participate in voluntary State engagement will not have performed activities that satisfy IPPTA requirements and therefore must complete all IPPTA processes and procedures.

Comment: Some commenters stated that IPPTA would duplicate requirements embodied in existing Federal reporting requirements. For example, these commenters cited the State-based Marketplace Annual Reporting Tool (SMART), annual independent external programmatic audits, State Based Marketplace Inbound (SBMI) reporting, performance monitoring data reporting, and reconciliation processes including the annual IRS PTC reconciliation as Federal requirements that may duplicate IPPTA. A few commenters recommended HHS build on existing audit requirements (for example, the independent, external programmatic audit) rather than create a new IPPTA requirement. One commenter recommended State Exchanges make a testing environment for HHS to run standard tests rather than create a new data collection process. Another commenter stated that both the independent external auditors and the IRS PTC reconciliation process already collect data that could be used to determine an improper payment rate.

Response: We appreciate the commenters' concerns that IPPTA would be duplicative of existing audits; however, IPPTA is not an audit program but instead is designed to test processes and procedures that support our review of determinations of APTC made by State Exchanges for the planned measurement of improper payments. Additionally, the independent external programmatic audits ensure oversight of a host of exchange activities beyond the scope of improper APTC payments. Moreover, the data collected as part of the Federal reporting requirements identified by the commenters do not provide us with information required by § 155.1510 such as information that verifies citizenship, social security number, residency, and other data specified below. This information is needed to review determinations of APTC, which is a necessary step to prepare for identifying and measuring improper payments of APTC, as required by PIIA.[276] For example, the IRS reconciliation process uses annual enrollment data and monthly reconciliation data provided by HHS to calculate the PTC and to verify reconciliation of APTC made to the QHP issuers on enrollees' individual tax returns. However, these annual enrollment data and monthly reconciliation data do not contain data to the level of required specificity (such as dates that electronic eligibility verifications were made) to address issues related to APTC and its calculation, particularly verification of citizenship, social security number, residency, MEC, SEP circumstance, income, family size, and DMIs related to document authenticity. Moreover, the annual enrollment data and the monthly reconciliation data are collected after an applicant has been determined eligible for APTC. We need pre-enrollment data that were used to verify an applicant's eligibility before the application is approved. Examining these areas in detail is necessary to identify underlying issues that may lead to improper payments. In contrast, the SMART allows State Exchanges to self-attest to their verification procedures for eligibility and enrollment transactions without submitting supporting data. Similarly, the annual independent external programmatic audits require State Exchanges to hire independent, external auditors to review eligibility and enrollment information collected by State Exchanges to identify deficiencies or errors in processes to make eligibility determinations for QHPs and APTC without submitting supporting data to HHS. Neither the SMART nor the independent, external programmatic audits measure, estimate, or report the amounts or rates of improper payments, or the systematic errors that may contribute to improper payments and do not provide the underlying data that would allow HHS to do so. Finally, these current oversight procedures do not allow for standardized comparison or analysis of improper payments across all State Exchanges, which will be necessary functions of the planned improper payment measurement program. For these reasons, we will require State Exchanges to submit the data and data documentation specified in the final rule to comply with PIIA requirements. We believe that IPPTA will assist State Exchanges to prepare for the planned measurement of improper payments, an activity with requirements that are distinct from existing Federal requirements. IPPTA will provide the data needed to conduct the pre-testing and assessment review processes in preparation for the planned measurement of improper payments. We note that in designing IPPTA, we have carefully reviewed the commenters' concerns regarding potential duplication of existing audit processes and analyzed the data fields used to accomplish existing Federal requirements. We have made every effort to minimize the burden on the State Exchanges by limiting the amount of data required (that is, application data associated with no fewer than 10 tax households).

Comment: Some commenters stated that IPPTA would create financial, administrative, and staffing burdens for the State Exchanges. A few commenters stated that they would incur technology upgrade costs to provide information in the format requested by IPPTA and one said HHS should wait until after the voluntary State engagement piloting is completed to enable State Exchanges to make an accurate assessment of technology costs. One commenter was opposed to the overall burden of IPPTA but was supportive of our desire to coordinate and consult with State Exchanges.

Response: We received several comments regarding the burden and resources (that is, budget, staff, time, technology upgrades) needed to prepare for and fulfill IPPTA's requirements. We understand these concerns and, therefore, are finalizing the establishment of the IPPTA with a modification to extend the pre-testing and assessment period from one calendar year to two calendar years without increasing or changing any of the IPPTA requirements in order to allow State Exchanges more time to perform and complete all IPPTA requirements. By doing so, we are extending the timeframes allotted for State Exchanges to execute the pre-testing and assessment procedures including the timeframes for the submission and review of data and data documentation. By extending the pre-testing and assessment period to two calendar years and not otherwise expanding the IPPTA requirements, we are providing the State Exchanges with the ability to spread their staffing, administrative, and other budgetary costs across 24 months of activity instead of 12 months as well as providing State Exchanges additional time to identify and address staffing capacity and technology capabilities.

The planning and orientation phase will involve collaboration between HHS and the State Exchanges to create the IPPTA plan, which will include a timeline for completing the required pre-testing and assessment processes. There is sufficient flexibility in this process that conceivably, the State Exchange could plan to complete, and achieve completion of all of the required processes within the span of one year if the State Exchange was able to dedicate the time and resources that would be so required.

[276] In 2016, we conducted a risk assessment of the APTC program and determined that the program was susceptible to significant improper payments. PIIA requires that Federal agencies produce a statistically valid estimate of improper payments for any programs deemed susceptible to significant improper payments.

We are committed to working with State Exchanges to address burden and resources during the orientation and planning processes, which would allow State Exchanges to complete the IPPTA. Finally, we acknowledge that State Exchanges may incur additional costs depending on their technology capabilities. We provided the public with our estimate of the burden and costs to State Exchanges in section IV., Information Collection Requirements. We are willing to continue to work with State Exchanges to help to resolve technology issues during the orientation and planning processes.

Comment: One commenter stated that the review methodology and associated data structure used by HHS for the FFE does not uniformly align with State Exchange practices. The commenter added that HHS is applying a standardized approach despite the flexibility provided to State Exchanges under the ACA.

Response: We note that IPPTA is intended to test processes and procedures that support our review of determinations of APTC made by State Exchanges. We acknowledge the complexities associated with the development of a planned measurement program tailored for each State Exchange and that the methodology used for the improper payment measurement program for the FFE does not directly translate to operationalization for State Exchange measurement. Those complexities, which include the State Exchange's mapping their source data to the Data Request Form (DRF) and validation and verification of the data by HHS, require close collaboration between HHS and each of the State Exchanges as described in § 155.1515(e)(2), and in part, form the basis for the necessity of the IPPTA program in preparing the State Exchanges for an improper payment measurement program. Through collaboration with the State Exchanges during IPPTA, we will make every attempt to resolve data structure issues that differ between the FFE data model and the State Exchanges.

Comment: A few commenters suggested that HHS provide State Exchanges with an exemption from the annual independent, external programmatic audit requirement under 45 CFR 155.1200(c) if HHS finalized IPPTA, and they suggested that continuing to require the audit would be duplicative of activities under IPPTA.

Response: The annual independent, external programmatic audits are one of the primary oversight tools for identifying and addressing State Exchange regulatory compliance issues, and the audit reports ensure oversight of a variety of exchange-related activities beyond the scope of potential improper payments of APTC. As part of the auditing process, we require State Exchanges to take corrective actions to address non-compliance issues that are identified through the annual audits and monitor the implementation of the corrective actions. We designed IPPTA to minimize the burden on the State Exchanges by limiting the amount of data required to only what is necessary to conduct the pre-testing and assessment review processes that will prepare State Exchanges for the planned measurement of improper payments. Modifying the annual independent, external programmatic audit requirement would eliminate a key oversight mechanism over activities beyond the scope of the SEIPM program and potentially impact our ability to adequately oversee program integrity in the State Exchanges.

Comment: One commenter requested more information regarding the sunsetting of the SEIPM piloting option.

Response: We appreciate the comment regarding the sunsetting of the voluntary State engagement. As stated in the preamble, IPPTA will replace the voluntary State engagement. Voluntary State engagement activities will cease by the end of 2023. We will provide further guidance after the publication of this final rule.

Comment: Some commenters expressed their position as neutral or did not express a position in support or opposition of IPPTA. These commenters expressed concerns regarding burden and duplication of existing Federal requirements. These commenters also suggested that HHS complete the voluntary piloting prior to establishing IPPTA.

Response: We appreciate those commenters who expressed various concerns but remained neutral overall to IPPTA, either expressly indicating their neutrality or choosing not to take a position in support or opposition of IPPTA. We have addressed the burden, duplication of existing Federal requirements, and voluntary State engagement in the preamble to this final rule.

a. Purpose and Scope (§ 155.1500)

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78270), we proposed to add a new subpart P to part 155, which addressed State Exchange and HHS responsibilities. We explained that we may use Federal contractors as needed to support the performance of IPPTA.

We proposed to add new § 155.1500 to convey the purpose and scope of IPPTA. In the proposed rule, at paragraph (a), we stated the purpose and scope of subpart P as setting forth the requirements of the IPPTA for State Exchanges. We explained that the proposed IPPTA is an initiative between HHS and State Exchanges. We stated in the proposed rule that the IPPTA requirements were intended to prepare State Exchanges for the planned measurement of improper payments, test processes and procedures that support our review of determinations of APTC made by State Exchanges, and provide a mechanism for HHS and State Exchanges to share information that will aid in developing an efficient measurement process.

We summarize and respond to public comments received on the purpose and scope of IPPTA below. After reviewing the public comments, we are finalizing this provision as proposed.

Comment: One commenter stated that consultation with State Exchanges is crucial to collecting accurate information and recommended HHS retain the proposed regulatory language requiring strong coordination and consultation with State Exchanges.

Response: We appreciate the recommendation to retain the language of the proposed rule that we work with State Exchanges including coordinating and consulting during the IPPTA period. We are retaining the language in the rule pertaining to coordinating with the State Exchanges during the IPPTA period. As stated in the preamble to the proposed rule (87 FR 78270), IPPTA is intended to be a collaborative effort between us and the State Exchanges.

b. Definitions (§ 155.1505)

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78270–71) we proposed to add new § 155.1505, which would codify the definitions of several terms that are specific to IPPTA and are key to understanding the processes and procedures of IPPTA. Specifically, we proposed to define the following terms as set forth below.

- We proposed to define ''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. In the proposed rule we explained that, 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 a business rule.

• We proposed to define ''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 proposed to define ''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 proposed to define ''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 proposed to define ''Pre-testing and assessment data request form'' to mean the document that specifies the structure for the data elements that HHS will require each State Exchange to submit.

• We proposed to define ''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. In the proposed rule, we proposed that the pre-testing and assessment period would cover one calendar year.

• We proposed to define ''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 proposed to define ''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 Exchanges' 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 Exchanges to HHS. In the proposed rule, we explained, at § 155.1515(g), that we were 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. We explained that the pre-testing and assessment report will not be released to the public by HHS unless otherwise required by law.

We summarize and respond to public comments received on the proposed definitions below. We are finalizing the definitions as proposed, with the following modification: we are changing the proposed definition of ''Pre-testing and assessment period'' to extend the pre-testing and assessment period from a one calendar year timespan to a 2-calendar year timespan, during which we will engage in pre-testing and assessment procedures with a State Exchange. As discussed earlier in this preamble, we are making this modification in response to comments received regarding burden and resources (that is, budget, staff, time, technology upgrades, etc.). By extending the pre-testing and assessment period from one calendar year to two calendar years without increasing or changing any of the IPPTA requirements, we are providing State Exchanges with more time to perform and complete all IPPTA requirements.

Comment: One commenter requested that HHS clarify the definition of ''entity relationship diagram.'' The commenter stated they did not understand how the diagram would be used to describe data elements, and the commenter also requested more information on how sample data would be collected.

Response: An entity relationship diagram is used to document the data structure of a database and the relationships of the various data elements that are used to align many pieces of data to the individual records within a data set. For the purposes of IPPTA, the entity relationship diagram would be used to aid in understanding the mapping of data from the data structures being used by the State Exchange to the structure of data being used for the review, which is collected in the data request form (DRF). In addition, an entity relationship diagram will provide an understanding of the relationships among State Exchange-provided data and can explain the data values provided by the State Exchange in the DRF. The properties associated with each entity need to be understood by the reviewers to ensure that the mapping of data and the population of the DRF have been performed correctly. During IPPTA planning, we will work with the State Exchanges to determine whether available documentation can satisfy the information needs for the entity relationship diagram.

c. Data Submission (§ 155.1510)

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206 at 78271), we proposed to add a new § 155.1510 which would address the data submission requirements to support the IPPTA. Consistent with this, we proposed to establish a pre-testing and assessment DRF to collect and compile information from each State Exchange. As explained below in section IV., Collection of Information Requirements, the pre-testing and assessment DRF was submitted to OMB for review and approval. We proposed that each State Exchange must submit to us 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).

We summarize and respond to public comments received on the proposed pre-testing and assessment DRF below. After reviewing the public comments, we are finalizing this provision as proposed.

Comment: Several commenters stated that they are willing to share more data and information with HHS and other Federal partners to ensure the effective and efficient operation of State Exchanges.

Response: We appreciate the willingness of these commenters to share more data and information with us and other Federal partners to ensure that the State Exchanges operate in an efficient and effective manner.

Comment: A few commenters suggested that HHS not require State Exchanges to produce information about their systems, business rules, or software. Two commenters recommended that HHS not require new data documentation but rather accept a State Exchange's existing data documentation. One commenter objected to the comprehensive submission of business rules and proposed using identified errors as the basis for root cause analysis. One commenter objected generally to the provision of system documentation including concerns that some documentation may be proprietary. One commenter objected to the detailed review of eligibility criteria and examination of associated data. Another commenter recommended that HHS allow State Exchanges to submit data documentation such as the data dictionary and entity relationship diagram in any format.

Response: We are not requiring State Exchanges to create new data documentation, but rather we are requiring State Exchanges provide us with existing or available data documentation as described in § 155.1510, such as business rules and policies used to determine an applicant's eligibility for APTC. This data documentation is necessary to test

our processes and procedures that support our review of determinations of APTC made by State Exchanges. We are seeking to test all the processes associated with IPPTA. Therefore, the information provided by State Exchanges regarding their systems and business rules will allow us to tailor review procedures to each State Exchange. A detailed review of eligibility criteria is necessary to create a measurement program that complies with the statutory requirements set forth in PIIA. Regarding the submission of the data dictionary and entity relationship diagram in any format, we agree with the commenter. We will allow State Exchanges to submit their data documentation as defined in this final rule in the format currently used by the State Exchange.

We will coordinate with State Exchanges to resolve any issues that may arise related to the potential proprietary nature of this data documentation and ensure that any such data documentation provided is not made publicly available, unless required by law.

• At paragraph (a)(1) in the proposal, we proposed 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) in the proposal, we proposed that the State Exchange must use the pre-testing and assessment DRF, 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. We explained that 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, SEP 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). We explained that we understand 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, we proposed that while the application data for each tax household does not need to address all the scenarios specified, the application data submitted for no fewer than 10 tax households should, when taken together as a whole, address all the characteristics in all the scenarios specified. We explained that, for example, the application data for one tax household may address lawful presence inconsistency adjudication but not special enrollment eligibility verification. Accordingly, we noted that the application data for another tax household should address special enrollment eligibility verification. In the proposal we stated that after receiving the application data associated with no fewer than 10 tax households from the State Exchange, we 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 did not collectively fulfill the scenarios, we proposed that we would coordinate with the State Exchange to select additional tax households. For the data submitted, we also would require the State Exchange to provide digital copies such as PDFs of supporting consumer-submitted documentation (for example, proof of residency, proof of citizenship).

• We also proposed that for each of the tax households, the State Exchange would align and populate the data in the pre-testing and assessment DRF with the assistance of HHS. We explained that we would require that the State Exchange electronically transmit the completed pre-testing and assessment DRF to HHS within the deadline specified in the pre-testing and assessment plan. We proposed that once we receive the transmission from the State Exchange, we then would execute the pre-testing and assessment processes and procedures on the application data.

We summarize and respond to public comments received on submission of application data for no fewer than 10 tax households using the pre-testing and assessment DRF that will be provided to State Exchanges by HHS and on the proposed scenarios specified by HHS to allow HHS to test all of the pre-testing and assessment processes and procedures below. After reviewing the public comments, we are finalizing § 155.1510(a) as proposed.

Comment: A few commenters support the sample size of no fewer than 10 tax households.

Response: We appreciate support of the no fewer than 10 tax household sample size.

Comment: One commenter agreed with the use of the pre-testing and assessment DRF to collect and compile information from each State Exchange.

Response: We appreciate support for collecting information from the State Exchanges using the pre-testing and assessment DRF.

• At paragraph (b) in the proposal, we proposed 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.

We did not receive any comments in response to the proposed pretesting and assessment data submission timeline. We are finalizing § 155.1510(b) as proposed.

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

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78271 through 72), we proposed to add a 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 IPPTA that are, in part, designed to test our review processes and procedures that support our review of determinations of the APTC made by State Exchanges, to improve the State Exchange's understanding of IPPTA, to prepare State Exchanges for the planned measurement of improper payments, and to provide us and the State Exchanges with a mechanism to share information that will aid in developing an efficient measurement process.

Comment: One commenter supported the need to prepare State Exchanges for the planned measurement of improper payments.

Response: We appreciate recognition of the need to prepare State Exchanges for the planned measurement of improper payments.

• At paragraph (a), we proposed the general requirement that the State Exchange must participate in IPPTA for a period of one calendar year that will occur in either 2024 or 2025, and that the State Exchange and HHS would work together to execute IPPTA procedures in accordance with

timelines in the pre-testing and assessment plan.

We did not receive any comments in response to the proposed requirement for State Exchanges to participate in IPPTA for one calendar year in either 2024 or 2025. In response to comments regarding burden and resources (that is, budget, staff, time, technology upgrades), and as previously discussed in the preamble of the rule, we are finalizing this provision with the following modification: we are extending the pre-testing and assessment period from one calendar year to 2 calendar years without increasing or changing any of the IPPTA requirements in order to provide State Exchanges with more time to perform and complete all IPPTA requirements. We are requiring State Exchanges to participate in IPPTA for a pre-testing and assessment period of 2 calendar years, which would begin in either 2024 or 2025.

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

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

We did not receive any comments in response to the proposed State Exchange IPPTA orientation process. We are finalizing these provisions as proposed.

• At paragraph (b)(2), we proposed that HHS, in collaboration with each State Exchange, would develop a pre-testing and assessment plan as part of the orientation process. We explained that 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. In the proposal, we noted that while we would need to meet milestones specified in the schedule and applicable deadlines due to the time span allotted for this proposed program, we would take into account feedback from the State Exchanges in an effort to minimize burden. We stated that the pre-testing and assessment plan would take into consideration relevant activities, if any, that were completed during voluntary State engagement. We explained that the pre-testing and assessment plan would include the pre-testing and assessment checklist.

We summarize and respond to public comments received on the proposed pre-testing and assessment plan below. After reviewing the public comments, we are finalizing this provision as proposed.

Comment: One commenter said that more information was needed to inform State Exchanges of how their activities would satisfy IPPTA requirements.

Response: We appreciate the cooperation and collaboration of State Exchanges that have participated in voluntary State engagement. We will work with State Exchanges during the IPPTA orientation and planning process to review the pre-testing and assessment checklist and confirm the State Exchange's completed activities that satisfy certain IPPTA requirements. One of the major activities in the voluntary State engagements has been the submission of data by the State Exchange, which includes the mapping of a State Exchange's source data to the data elements in our DRF. The DRF has been used by State Exchanges participating in the pilot option of the voluntary State engagement to collect and transmit application data for testing. In the scenario that a State Exchange submitted data on the DRF during the piloting option of voluntary State engagement, and where review processes were not able to be completed due to the sunsetting of voluntary State engagement activities, we will incorporate the previously submitted data to satisfy IPPTA data submission requirements. Similarly, in the scenario where data was submitted by a State Exchange, but the data was not sufficient to execute the review methodology, we will incorporate the previously submitted data into IPPTA and continue working with the State Exchange for the purpose of satisfying IPPTA data submission requirements. Our general position is that a State Exchange that submitted data while participating in the piloting option of voluntary State engagement will not be required as part of IPPTA to submit new data for a more recent benefit year. State Exchanges that did not submit data as part of the voluntary State engagement are required to submit data for the benefit year most recent to their designated IPPTA period agreed upon as part of the orientation and planning process.

• At paragraph (b)(3), we proposed that we would issue a pre-testing and assessment plan specific to a State Exchange at the conclusion of the pre-testing and assessment planning process. We explained that 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.

We did not receive any comments in response to the proposal that we would issue a pre-testing and assessment plan specific to a State Exchange at the conclusion of the pre-testing and assessment planning process. We also did not receive any comments in response to the proposal that the pre-testing and assessment plan would be used for internal use only and would not be made publicly available by HHS unless required by law. We are finalizing this provision as proposed.

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

• At paragraph (c)(1), we proposed the requirements associated with our 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.

We did not receive any comments in response to the proposed requirement for HHS to notify State Exchanges of the pre-testing and assessment data request period. We are finalizing these provisions as proposed.

• At paragraph (c)(2), we proposed 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 IPPTA during the pre-testing and assessment period. We explained, for example, that we 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 proposed 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 proposed this requirement because any lack of clarity in how State Exchanges make eligibility determinations and payment

calculations could impact our ability to assist the State Exchange in understanding the pre-testing and assessment processes and procedures and could affect our recommendations in the pre-testing and assessment report.

We did not receive any comments in response to the proposed requirements associated with information that State Exchanges must provide to HHS throughout the pre-testing and assessment period 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 IPPTA during the pre-testing and assessment period. We are finalizing this provision as proposed.

• At paragraph (d), we proposed the requirements regarding the submission of required data and data documentation by State Exchanges, and we stated that, as specified in § 155.1510(a), we 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.

We did not receive any comments to the specific proposed requirement for HHS to coordinate data documentation tracking and management with each State Exchange. We responded to related comments regarding the underlying data submission requirements that appear in § 155.1510(a)(2). We are finalizing this provision as proposed.

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

• At paragraph (e)(1), we proposed the requirements associated with our 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 (2).

We did not receive any comments in response to the proposed requirement for HHS to coordinate data documentation tracking and management with each State Exchange. We are finalizing these provisions as proposed.

• At paragraph (e)(2), we proposed the requirements associated with our 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 our standardized set of data elements.

We summarize and respond to public comments received on the proposed requirement for HHS to assist each State Exchange with data alignment to a standardized set of data elements below. After reviewing the public comments, we are finalizing this provision as proposed.

Comment: One commenter stated that HHS should use its own resources to map the State Exchange data elements to the pre-testing and assessment DRF.

Response: We considered an alternative to requiring each State Exchange to submit their source data using the pre-testing and assessment DRF. That alternative would have allowed a State Exchange to provide to us the required source data in an unstructured format. We would have been required to map the source data to the required data elements. The mapping process would have required consultative sessions with each State Exchange and a validation process to ensure accurate mapping. Some State Exchanges stated during voluntary State engagement that they preferred mapping their data to the data elements in the DRF in order to ensure accuracy of mapping. We believe that the consultative process suggested by the commenter would require more frequent and resource-intensive meetings, costing each party more than use of standard data fields in the pre-testing and assessment DRF. The regulatory alternative was documented in the proposed rule (87 FR 78206, 78313) and no additional comments were received in favor of that option. For these reasons, we are finalizing this provision as proposed. We are requiring that HHS coordinate with each State Exchange to aid in aligning the data specified in § 155.1510(a)(2) from the State Exchange's existing structure to the standardized set of data elements required for IPPTA.

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

We did not receive any comments in response to the proposed requirement for HHS to coordinate with each State Exchange to interpret and validate the data specified. We are finalizing this provision as proposed.

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

We did not receive any comments in response to the proposed requirement for HHS to use the data and data documentation submitted by the State Exchange to execute the pre-testing and assessment procedures. We are finalizing this provision as proposed.

• At paragraph (f), we proposed the requirements that we would issue the pre-testing and assessment checklist in conjunction with and as part of the pre-testing and assessment plan. We explained that the pre-testing and assessment checklist criteria we proposed 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);

We did not receive any comments in response to the proposed requirement for the pre-testing and assessment checklist criteria to include the State Exchange's submission of the data documentation as specified. We are finalizing this provision as proposed.

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

We did not receive any comments in response to the proposed requirement for the pre-testing and assessment criteria to include the State Exchange's submission of the data for processing and testing. We are finalizing this provision as proposed.

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

We did not receive any comments in response to the proposed requirement for the pre-testing and assessment criteria to include the State Exchange's completion of the pre-testing and assessment processes and procedures related to the IPPTA program. We are finalizing this provision as proposed.

• At paragraph (g), we proposed that, subsequent to the completion of a State Exchange's pre-testing and assessment period, we will prepare and issue a pre-testing and assessment report specific to that State Exchange. We proposed that the pre-testing and assessment 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 did not receive any comments in response to the proposal that, subsequent to the completion of a State Exchange's pre-testing and assessment period, we will prepare and issue a pre-testing and assessment report specific to that State Exchange. We also did not receive any comments in response to the proposal that 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 are finalizing this provision as proposed.

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)

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78272 through 78273), for the 2024 benefit year, we proposed 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 stated 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.[277] 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

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 we stated in the proposed rule, 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).

As we explained in the proposed rule (87 FR 78273), 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.

We stated in the proposed rule (87 FR 78273) that the proposed user fee rate for all participating FFE issuers of 2.5 percent of total monthly premiums was based on estimated costs, enrollment (including anticipated establishment of SBEs in certain States in which FFEs currently are operating), and premiums for the 2023 PY. We refer readers to the proposed rule (87 FR 78273) for a full description of how the proposed 2024 benefit year FFE user fee rate was developed.

b. SBE–FP User Fee Rates 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 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. We explained in the proposed rule that 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. We stated that 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. We refer readers to the proposed rule (87 FR 78273 through 78274) for a full description of how the proposed 2024 benefit year SBE–FP user fee rate of 2.0 percent of total monthly premiums was developed.

We sought comment on the proposed 2024 user fee rates.

After reviewing the public comments and revising our projections based on newly available data that impacted our enrollment projections, we are finalizing for the 2024 benefit year a user fee rate for all issuers offering QHPs through an FFE of 2.2 percent of the monthly premium charged by the issuer for each policy under plans where enrollment is through an FFE, and a user fee rate for all issuers offering QHPs through an SBE–FP of 1.8 percent of the monthly premium charged by the issuer for each policy under plans offered through an SBE–FP. We summarize and respond to public comments received on the proposed 2024 benefit year FFE and SBE–FP user fee rates below.

Comment: Some commenters supported the proposed 2024 user fee rates by agreeing that a lower user fee rate would exert downward pressure on premiums. A few commenters supported user fee rate reduction in future years too. One commenter stated that lower user fee rates could incentivize additional issuers to participate in the Exchanges, providing consumers with additional choice. One supporting commenter wanted HHS to monitor whether a reduced user fee rate continued to fully serve consumers' needs moving forward. Many commenters appreciated the increased funding for consumer outreach.

Response: We proposed lowering the 2024 user fee rates in the proposed rule to 2.5 percent of monthly premiums charged by issuers for each policy under plans offered through an FFE and 2.0 percent of monthly premiums charged by issuers for each policy under plans offered through an SBE–FP based on our enrollment projections at the time. After publishing the proposed rule, two major

[277] See Circular No. A–25 Revised, available at *https://obamawhitehouse.archives.gov/omb/circulars_a025/.*

events have changed our estimated enrollment for benefit year 2024. The first event was the record 2023 Exchange Open Enrollment, with the number of plan selections exceeding our enrollment estimates.[278] The second event was the Consolidated Appropriations Act, 2023, signed into law of December 29, 2022, which included provisions that provided certainty that Medicaid redeterminations would take place beginning in 2023. These two changes, both of which took place between the publication of the proposed rule and the final rule, prompted us to reassess the 2024 projected enrollment estimates used in our user fee calculations. After additional analysis of increased future expected enrollment, we have determined that further reduction to the 2024 user fee rates is warranted.

FFE and SBE–FP user fees are collected from participating issuers as a percentage of total monthly premiums, which is calculated as the product of monthly enrollment and premiums. The increased future expected enrollment resulting from the record 2023 Open Enrollment and the Consolidated Appropriations Act, 2023, increased overall expected user fee collections under the proposed user fee rates of 2.5 percent of monthly premiums for FFE issuers and 2.0 percent of monthly premiums for SBE–FP issuers above levels determined to be necessary to fully fund Exchange operation. This increased collection estimate allowed for additional reductions of the user fee rates to 2.2 percent of monthly premiums for FFE issuers and 1.8 percent of monthly premiums for SBE–FP issuers without decreasing total estimated collections below levels necessary to fully fund Exchange operations.

Accordingly, we are finalizing user fee rates of 2.2 percent of monthly premiums charged by issuers for each policy under plans offered through an FFE and 1.8 percent of monthly premiums charged by issuers for each policy under plans offered through an SBE–FP. As discussed in the proposed rule (87 FR 78273), we believe that the lower 2024 user fee rates will exert downward pressure on premiums when compared to the user fee rates from prior years, and ensure adequate funding for Federal Exchange operations. We also agree that lower user fee rates may incentivize additional issuers to participate in the Exchanges, thereby promoting competition and improving consumer choice. HHS will continue to calculate the FFE and SBE–FP user fee rate annually in a manner that ensures sufficient funding for operations, ensuring that consumers' needs are met and consumer outreach is appropriately funded.

Comment: Many commenters expressed concern about the timing of decreased user fee rates considering the high anticipated volume of Medicaid redeterminations. These commenters suggested additional investment in outreach and enrollment and requested that the user fee rates be kept at their current levels. Several commenters stated that lower user fee rates could reduce funding for community health workers and encourage private navigators that are incentivized to direct consumers to certain private products. A few commenters supported using the higher pre-2022 user fee rates to improve *HealthCare.gov.* One commenter suggested retaining or increasing user fee rates to devote additional resources to hard to reach populations. One commenter suggested that reducing user fee rates may undermine the historic enrollment gains for 2023. One commenter disagreed that reducing user fee rates will result in downward pressure on premiums, citing other factors as more impactful drivers of premium increases.

Response: Although we are reducing the user fee rates, we are not reducing our user-fee budget and are considering the additional cost for Medicaid redeterminations, including providing consumer outreach and education related to unwinding, in our estimated budget. With these estimated costs, we are still able to reduce the user fees and retain this budget because we anticipate higher Exchange enrollment levels due to Medicaid redeterminations, and we expect the projected total premiums where the user fee applies to increase, thereby increasing the amount of user fee that will be collected. Thus, we are able to reduce the user fee rate without reducing the budget. We believe that any additional costs associated with Medicaid redeterminations will be offset by the higher expected enrollment and, even after accounting for the impact of the lower user fee rates, we estimate that we will have sufficient funding available to fully fund user-fee eligible Exchange activities in 2024, even with increased budget needs.

To further explain, due to high levels of anticipated enrollment through the end of 2025, and the increased total amount of user fees that will be collected as a result, we believe that a reduced user fee rate will not result in reduced funding to Exchange functions that address consumers' needs, including improvements to the *HealthCare.gov* website, outreach and enrollment campaigns, and the Navigator program. We understand that this funding is particularly impactful in improving coverage for hard to reach and underserved populations, which is why our estimated budget continues to estimate fully covering the costs of these programs, even with increased budgetary spending on these essential activities.

We also disagree that reducing user fees may undermine the historic enrollment gains for 2023, as we do not believe that the user fee rates have direct impact on major enrollment trends. Instead, we believe that the historic enrollment gains can be attributed to a number of factors that are non-user fee rate related, such as the enhanced PTC subsidies in section 9661 of the ARP being extended through the 2025 benefit year in section 12001 of the IRA.

Finally, while we acknowledge that there are many factors that drive premiums increases, we maintain that reduced user fee rates will tend to exert downward pressure on premiums, with issuers passing the additional savings from reduced user fees on to Exchange enrollees through lower premiums.

For these reasons, we are finalizing the reduced user fee rates for the 2024 benefit year of 2.2 percent of monthly premiums charged by issuers for each policy under plans offered through an FFE and 1.8 percent of monthly premiums charged by issuers for each policy under plans offered through an SBE–FP. As always, we will reassess the FFE and SBE–FP user fee rates for the 2025 benefit year and propose those rates in the proposed 2025 Payment Notice. We also note that we will continue to look for opportunities to reduce these user fee rates in the future, while ensuring that we will be able to fully fund all Exchange activities.

Comment: A few commenters stated that HHS should adopt a PMPM user fee structure, stating that administrative costs do not track with premium changes and a PMPM user fee would avoid higher fee amounts based solely on premium increases.

Response: We did not propose any changes to the user fee structure, as such the user fee rates will continue to be set as a percent of the premium. However, we will continue to engage with interested parties regarding how the FFE and SBE–FP user fee policies

[278] Biden-Harris Administration Announces Record-Breaking 16.3 Million People Signed Up for Health Care Coverage in ACA Marketplaces During 2022–2023 Open Enrollment Season, available at *https://www.cms.gov/newsroom/press-releases/biden-harris-administration-announces-record-breaking-163-million-people-signed-health-care-coverage.*

can best support consumer access to affordable, quality health insurance coverage through the Exchanges that use the Federal platform. We also note that, even if administrative costs do not trend with premium changes, we propose and finalize user fee rates each benefit year and would have the opportunity to adjust the user fee rates to avoid higher fee amounts based solely on premium increases. Therefore, even if administrative costs do not trend with premium changes, we do not believe that would necessarily justify a PMPM user fee cost structure.

Comment: One commenter appreciated the increased transparency around user fees, and encouraged additional transparency in the methodology used to set the user fee rates, as well as how user fees support HHS' policy goals for the Exchanges. A few other commenters recommended greater transparency in how the user fee rates are determined and requested enumerated costs of providing Federal eligibility and enrollment platform service and infrastructure to each State.

Response: We provided additional information in the proposed rule (87 FR 78272 through 78274), explaining the impact of stable contract cost estimates, the enhanced PTC subsidies in section 9661 of the ARP being extended in section 12001 of the IRA through the 2025 benefit year, anticipated effects of the IRA on enrollment, and States transitioning from FFEs or SBE–FPs to SBEs, as well as the enrollment impacts of section 1332 State innovation waivers. Additionally, we note that FFE and SBE–FP user fee costs are not allocated to or provided to each State. User fees cover activities performed by the Federal government that provide issuers offering a plan in an FFE or SBE–FP with a special benefit. As stated, these services are generally IT, eligibility, enrollment, and QHP certification services that are more efficiently conducted in a consolidated manner across the Federal platform, rather than by States, so that the services, service delivery, and infrastructure can be the same for all issuers in the FFEs and SBE–FPs. For example, all FFE and SBE–FP issuers send their 834 enrollment transactions to the Federal platform database, which are processed consistently regardless of State. Contracts are acquired to provide services for the Federal platform. The services do not differ by State, and therefore, we do not calculate costs on a State-by-State basis. Additionally, because HHS is not permitted to publicly provide information that is confidential due to trade secrets associated with contracting, there are limits in our ability to provide detailed information about our budget.

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, we 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 did not propose to change the methodology for these parameters for the 2024 benefit year, and therefore, we published these parameters in guidance on December 12, 2022.[279]

3. Standardized Plan Options (§ 156.201)

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78274 through 78279), we proposed to exercise our authority under sections 1311(c)(1) and 1321(a)(1)(B) of the ACA to make several minor updates to our approach for 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. We refer readers to the proposed rule (87 FR 78274 through 78275) for discussion of our prior and current standardized plan option policies.

First, in contrast to the policy finalized in the 2023 Payment Notice, we proposed, for PY 2024 and subsequent PYs, to no longer include a standardized plan option for the non-expanded bronze metal level. Accordingly, we proposed 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 proposed 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 proposed 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.

As we explained in the proposed rule (87 FR 78276), we proposed to discontinue standardized plan options for the non-expanded bronze metal level mainly due to AV constraints. Specifically, we explained that 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, we explained that 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 explained that we believe that discontinuing non-expanded bronze standardized plan options would minimize burden without causing deleterious consequences. We also clarified 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 further clarified 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.

Consistent with our approach in the 2023 Payment Notice, we did not propose 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 also explained that we would continue to require issuers to offer these plan variations for all standardized plan options offered, and we proposed 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,

[279] *https://www.cms.gov/files/document/2024-papi-parameters-guidance-2022-12-12.pdf.*

those plan variations will themselves not be standardized plan options based on designs specified in this rulemaking.[280]

Similar to the approach taken in the 2023 Payment Notice, we proposed 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 to accommodate State cost-sharing laws; and decreasing the AVs for these plan designs to be at the floor of each AV de minimis range primarily by increasing deductibles.

Furthermore, consistent with the approach taken in the 2023 Payment Notice, we proposed to create two sets of standardized plan options at the aforementioned metal levels, with the same sets of designs applying to the same sets of States as in the 2023 Payment Notice. Specifically, we proposed that 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 9 and Table 10 for the two sets of standardized plan options we are finalizing for PY 2024.

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

Also, consistent with our policy in PY 2023, we stated that we would continue to apply these requirements to applicable issuers in the individual market but not in the small group market. We also explained that we 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,[281] from the requirement to offer the standardized plan options included in this rule.

In addition, we stated that we would continue to exempt issuers in SBEs from these requirements for several reasons. First, we explained that we did not wish to impose duplicative standardized plan option requirements on issuers in the eight SBEs that already have standardized plan option requirements. Additionally, we explained that we continue to believe that SBEs are best positioned to understand both the nuances of their respective markets and consumer needs within those markets. Finally, we explained that we continue to believe that States that have invested the necessary time and resources to become SBEs have done so 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 explained that 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 further explained that 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 continue to 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. Consistent with our PY 2023 policy, we stated that 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 provided under the requested deviation as is provided on *HealthCare.gov.*

Consistent with the approach to plan designs in the 2023 Payment Notice, we explained that we would 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 stated that we believe the use of four tiers of prescription drug cost-sharing in the standardized plan options would continue to allow for predictable and understandable drug coverage. We further explained that we believe the use of four tiers of prescription drug cost-sharing would 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.

We also explained that the continued use of four tiers would 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 noted that we would consider including additional drug tiers for future years, and invited comment on the appropriate number of drug tiers to use in standardized plan options in the future. However, we explained that 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.

In addition, we noted concerns that issuers may not be including specific drugs at appropriate cost-sharing tiers for the standardized plan options; for example, that 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 explained that 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 proposed 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 all covered brand name drugs in either the standardized

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

[281] See Or. Admin. R. 836–053–0009.

plan options' preferred brand or non-preferred brand drug cost-sharing tiers, or the 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 specified 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 proposed the approach described in this section for PY 2024 and subsequent PYs for several reasons. To begin, we explained that we were 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. We explained that 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 stated that 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, we explained that with these standardized plan options, consumers would continue to be able to take other meaningful factors into account, such as networks, formularies, and premiums, when selecting a plan option. We stated that we further believe these standardized plan options include several distinctive features, such as enhanced pre-deductible coverage for several benefit categories, that would continue to play an important role in reducing barriers to access, combatting discriminatory benefit designs, and advancing health equity. We explained that including enhanced pre-deductible coverage for these benefit categories would ensure consumers are more easily able to access these services without first meeting their deductibles. Furthermore, we explained that including copayments instead of coinsurance rates for a greater number of benefit categories would 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 proposed to maintain a high degree of continuity for 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 explained that we believe that 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, we explained that if these standardized plan options 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. We stated that, ultimately, we believe that consistency in standardized plan options is important to allow both issuers and enrollees to become accustomed to these plan designs.

We sought comment on our proposed approach to standardized plan options for PY 2024 and subsequent PYs.

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TABLE 9: 2024 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%	70.01%	73.00%	87.03%	94.06%	78.02%	88.10%
Deductible	$7,500	$5,900	$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 10: 2024 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%	70.01%	73.00%	87.04%	94.08%	78.04%	88.11%
Deductible	$7,500	$5,900	$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.

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After reviewing public comments, we are finalizing our proposed policies with respect to standardized plan options for PY 2024 and subsequent PYs, as proposed, except as follows. First, we are not finalizing the proposed requirement 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 all covered brand name drugs in either the standardized plan options' preferred brand or non-preferred brand drug cost-sharing tiers, or the specialty drug tier if there is an appropriate and non-discriminatory basis in accordance with § 156.125 for doing so.

Additionally, we note that both of the standard silver plan designs finalized in this rule, as set forth in Tables 9 and 10 above, differ slightly from the corresponding plan designs in the proposed rule (87 FR 78278 through 78279). Specifically, in this final rule, for both of these standard silver plans, we are reducing the deductible by $100 from $6,000 to $5,900, which increases the AV for these plans from 70.00 percent to 70.01 percent. We are making this change to rectify an error in our use of the proposed AV Calculator and Plans and Benefits Template. Specifically, the proposed AV Calculator produced an AV output of 69.998 percent for both of these standard silver plans.

However, the proposed AV Calculator rounds to only two decimal places, which resulted in the AV output for both of these plans being rounded up to 70.00 percent. With a permissible AV de *minimis range* for the standard silver metal level of 70.00 percent to 72.00 percent, these standard silver plans (with an unrounded AV of 69.998 percent) would have failed the AV *de minimis* range validation within the Plans and Benefits Template, meaning issuers would not have been able to successfully submit these plans during QHP certification. We designed these plans to have AVs near the floor of each *de minimis* range to ensure competitive premiums for these plans. Slightly modifying the deductibles for these plans ensures that they will continue to have competitive premiums and AVs within the permissible AV *de minimis* range. All other aspects of these plan designs remain unchanged from the corresponding plan designs in the

proposed rule. Given that the same rounding logic is present in the final AV Calculator and the final Plans and Benefits Template, we note that this change must also be made in the final versions of each of these tools.

We summarize and respond to public comments received on the proposed policies with respect to standardized plan options below.

Comment: Many commenters expressed support for continuing to require FFE and SBE–FP issuers to offer standardized plan options. These commenters explained that standardized plan options serve an important role in simplifying the plan selection process for consumers purchasing health insurance through the Exchanges. These commenters also explained that the plan selection process could be further simplified if the requirement for issuers to offer standardized plan options were paired with the proposed requirements in § 156.202 in the proposed rule to reduce the risk of plan choice overload by either directly limiting the number of non-standardized plan options that issuers can offer through the Exchanges or by implementing a meaningful difference standard.

These commenters explained that the continued emphasis on efforts to further simplify the plan selection process is especially important given the continued proliferation of available plan choices offered through the Exchanges, as was described in greater detail in § 156.202 of the preamble of the proposed rule (87 FR 78279 through 78283). Commenters further explained that having an overwhelming number of plan choices to consider during the plan selection process significantly exacerbates the risk of plan choice overload, which also increases the risk of suboptimal plan selection and unexpected financial harm. Commenters thus explained that continuing to require issuers to offer these standardized plan options would act as one prong in a multi-pronged strategy to meaningfully simplify the plan selection process, thereby reducing the risk of suboptimal plan selection and unexpected financial harm to consumers.

Commenters who supported continuing to require issuers to offer standardized plan options also explained that the standardized plan options included in the proposed rule also contain several distinctive features, such as enhanced pre-deductible coverage for a wide range of benefit categories, including primary care visits, urgent care visits, specialist visits, mental health and substance use disorder outpatient office visits, speech therapy, occupational therapy, physical therapy, and generic drugs. Commenters explained that the enhanced pre-deductible coverage for these benefit categories would continue to serve an important role in reducing barriers to access for services critical to health. Commenters supportive of these standardized plan options also explained that including copayments instead of coinsurance rates as the form of cost sharing for as many benefit categories as possible would continue to enhance the predictability of costs for consumers enrolled in these plans, thus further reducing the risk of unexpected financial harm.

Conversely, several commenters opposed continuing to require issuers to offer these standardized plan options. These commenters explained that QHPs are sufficiently standardized due to requirements pertaining to EHB, annual limitations on cost sharing, metal tiers, and the recently narrowed AV *de minimis* ranges for each metal tier. These commenters also explained that continuing to require issuers to offer these standardized plan options would inhibit issuer innovation in plan design, reducing the degree of consumer choice. Several commenters also noted that requiring issuers to offer standardized plan options in PY 2023 contributed to the sharp increase in plans offered during this past Open Enrollment, which further increased the risk of plan choice overload.

Response: We agree that continuing to require issuers to offer these standardized plan options will serve an important role in simplifying the plan selection process, especially when done in conjunction with reducing the risk of plan choice overload by directly limiting the number of non-standardized plan options that issuers can offer as well as with further enhancing and optimizing choice architecture and the consumer experience on *HealthCare.gov.* We agree with commenters that simplifying the plan selection process will reduce the risk of suboptimal plan selection and unexpected financial harm to consumers. We also agree that the enhanced pre-deductible coverage and the inclusion of copayments instead of coinsurance rates for a broad range of benefit categories in these standardized plan options will continue to serve as important forms of consumer protection.

We further believe that this additional degree of standardization—beyond the existing requirements pertaining to EHB, annual limitations on cost sharing, metal tiers, and the recently narrowed AV *de minimis* ranges for each metal tier—for plans offered through the Exchanges is warranted given the continued proliferation of available plan choices offered through the Exchanges, a stable trend that has continued unabated for several years. We believe the overwhelming number of plan choices necessitates taking measures to further simplify the consumer experience in order to reduce the risk of suboptimal plan selection.

We acknowledge that requiring issuers to offer these standardized plan options contributed to the increase in the total number of plans offered through the Exchanges. However, we note that in the 2023 Payment Notice (87 FR 27318), we encouraged issuers to modify their existing non-standardized plan offerings—in accordance with uniform modification requirements at § 147.106(e)—to conform with the cost-sharing parameters of the standardized plan options finalized in the 2023 Payment Notice in order to significantly reduce the number of total new plan offerings on the Exchanges. We reiterate this encouragement.

Additionally, since these standardized plan options contain several distinctive benefits, such as enhanced pre-deductible coverage and a preference for copayments instead of coinsurance rates, and since we believe these standardized plan options play an important role in simplifying the plan selection process, we believe limiting the number of non-standardized plan options that issuers can offer will offset this increase in the number of total plan offerings.

Finally, we disagree that continuing to require issuers to offer these standardized plan options will inhibit issuer innovation in plan design and reduce consumer choice. First, given that issuers will still be permitted to offer two non-standardized plan options per product network type, metal level, inclusion of dental or vision benefit coverage, and service area, we believe that issuers will continue to have sufficient flexibility to innovate and that consumers will continue to retain a satisfactory degree of choice.

Additionally, as is explained in greater detail in the section of the preamble to this rule addressing § 156.202, a 2016 report by the RAND Corporation reviewing over 100 studies 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.[282] We also referred to a

[282] Taylor EA, Carman KG, Lopez A, Muchow AN, Roshan P, and Eibner C. Consumer

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.[283] As we note in the section of the preamble to this rule addressing § 156.202, with the limit we are finalizing on the number of non-standardized plans that may be offered, we estimate (based on Plan Year 2023 data) that the weighted average number of non-standardized plan options (which does not take into consideration standardized plan options) available to each consumer will be reduced from approximately 89.5 in PY 2023 to 66.3 in PY 2024, while the weighted average total number of plans (which includes both standardized and non-standardized plan options) available to each consumer will be reduced from approximately 113.7 in PY 2023 to 90.5 in PY 2024, which we believe will still provide consumers a satisfactory degree of choice and will continue to allow them to select a plan that meets their unique health needs.

Altogether, we believe the standardized plan option requirements at § 156.201 in conjunction with the non-standardized plan option limits at § 156.202 will meaningfully enhance consumer choice by allowing consumers to more easily and meaningfully compare available plan choices by reducing the risk of plan choice overload.

Comment: Many commenters supported maintaining a high degree of continuity in both the broader policy approach as well as in specific plan designs from the previous plan year. These commenters explained that maintaining a consistent approach between plan years would maintain predictability for consumers currently enrolled in these plans. These commenters further explained that introducing drastic changes in the plan designs would unnecessarily risk disruption for issuers, states, and enrollees.

Response: We agree that maintaining the highest degree of continuity possible in both the broader approach, as well as in the specific plan designs from the previous plan year is highly desirable, mainly in order to maintain predictability, to minimize the risk of disruption for issuers, States and enrollees, and to minimize issuer burden.

Comment: Many commenters expressed concerns about several aspects of these plan designs. Specifically, several commenters expressed concern about the high deductibles for these plans. These commenters explained that having high deductibles acts as a significant barrier that makes it more difficult for consumers to obtain the care they need. Thus, many commenters recommended lowering the deductibles for these plans in order to decrease barriers to access. Commenters also emphasized the need to expand pre-deductible coverage to a broader range of benefit categories, including laboratory services, x-rays and diagnostic imaging, outpatient facility fees, outpatient surgery physician fees, and more tiers of prescription drug coverage.

Response: We agree that high deductibles can act as a barrier to obtaining health care services, and that expanding pre-deductible coverage to a broader range of benefit categories would help to expand access to health care services. However, to ensure these plans have design attributes that reflect the most popular plan offerings, to maintain reasonable cost sharing amounts, to continue exempting benefit categories that contain some of the most frequently utilized health care services from the deductible, and to ensure these plans have competitive premiums, all the while maintaining an AV within the permissible AV *de minimis* range, we are unable to materially lower the deductibles or exempt additional benefit categories from the deductibles in these plan designs. We note that we will consider these modifications in future PYs.

Comment: Several commenters supported excluding plan designs for standardized plan options at the non-expanded bronze metal level. These commenters explained that excluding non-expanded bronze plan designs would reduce issuer and State burden, as there would be fewer plans for issuers to offer and for States to certify. These commenters also explained that the non-expanded bronze plan standardized plan options finalized in the 2023 Payment Notice did not include pre-deductible coverage for any services, which places consumers at risk of unexpected financial harm. Additionally, commenters explained that issuers generally chose to offer standardized plan options at the expanded bronze metal level instead of the non-expanded bronze metal level in PY 2023 since these plans included pre-deductible coverage for a range of benefit categories.

Conversely, several commenters opposed excluding plan designs for standardized plan options at the non-expanded bronze metal level, explaining that consumers currently enrolled in these low-cost plans would lose access to their current plan offerings.

Response: We agree that excluding plan designs for standardized plan options at the non-expanded bronze metal level will reduce issuer and State burden with minimal consumer harm since these plan designs contain no pre-deductible coverage. In addition, as noted in the proposed rule, few issuers chose to offer non-expanded bronze standardized plan options in PY 2023. We also note that although consumers currently enrolled in standardized plan options at the non-expanded bronze metal level would lose access to their current plan offering, these consumers could continue to have access to non-standardized plan options at the non-expanded bronze metal level, if the issuer continues to offer such a plan. We believe non-standardized plan options at the non-expanded bronze metal level would be appropriate replacements for consumers' current standardized plan offerings at that level since there is little material difference between a standardized plan option at the non-expanded bronze metal level and a non-standardized plan option at the non-expanded bronze metal level—primarily due to severe AV constraints.

Comment: Several commenters supported continuing to include only four tiers of prescription drug cost sharing in the formularies of the standardized plan options. These commenters generally explained that doing so would allow consumers to better understand their drug coverage, thereby reducing the risk of unexpected financial harm. These commenters also noted that the continuity in this aspect of the plan designs is highly desirable for consumers, and that this would further minimize the risk of disruption for these consumers.

Conversely, several commenters supported including more than four tiers of prescription drug cost sharing in the formularies of the standardized plan options. These commenters instead recommended permitting the inclusion of five or six tiers, explaining that this formulary structure is common practice in the commercial market. These commenters explained that including additional tiers of cost sharing in these formularies would promote competition among manufacturers for favorable formulary placement, thus reducing costs for consumers.

Decisionmaking in the Health Care Marketplace. RAND Corporation. 2016.

[283] 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.

Response: While we acknowledge that the inclusion of five or six tiers in formularies is common practice in the commercial market, we believe the advantages of maintaining four tiers in these standardized plan option formularies outweigh the advantages of permitting additional tiers at this time. Specifically, we agree that continuing to include only four tiers of prescription drug cost sharing in the formularies of these standardized plan options will continue to allow for more predictable and understandable drug coverage, thereby reducing the risk of unexpected financial harm for consumers enrolled in these plans.

Additionally, we believe that not finalizing the proposed formulary tiering placement regulations that would have required issuers to place all covered generic drugs in the generic cost-sharing tier and all brand drugs in either the preferred or non-preferred brand cost-sharing tier (or the specialty cost-sharing tier, with an appropriate and non-discriminatory basis) (as discussed later in this section) for PY 2024 will continue to facilitate competition among manufacturers for favorable formulary placement, reducing costs for consumers, which we believe is especially important given the other significant policies finalized in this rule.

We also note that the four-tier design feature is consistent with the plan designs for PY 2023. As noted in the proposed rule (87 FR 78277), we believe that the use of four tiers plays an important role in facilitating the consumer decision making process by allowing consumers to more easily compare formularies between plans, and allows for easier year-to-year comparison with their current plan. Thus, in order to minimize the degree of disruption for enrollees, we will continue to include only four tiers of prescription drug cost-sharing (excluding the zero-cost share preventive drugs and the medical services drugs cost-sharing tiers) in these standardized plan options for PY 2024.

Comment: Several commenters supported requiring issuers to place all covered generic drugs in the generic drug cost sharing tier and all covered brand drugs in either the preferred brand or non-preferred brand drug cost sharing tiers—or the specialty tier, with an appropriate and non-discriminatory basis—in the standardized plan options. These commenters explained that introducing such a requirement would enhance predictability for consumers and allow them to anticipate the expected costs for prescription drugs, which would further decrease the risk of unexpected financial harm. Commenters further explained that this requirement would act as an important step in ensuring that patients are not forced to overpay for low-cost generic prescription drugs.

Several commenters further explained that generic drugs are a major source of cost savings for patients and systems. These commenters cited recent analyses that demonstrated that generics comprise roughly 91 percent of prescriptions yet only account for 18.2 percent of prescription drug spending. These commenters also cited analyses that demonstrated that generics save hundreds of billions of dollars in prescription drug spending overall, with demonstrated patient savings of $373 billion in 2021. These commenters also explained how the number of generic drugs covered on generic cost sharing tiers has been steadily decreasing over the years. These commenters explained that as recently as 2016, 65 percent of generic drugs were covered on generic tiers, but in 2022, only 43 percent of generic drugs were covered on generic tiers—a decrease of 22 percent in just six years.

Conversely, several commenters opposed requiring issuers to place all covered generic drugs in the generic drug cost sharing tier and all covered brand drugs in either the preferred brand or non-preferred brand drug cost sharing tiers—or the specialty tier, with an appropriate and non-discriminatory basis—in these standardized plan options.

Specifically, commenters explained that there are numerous examples of high-cost generic prescription drugs that have lower-cost, clinically similar brand-name prescription alternatives. Similarly, commenters explained that there are brand-name prescription drugs that may offer clinical and financial value that supports tiering lower than the preferred brand tier. Thus, commenters explained that the traditional viewpoint that generic drugs are the lowest-cost or highest value option is not always necessarily the case. Commenters further stated that it is commonplace in all market segments to shift generics to lower tiers only at the point where they become the most cost-effective option. Commenters also explained that the purpose of tiered formularies is to encourage the use of high value drugs—not to encourage the use of generic drugs, per se, especially since generic prescription drugs are no longer consistently inexpensive or high-value.

In addition, several commenters expressed concern that requiring brand prescription drugs to be placed on a higher cost sharing tier could result in decreased medication adherence, which would be especially detrimental for consumers with chronic conditions that require treatment with brand-name prescription drugs (such as asthma medications and insulin). Moreover, several commenters noted that this policy would force the placement of clinically inappropriate and high-priced prescription drugs on lower tiers, thus undermining the work of Pharmacy & Therapeutics Committees that considers multiple factors when deciding the tier on which to place each prescription drug.

Several commenters also expressed concern that this requirement would incentivize manufacturers to take advantage of mandatory tier placement by raising the cost of certain drugs. Similarly, several commenters expressed concern that this requirement would limit PBM flexibility to effectively manage formularies and enrollee drug spending, as well as PBM and issuer position in negotiations with manufacturers.

Moreover, these commenters were concerned that this policy could lead to more administrative costs and may require issuers to maintain two sets of formularies for standardized and non-standardized plan options, and that this may lead to more confusion for consumers. Ultimately, several commenters noted that this policy may have the unintended effect of increasing costs for consumers through the cost of each tier with higher out-of-pocket costs, cost-sharing, and the price of premiums.

Response: We agree that requiring generic prescription drugs to be placed in the generic drug cost sharing tier and brand drugs in the preferred or non-preferred brand drug cost sharing tiers (or the specialty tier, with an appropriate and non-discriminatory basis) would enhance predictability for consumers and could potentially result in patient cost savings. However, comments regarding the changing nature of the costs of brand name drugs and generics, flexibility in designing formularies, and decreased medication adherence have led us to determine that we should further investigate the potential impact of this proposed requirement. For example, we believe that there may be merit in examining drug tiering more broadly, and not just as related to standardized plan options. Furthermore, as noted earlier in this section, we value maintaining the highest degree of continuity possible in both the broader approach, as well as in the specific plan designs from the

previous plan year and we intend to minimize disruption while still improving on our policies. As such, we are not finalizing this requirement for PY 2024, but we intend to conduct further investigation for future PYs.

Comment: Several commenters had specific recommendations regarding the manner in which these standardized plan options are displayed as well as broader aspects of choice architecture and the user experience on *HealthCare.gov.*

Specifically, several commenters recommended including a more granular level of detail to highlight important differences between plans, such as by displaying both the product ID and network ID of plans. Additionally, several commenters underscored the need to streamline the plan selection process by adding more filters and sort orders to highlight innovative plan designs and plans with supplemental benefits, to prioritize lower deductible plans, or to prioritize plans with particular cost sharing types and amounts. Several commenters recommended including additional screener questions to assess consumer preferences for cost, providers, prescription drugs, utilization, and cost-sharing assistance. Several commenters recommended including display features that would further facilitate consumer education and understanding, such as through pop-ups on screen and accompanying explanatory messages clarifying what distinguishes ''Easy Pricing'' plans from non-standardized plan options.

Finally, several commenters explained that enhancing choice architecture and the user experience on *HealthCare.gov* would be a more effective and less disruptive method to simplify the plan selection process and facilitate consumer decision-making than limiting the number of non-standardized plan options that issuers can offer through the Exchanges.

Response: We appreciate the commenters' recommendations and will take them into consideration. We agree that enhancing choice architecture and the user experience on *HealthCare.gov* can serve an important role in simplifying the plan selection process, but we also believe that these enhancements must be made in conjunction with other steps—such as enhancing comparability by requiring issuers to offer standardized plan options, and by reducing the risk of plan choice overload by limiting the number of non-standardized plan options that issuers can offer. Ultimately, we believe that multifaceted problems such as plan choice overload, suboptimal plan selection, and unexpected financial harm are best mitigated through multifaceted approaches.

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

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78279), we proposed to exercise the authority under sections 1311(c)(1) and 1321(a)(1)(B) of the ACA to add § 156.202 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 for, among other things, the offering of QHPs through such Exchanges.

In the proposed rule (87 FR 78279), we explained that under this proposed limit, 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, we explained that 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 final rule, we proposed to not apply this requirement to issuers in SBEs for several reasons. First, we explained that we did not wish to impose duplicative requirements on issuers in the SBEs that already limit the number of non-standardized plan options. Additionally, we stated that we believe that SBEs are best positioned to understand both the nuances of their respective markets and consumer needs within those markets. Finally, we explained that we believe that States that have invested the necessary time and resources to become SBEs have done so to implement innovative policies that differ from those on the FFEs, and that we did not wish to impede these innovative policies, so long as they comply with existing legal requirements.

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

Finally, also in alignment with the approach taken with respect to standardized plan options in the 2023 Payment Notice and this final rule, we proposed that this 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, we explained that 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, we stated that we do not believe the same requirements should be applied to these other markets.

We also explained that we believe 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 we did ultimately choose to limit the number of non-standardized plan options that issuers can offer. Thus, we stated that 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.

We stated in the proposed rule (87 FR 78280) that, under this proposed limit, we 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, which we stated we believe would still provide consumers with a sufficient number of plan offerings.[284] Furthermore, we estimated that approximately 60,949 of a total 106,037 non-standardized plan option plan-county combinations offered in PY 2022 (amounting to 57.5 percent of non-standardized plan option plan-county combinations) would be discontinued as a result of this limit, a number we stated would still provide consumers with a sufficient degree of choice during the plan selection process.[285]

Finally, we stated that if this limit were adopted, we estimated 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.[286] We also explained that we 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, we explained that we 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, we also 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, we noted that although we continue to prioritize competition and choice on the Exchanges, we were concerned about plan choice overload, which can result when consumers have too many choices in plan options on an Exchange. We referred to a 2016 report by the RAND Corporation reviewing over 100 studies which concluded that having too many health plan choices can lead to poor enrollment decisions due to the difficulty consumers face in processing complex health insurance information.[287] We also referred to a study of consumer behavior in Medicare Part D, Medicare Advantage, and Medigap that demonstrated that a choice of 15 or fewer plans was associated with higher enrollment rates, while a choice of 30 or more plans led to a decline in enrollment rates.[288]

With this concern in mind, we explained in the 2023 Payment Notice that we were interested in exploring possible methods of improving choice architecture and preventing plan choice overload. We expressed interest in exploring the feasibility and utility of limiting the number of non-standardized plan options that 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, we 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, or 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, in the proposed rule (87 FR 78280 through 78281), we noted that during the standardized plan option interested party engagement sessions we 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, we explained in the proposed rule (87 FR 78281) that QHP submission data supports the argument that enacting such a limit would be beneficial for consumers, noting that there has been a sizeable increase in the weighted average number of plans available per enrollee and plans offered per issuer in recent years. We refer readers to the proposed rule further discussion. With this continued plan proliferation for both enrollees and issuers, we explained that we believe 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.*

We also stated in the proposed rule (87 FR 78281) that to reduce the risk of plan choice overload, we 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. We explained that we agree 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, we stated that we made several enhancements to *HealthCare.gov* for the open enrollment period for PY 2023. We also explained

[284] 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.

[285] Plan-county combinations are the count of unique plan ID and Federal Information Processing Series (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.

[286] These calculations assumed 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.

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

[288] 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.

that we intend to continue conducting research to inform further enhancements to the consumer experience on *HealthCare.gov* for PY 2024 and subsequent PYs.

That said, we explained that we believe that enhancing choice architecture on *HealthCare.gov* is necessary but, alone, insufficient to reduce the risk of plan choice overload for several reasons. First, we stated that *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, we noted that 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, we explained that we believe consumers enrolling in QHPs through these alternative pathways would not benefit to the same degree as those enrolling through *HealthCare.gov* if we 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, we explained that we believe a more comprehensive approach to reducing plan choice overload that would also benefit those utilizing these alternative enrollment pathways was required.

Furthermore, we explained that while making 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, we explained that we believe 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 would continue unless limits on the number of these plans are set. We also explained that near-duplicate plans are the most difficult to filter and sort out by interface improvements, and would therefore be most effectively addressed by limiting the number of non-standardized plan options.

As such, we explained that we believe 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, we explained that we believe 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, we explained that we believe limiting the number of non-standardized plan options that issuers can offer in conjunction with enhancing the plan comparison experience on *HealthCare.gov* would be 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.

In addition, we proposed, 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 impose a new meaningful difference standard for PY 2024 and subsequent PYs, which would be more stringent than the previous standard finalized in the 2015 and 2017 Payment Notices. 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), we proposed 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.

We explained that 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 further explained that we believe 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 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 53.2 in PY 2024, which we explained we believe would still provide consumers with a sufficient number of plan offerings. In addition, we estimated 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, which we stated we believe would still provide consumers with a sufficient degree of choice during the plan selection process.[289] We estimated that if this dollar deductible difference threshold were adopted, 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.[290]

We sought 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 sought 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 sought comment on the advantages and disadvantages of utilizing a phased approach 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 sought comment on the effect that

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

[290] These calculations assumed 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.

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 sought 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). We also sought 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.

In addition, we sought 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 sought 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 sought 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.

After reviewing the public comments, we are finalizing § 156.202 with modification. Specifically, for PY 2024, we are limiting the number of non-standardized plan options that issuers of QHPs can offer through Exchanges on the Federal platform (including the SBE–FPs) to four non-standardized plan options per product network type, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage, in any service area. For PY 2025 and subsequent plan years, we are limiting the number of non-standardized plan options that issuers of QHPs can offer through Exchanges on the Federal platform (including the SBE–FPs) to two non-standardized plan options per product network type, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage, in any service area.

We note that for PY 2024 and subsequent PYs, we are permitting additional flexibility specifically for plans with additional dental and/or vision benefit coverage. Under this modified requirement for PY 2024, For example, an issuer will be permitted to offer four non-standardized gold HMOs with no additional dental or vision benefit coverage, four non-standardized gold HMOs with additional dental benefit coverage, four non-standardized gold HMOs with additional vision benefit coverage, and four non-standardized gold HMOs with additional dental and vision benefit coverage, as well as four non-standardized gold PPOs with no additional dental or vision benefit coverage, four non-standardized gold PPOs with additional dental benefit coverage, four non-standardized gold PPOs with additional vision benefit coverage, and four non-standardized gold PPOs with additional dental and vision benefit coverage, in the same service area.

Under this modified requirement, for PY 2025, for example, an issuer will be permitted to offer two non-standardized gold HMOs with no additional dental or vision benefit coverage, two non-standardized gold HMOs with additional dental benefit coverage, two non-standardized gold HMOs with additional vision benefit coverage, and two non-standardized gold HMOs with additional dental and vision benefit coverage, as well as two non-standardized gold PPOs with no additional dental or vision benefit coverage, two non-standardized gold PPOs with additional dental benefit coverage, two non-standardized gold PPOs with additional vision benefit coverage, and two non-standardized gold PPOs with additional dental and vision benefit coverage, in the same service area.

By finalizing the proposed policy with modifications to increase the limit on the number of non-standardized plan options that issuers can offer to four instead of two for PY 2024, and to factor the inclusion of dental and/or vision benefit coverage into this limit, we estimate (based on PY 2023 enrollment and plan offering data) that the weighted average number of non-standardized plan options available to each consumer will be reduced from approximately 89.5 in PY 2023 to 66.3 in PY 2024, while the weighted average total number of plans (which includes both standardized and non-standardized plan options) available to each consumer will be reduced from approximately 113.7 in PY 2023 to 90.5 in PY 2024.

Furthermore, we estimate that approximately 17,532 of the total 101,453 non-standardized plan option plan-county combinations (17.3 percent) will be discontinued as a result of this limit in PY 2024. Relatedly, we estimate that approximately 0.81 million of the 12.2 million enrollees on the FFEs and SBE–FPs (6.6 percent) will be affected by these discontinuations in PY 2024. Finally, in terms of the impact on network availability, for PY 2024, we estimate an average reduction of only 0.03 network IDs per issuer, product network type, metal level, and service area, meaning we anticipate network IDs to remain largely unaffected by this limit for PY 2024.

We note that, for PY 2025, we are unable to provide meaningful estimates at this time for the weighted average number of non-standardized plan options available to each consumer; the weighted average number of total plans available to each consumer; the number of plan-county discontinuations; the number of affected enrollees; and the average reduction of network IDs per issuer, product network type, metal level, and service area under the limit of two non-standardized plan options per issuer, product network type, metal level, inclusion of dental and/or vision benefit, and service area.

For these estimates to be meaningful, they will need to be based on plan offering and enrollment data for PY 2024, which will not be available until the end of the current QHP certification cycle for PY 2024 and the end of the 2024 OEP, respectively. We anticipate that the broader landscape of plan offerings as well as the composition of individual issuers' portfolios of plan offerings will undergo significant changes as a result of the limit of four non-standardized plan options in PY 2024, and that any estimates based on data sourced from a plan year before this limit is enacted would not be meaningfully predictive of the landscape of plan offerings or individual issuers' portfolios of plan offerings for a plan year after this limit is enacted.

Furthermore, these estimates would not be able to take into account the exceptions process we intend to propose that would allow issuers to offer non-standardized plan options in excess of the limit of two for PY 2025 and subsequent plan years, because we intend to propose the exceptions

process, as well as the specific criteria and thresholds to be included in this exceptions process, in the 2025 Payment Notice proposed rule, and we do not yet know whether or how such a proposal would be finalized.

We also offer further clarification regarding the specific dental and/or vision benefit coverage a non-standardized plan option would need to include in order to qualify for this additional flexibility, which is also reflected in the finalized regulation text at § 156.202(c). Specifically, we clarify that a non-standardized plan option must include any or all of the following adult dental benefit coverage in the ''Benefits'' column in the Plans and Benefits Template: (1) Routine Dental Services (Adult), (2) Basic Dental Care—Adult, or (3) Major Dental Care—Adult. We also clarify that a non-standardized plan option must include any or all of the following pediatric dental benefit coverage in the ''Benefits'' column in the Plans and Benefits Template: (1) Dental Check-Up for Children, (2) Basic Dental Care—Child, or (3) Major Dental Care—Child. Finally, we clarify that a non-standardized plan option must include the following adult vision benefit coverage in the ''Benefits'' column in the Plans and Benefits Template: Routine Eye Exam (Adult).

We are making these modifications primarily to decrease the risk of disruption for both issuers and enrollees, and to provide increased flexibility to issuers. Specifically, many commenters supported adopting a more gradual approach in which the number of non-standardized plan options that issuers can offer is gradually decreased over a span of several plan years, instead of directly adopting a limit of two for PY 2024. Additionally, regarding the modification to factor the inclusion of dental and/or vision benefits into this limit, Issuers have frequently offered these specific benefit categories as additional benefits in otherwise identical plan options, accounting for the vast majority of product ID-based variation (approximately 84 percent of such variation) offered by issuers within a given metal level, network type, and service area in PY 2022.

We are not finalizing a new meaningful difference standard. We summarize and respond to public comments received on the proposed non-standardized plan option limits and the alternative meaningful difference standard below.

Comment: Many commenters agreed that the number of plan choices available through the Exchanges has increased to a point that is beyond productive for consumers, and many commenters agreed that additional action should be taken to reduce the risk of plan choice overload. As such, many of these commenters supported directly limiting the number of non-standardized plan options that issuers can offer. These commenters explained that adopting this specific approach to reduce the risk of plan choice overload would be most effective in further simplifying and streamlining the Exchange experience, aligning with some of the primary goals of the Exchanges—fostering competition among issuers and facilitating a consumer-friendly experience for individuals looking to purchase health insurance.

As commenters further explained, limiting the number of non-standardized plan options is especially important at this time because many consumers currently face an overwhelming number of health plans to choose from on the Exchanges, and these consumers must navigate the complexity of each of these options to be able to select a health plan that meets their unique health care needs and budgetary realities.

Commenters explained that having an overwhelming number of options makes it difficult to easily and meaningfully compare all available options, which increases the risk of plan choice overload and suboptimal plan selection as well as the risk of unexpected financial harm, especially for consumers with a lower degree of health care literacy. Commenters thus explained that limiting the number of non-standardized plan options would allow consumers to more easily and meaningfully compare available plan options and select a plan that best meets their unique health care needs, which would particularly benefit those with lower degrees of health care literacy and those most at risk of unexpected financial harm.

Several commenters also pointed to the fact that several SBEs have successfully limited the number of non-standardized plan options that issuers can offer as evidence that adopting such a policy would benefit consumers in States with an FFE or SBE–FP. Several commenters also explained that codifying this requirement would serve as a helpful template for consideration by SBEs that do not currently limit the number of non-standardized plan options but may be interested in doing so in the future.

Response: We agree that the risk of plan choice overload has continued to increase over the last several years and that additional action should be taken to reduce this risk. We also agree that limiting the number of non-standardized plan options that issuers can offer is the most effective strategy to mitigate this risk, especially when done in conjunction with requiring issuers to offer standardized plan options and enhancing choice architecture on *HealthCare.gov.*

Specifically, we agree that these limits will allow consumers to more meaningfully compare available plan options and select a health plan that best meets their unique health needs. These limits will also allow consumers to take more factors into consideration when comparing and selecting a health plan—such as providers, networks, formularies, and quality ratings. We also agree that these changes would reduce the risk of suboptimal plan selection, which would greatly benefit disadvantaged populations who can least afford experiencing unexpected financial harm.

Comment: Several commenters opposed limiting the number of non-standardized plan options that issuers can offer. Several of these commenters explained that limiting the number of these plans would impose a significant burden on issuers as they develop product portfolios for PY 2024. These commenters explained that issuers have already made strategic decisions about plan offerings and participation, and that finalizing these changes for PY 2024 would result in significant operational challenges. These commenters also expressed concern that we are proposing the concurrent implementation of multiple substantive provisions—such as changes to the re-enrollment hierarchy and changes to standardized plan option formulary tiering—that would be extremely disruptive if finalized simultaneously.

Many commenters also explained that a significant number of Exchange enrollees would lose access to the plans they are currently enrolled in and would consequently be relegated to enrollment in plans they did not choose. Many of these commenters pointed to the estimate that this provision would force 2.72 million enrollees on the FFE and SBE–FPs (26.6 percent of total enrollees) to change plans due to plan discontinuations in PY 2024. Many of these commenters explained that these plan discontinuations would put consumers at risk of unexpected financial harm, such as from changing the cost-sharing structure, formularies, or networks from the plans they are currently enrolled in.

Many commenters also explained that these plan discontinuations would come at a time when issuers will be preparing

for and processing a deluge of Medicaid redeterminations with the unwinding of the Public Health Emergency. Commenters explained that approximately 10 million current Medicaid enrollees will be eligible for other forms of coverage, including approximately one million of these enrollees who are expected to be eligible for Exchange coverage. Commenters explained that for this reason, the Exchanges need to be prepared for a massive influx of enrollees over the coming months, and that major policy changes could cause severe disruption for both consumers and issuers at a critical time.

Commenters also explained that limiting the number of non-standardized plan options that issuers can offer would inhibit issuer innovation and force issuers to drastically reduce the unique plan designs they have thoughtfully developed to best serve their members' health care needs, which would in turn force consumers into a ''one-size fits all'' benefit offering.

Many commenters also explained how limiting the number of non-standardized plan options that issuers can offer would have unintended impacts on provider networks. These commenters explained that many issuers would likely drop plans with broader networks to maintain competitive plan premiums, which would ultimately move the market in the direction of plans with restricted provider networks. Commenters further explained that this change could result in further disruption and the loss of providers consumers are accustomed to. Commenters also explained that there are consumers who are well-served by smaller, less expensive networks, and there are consumers who are willing to pay more for a larger of pool of providers and facilities—and that both groups deserve the same access to plan choice.

Several commenters also explained that the proposed limit would negatively impact HSA-eligible high-deductible health plan (HDHP) offerings since issuers would likely discontinue these plan offerings due to low enrollment if non-standardized plan options were limited. Thus, several commenters recommended that HSA-eligible HDHPs be exempt from these limits.

Several commenters pointed to other health coverage options, such as Medicare Advantage, which do not limit the number of plans an issuer can offer. These commenters explained that, in 2022, Medicare beneficiaries had a choice of 23 stand-alone Medicare Part D plans and 31 Medicare Advantage plans offering Part D, on average. Similarly, these commenters explained that in 2023, Medicare beneficiaries had a choice of 43 Medicare Advantage plans, on average.

Several commenters also explained that although the proposed limits may be appropriate for geographic areas with high rates of both issuer participation and plan choice proliferation, these limits would not be appropriate for geographic areas with lower rates of issuers participation and a more restricted range of plan offerings. These commenters explained that several States have service areas with only one issuer and a limited number of plan offerings, and that these limits would severely restrict consumer choice in these counties.

Several commenters also explained that limiting the number of non-standardized plan options that issuers can offer could discourage new market entrants and disadvantage smaller issuers since larger holding companies operating multiple issuers would still be able to have each issuer offer its own non-standardized plan options.

Response: We disagree that issuers will have insufficient time to operationalize these changes, as we have regularly issued new requirements for the following plan year in that plan year's Payment Notice, as we are doing here. Additionally, although we acknowledge that the termination of numerous non-standardized plan options would entail burden for issuers (such as by affecting issuers' balance of enrollment across plans, by affecting the premium rating for each of those plans, and by requiring issuers to send discontinuation notices for enrollees whose plans are being discontinued), we believe that the advantages of enacting these changes outweigh the disadvantages of doing so.

Specifically, with plan proliferation continuing unabated for several years, consumers have had to select from among record numbers of available plan options. Having such high numbers of plan choices to select from makes it increasingly difficult for consumers, especially those with lower rates of health care literacy, to easily and meaningfully compare all available plan options. This subsequently increases the risk of suboptimal plan selection and unexpected financial harm for those who can least afford it. Thus, although we acknowledge the burden imposed on issuers subsequent to the imposition of these limits in PY 2024, we believe these changes align with the original intent of the Exchanges—to facilitate a consumer-friendly experience for individuals looking to purchase health insurance. We believe this change will continue to benefit consumers on the Exchanges over numerous years. We further note that we intend to offer the necessary guidance and technical assistance to facilitate this transition, such as through the 2024 Letter to Issuers and QHP certification webinars.

Furthermore, based on PY 2022 QHP submission and enrollment data, we have determined that each issuer's enrollment is predominately concentrated among its top several plan offerings per product network type and metal level, with the smaller remaining portion of enrollment distributed more evenly among several plans. Specifically, we determined that, on average, 71 percent of each issuer's enrollment is concentrated among its top two plan offerings per product network type and metal level, and 83 percent of each issuer's enrollment is concentrated among its top three plan offerings per product network type and metal level—meaning that the remaining portion of each issuer's enrollment is more evenly distributed among issuer's less popular offerings. As such, we believe making these changes will simply concentrate enrollment among each issuer's top current plan offerings.

We also acknowledge that, as a result of limiting the number of non-standardized plan options, a significant number of consumers will have the plans they are currently enrolled in discontinued and will as a result be auto-reenrolled into another non-standardized plan option or standardized plan option offered by the issuer—similar to how this scenario would be handled prior to the imposition of these new requirements under the existing reenrollment hierarchy. We believe affected enrollees auto-reenrolled into standardized plan options would benefit from the several important distinctive features, such as enhanced pre-deductible coverage and copayments instead of coinsurance rates for a broad range of benefit categories, that serve as important forms of consumer protection. Furthermore, these standardized plan options were designed to incorporate design features that reflect the most popular current QHP offerings that millions of enrollees are already accustomed to. As such, we believe affected enrollees auto-reenrolled into standardized plan options will not experience disruption since these standardized plan options will not differ substantially from the discontinued plans that the majority of consumers are currently enrolled in.

Additionally, many commenters explained that a large number of current non-standardized plan option offerings differ in only minor ways from one another, and that consumers are often unaware of these minor differences. Thus, in the scenario that affected enrollees are auto-reenrolled into a non-standardized plan option (instead of a standardized plan option), we believe that the new plans these affected enrollees will be auto-reenrolled into will not differ significantly from the plan they are currently enrolled in. Thus, in short, we believe that the majority of affected enrollees would not experience significant disruption if they were crosswalked into either equivalent standardized plan option offerings or other non-standardized plan offerings. We also note that enrollees dissatisfied with the plan they are re-enrolled in will have the option to actively select a different plan offering for PY 2024, if desired.

We also note that phasing in the reduction in the number of non-standardized plan options that issuers can offer, beginning with four for PY 2024, will also significantly reduce the number of plan discontinuations and affected enrollees for PY 2024. Specifically, based on PY 2022 data, we originally estimated that a limit of two non-standardized plan options would result in approximately 60,949 of a total 106,037 non-standardized plan option plan-county combinations (57.5 percent) being discontinued, and approximately 2.72 million of the 10.21 million enrollees in the FFEs and SBE–FPs (26.6 percent) being affected. That said, under the limit of four non-standardized plan options that we are finalizing in this rule for PY 2024, based on PY 2023 data, we estimate that approximately 17,532 of the total 101,453 non-standardized plan option plan-county combinations (17.3 percent) will be discontinued as a result of this limit, and approximately 0.81 million of the 12.2 million enrollees on the FFEs and SBE–FPs (6.6 percent) will be affected by these discontinuations in PY 2024.

We anticipate that reducing the limit on non-standardized plan options from four in PY 2024 to two in PY 2025 and subsequent plan years will result in additional plan-county discontinuations and affected enrollees in PY 2025. That said, as described previously, we are unable to provide meaningful estimates for these plan-county discontinuations and affected enrollees for PY 2025 at this time due to PY 2024 plan offering and enrollment data limitations. In addition, as discussed previously, these estimates would not be able to take into account the exceptions process we intend to propose that would allow issuers to offer non-standardized plan options in excess of the limit of two for PY 2025 and subsequent plan years, because we intend to propose the exceptions process, as well as the specific criteria and thresholds to be included in this exceptions process, in the 2025 Payment Notice proposed rule, and we do not yet know whether or how such a proposal would be finalized.

We also clarify that the same rules and processes regarding binder payments for scenarios unrelated to non-standardized plan option limits (for example, scenarios from previous years where a particular plan offering is discontinued, and affected enrollees are auto-reenrolled from the discontinued plan into a different plan offered by the same issuer) apply to non-standardized plan option limit scenarios. Specifically, we clarify that for such renewals of effectuated coverage, a binder payment is not required, as the renewal is a continuation of effectuated coverage, and no new effectuation is required. The Exchanges on the Federal platform also do not require a binder payment for passive re-enrollments that continue effectuated coverage in another plan within the same product (or to a different plan in a different product offered by the same issuer, if the current product will no longer be available to the enrollee, consistent with the hierarchy for reenrollment specified at § 155.335(j)(2)) for the same subscriber.

This means, when consumers are auto-reenrolled into another non-standardized plan option or standardized plan option as a result of limiting the number of non-standardized plan options, no binder payment is required when subscribers in already effectuated policies are auto-reenrolled into coverage offered by the same issuer. If, however, the enrollee were to be moved into a plan from a different issuer, a binder payment would be required. Alternate enrollments, for QHP enrollees whose current year coverage is no longer available through the Exchange and for whom a plan offered by a different issuer is selected, are new enrollments, not renewals, and thus require a binder payment to effectuate.

We also acknowledge that a significant number of consumers will be affected by Medicaid eligibility redeterminations and will likely seek Exchange coverage as a result in PY 2024. We believe this timing offers a unique opportunity to help ensure that these consumers are able to meaningfully compare available plan options, select a health plan that best meets their health needs, and weigh standardized plan design features such as enhanced pre-deductible coverage for a greater number of benefits, enhanced price predictability in the form of copayments over coinsurance for a range of benefit categories, and copayments for all tiers of prescription drug coverage—including the non-preferred brand and specialty tiers, which are several relatively uncommon plan design features.

We disagree that these limits will inhibit issuer innovation and unnecessarily constrain consumer choice. In PY 2024, issuers will still retain the ability to offer at least five plans per product network type, metal level, and service area—four non-standardized plan options and at least one standardized plan option—such that issuers will continue to retain the ability to innovate in plan designs. This figure does not include the additional flexibility permitted for plans that include dental and/or vision benefit coverage, nor does it include catastrophic plans, which will allow issuers to offer additional plans beyond the five per product network type, metal level, and service area.

Under our incremental approach to phasing in limits to non-standardized plan options, in PY 2025 and subsequent plan years, issuers will retain the ability to offer at least three plans per product network type, metal level, and service area—two non-standardized plan options and at least one standardized plan option—such that issuers will continue to retain the ability to innovate in plan designs. Similar to PY 2024, this figure does not include the additional flexibility permitted for plans that include dental and/or vision benefit coverage, nor does it include catastrophic plans, which would allow issuers to offer additional plans beyond the three per product network type, metal level, and service area. As noted, we also intend to propose an exceptions process in the 2025 Payment Notice proposed rule that could, if finalized, further expand this range of possible plan offerings in PY 2025 and subsequent plan years.

Moreover, we reiterate that issuers are not limited in the number of standardized plan options that they can offer and thus retain the ability to innovate in their standardized plan options, so long as this innovation conforms with the required cost-sharing specifications. As previously discussed, we also believe that limiting the number of non-standardized plan options reduces the risk of plan choice overload, which actually enhances the plan selection process by making it easier to

more meaningfully compare available options.

Furthermore, we believe that, even with the limit on the number of non-standardized plan options an issuer may offer, the expected weighted average number of plan offerings available to each enrollee will remain sufficiently high to permit a satisfactory degree of choice. The limit being finalized in this rule is estimated to reduce the weighted average number of total plan offerings (which includes both standardized and non-standardized plan options offerings) from approximately 113.7 in PY 2023 to 90.5 in PY 2024, meaning consumers will continue to have more than enough plan choices to select from among. Even under the originally proposed limit of two non-standardized plan options per issuer, product network, type, metal level, inclusion of dental and/or vision benefits, and service area (which will be the limit for PY 2025 and subsequent plan years), we estimate that the weighted average number of total plan offerings available to each consumer will be 65.3—which will still permit a sufficient degree of consumer choice.

Similarly, we believe this flexibility will ensure that enrollees continue to have access to a sufficiently wide range of networks, ranging from broader and more encompassing networks with larger pools of providers and facilities to narrower and less expansive networks with smaller pools of providers and facilities. Additionally, as previously described, for PY 2024, we estimate an average reduction of only 0.03 network IDs per issuer, product network type, metal level, and service area combination, meaning we anticipate network IDs to remain largely unaffected by this limit for PY 2024. Furthermore, we once more reiterate that issuers are not limited in the number of standardized plan options that they can offer and thus retain the ability to continue to offer these network variations in their standardized plan options, if so desired.

While we acknowledge that this limit may affect HSA-eligible HDHP offerings, we do not believe that an exception to the limit is warranted for these plan offerings as there has been a steady decrease in both the proportion of HSA-eligible HDHP offerings and enrollment in these plan offerings (especially at the silver, gold, and platinum metal levels) over the past several years. The proportion of total plan offerings that are HSA-eligible HDHPs has decreased from 7 percent in PY 2019 to 3 percent in PY 2023. Most of these remaining plans are offered at the bronze metal level, with HSA-eligible HDHP offerings constituting 14 percent of plan offerings at the bronze metal level in PY 2023 (and 2 percent, 1 percent, and 0 percent at the non-CSR silver, gold, and platinum metal levels in the same year, respectively).

Total enrollment in these plans has decreased from 8 percent in PY 2019 to 5 percent in PY 2022. Similar to the PY 2023 plan offering data, most of this enrollment is concentrated at the bronze metal level, with HSA-eligible HDHPs constituting 14% of enrollment at the bronze metal level in PY 2022 (and 2 percent, 2 percent, and 0 percent at the non-CSR silver, gold, and platinum metal levels in the same year, respectively). We believe the fact that there is a steadily decreasing number of issuers choosing to offer these plans, as well as a steadily decreasing number of consumers choosing to enroll in these plans, reflects both issuer and consumer preference evolving away from these types of plan offerings.

Furthermore, due to severe AV constraints at the bronze metal level, issuers are significantly constrained in how they are able to design their plan offerings at this metal level. This is especially true for the non-expanded bronze metal level, in which it is not possible to include any pre-deductible coverage while maintaining an AV inside the permissible AV *de minimis* range—which is also the main reason we excluded a standardized plan design for the non-expanded bronze metal level in each set of the plan designs for PY 2024 finalized in this rule. This means that issuers of plans at the bronze metal level do not have as much leeway to vary their plan offerings compared to offering plans at other metal levels that do not have as severe AV constraints—such as the silver, gold, and platinum metal levels.

With issuers subject to these severe AV constraints at the bronze metal level in particular, and with the ability of issuers to vary plan designs at the bronze metal level significantly limited, we believe the four-plan limit in PY 2024 and the two-plan limit in PY 2025 and subsequent plan years (per product network type, metal level, inclusion of dental and/or vision benefit, and service area) will satisfactorily accommodate the full scope of plans that issuers wish to offer, including HSA-eligible HDHPs (at the bronze metal level, where the majority of these plans are offered). We encourage issuers to offer an HSA-eligible HDHP at the bronze metal level as one of their plan designs, if so desired.

We also acknowledge that issuers that offer Medicare Advantage plans are not limited in the number of plans they can offer. That said, the average number of plans that Medicare beneficiaries had access to in PY 2023 is still lower than the estimated weighted average number of total plan offerings that Exchange consumers would have to choose from with the limit we are finalizing on non-standardized plan options for both PY 2024 and PY 2025 and subsequent plan years.

In addition, we acknowledge that different States and counties have differing rates of issuer participation, and thus, differing rates of plan choice proliferation. Thus, we acknowledge that the risk of plan choice overload is more pronounced in certain counties than others. That said, we believe the limit of four non-standardized plan options for PY 2024 and the limit of two non-standardized plan options for PY 2025 and subsequent years (with additional flexibility permitted for plans with additional dental and vision benefits, and subject to a potential exceptions process for the limit of two non-standardized plan options beginning in PY 2025—which we intend to propose in the 2025 Payment Notice proposed rule) strikes an appropriate balance in reducing the risk of plan choice overload and preserving a sufficient degree of consumer choice, even for consumers in counties with lower rates of issuer participation.

For example, even in counties that have only two issuers, with each issuer seeking to offer the maximum number of plans possible under the limit we are finalizing, consumers in PY 2024 would still theoretically have the ability to select from at least five plans per issuer, product network type, and metal level—four of which would be non-standardized, and at least one of which would be standardized. In this scenario, if both of these issuers offered both PPO and HMO versions of these plans, they could each theoretically offer at a minimum, ten expanded bronze plans, ten silver plans (not including CSR silver plans), ten gold plans, and ten platinum plans, if desired, meaning the total number of plan offerings available to consumers in that county will be 20 per metal level, and 80 altogether. In this scenario, the number of plans could conceivably be higher if both issuers offered more than one standardized plan option per product network type and metal level, higher yet if issuers offer additional plan variations of non-standardized plan options with dental and/or vision benefit coverage, and higher yet if issuers choose to also offer catastrophic plans.

Similarly, under a non-standardized plan option limit of two, consumers in PY 2025 will still theoretically have the

ability to select from at least three plans per issuer, product network type, and metal level—two of which will be non-standardized, and at least one of which will be standardized. In this scenario, if both of these issuers offered both PPO and HMO versions of these plans, they could each theoretically offer at a minimum, six expanded bronze plans, six silver plans (not including CSR silver plans), six gold plans, and six platinum plans, if desired, meaning the total number of plan offerings available to consumers in that county would be 12 per metal level, and 48 altogether. Similar to PY 2024, In this scenario, the number of plans could conceivably be higher if both issuers offered more than one standardized plan option per product network type and metal level, higher yet if issuers offer additional plan variations of non-standardized plan options with dental or vision benefit coverage, and higher yet if issuers choose to also offer catastrophic plans.

We also acknowledge that there could potentially be scenarios in which counties have a single issuer not seeking to offer the maximum number of plans possible under this limit and instead chooses to offer no non-standardized plan options (since these plans are not required to be offered). In this scenario, an issuer could theoretically choose to only offer plans of one product network type at only the required metal levels (silver and gold), which would mean that there would only be two plan offerings in that particular county (for example, standardized silver HMO and standardized gold HMO). This will be true for both PY 2024 (when the limit is four non-standardized plan options) and for PY 2025 (when the limit is two non-standardized plan options), since the issuer in this scenario would be offering the bare minimum number of plans, and will therefore not be affected by the maximum limit on the number of non-standardized plan options, whether four or two.

Though we discourage such an approach, we believe this scenario would not differ substantially from the scenario before standardized plan option requirements were introduced. For example, if that same issuer, prior to the imposition of the standardized plan option requirements, chose to offer the minimum number of plans in a particular service area (specifically, one non-standardized silver HMO and one non-standardized gold HMO), then in PY 2023 also began to offer one standardized silver HMO and one standardized gold HMO, then in PY 2024 discontinued the non-standardized silver and gold HMOs, then consumers would have access to the same number of plans they did in PY 2022, before either standardized plan option requirements and non-standardized plan option limits were enacted. Similar to the previous discussion, this would also be true whether the limit on the number of non-standardized plan options is four in PY 2024 or two in PY 2025.

Furthermore, we disagree that limiting the number of non-standardized plan options that issuers can offer will discourage new market entrants and disadvantage smaller issuers since larger holding companies operating multiple issuers would still be able to have each issuer offer its own non-standardized plan options. To the contrary, we believe that limiting non-standardized plan options—in conjunction with requiring issuers to offer standardized plan options—can serve to even the playing field between larger and more well-established issuers and smaller issuers newer to the market, because all issuers will be required to offer plans with standardized cost sharing for a key set of EHB, and issuers will no longer be permitted to flood the market with plans with only minor differences between them.

Comment: Several commenters supported a limit of either two or four non-standardized plan options per product network type, metal level, and service area, while others recommended adopting a slightly looser or stricter limit, including for only particular metal levels. Several commenters recommended not permitting additional variation only for specific benefits such as adult dental and adult vision benefits because doing so would likely cause confusion for consumers as to their options to obtain such benefits through medical QHPs or stand-alone dental or vision plans. Several other commenters recommended taking additional factors into account for any limit, such as particular networks (instead of product network types) and particular benefit packages (in the form of product IDs)—such that issuers would be permitted to offer two non-standardized plan options per product ID, network ID, metal level, and service area, for example.

Response: We believe that finalizing a limit for PY 2024 of four non-standardized plan options and a limit for PY 2025 and subsequent plan years of two non-standardized plan options per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area strikes an appropriate balance between simplifying the plan selection process and maintaining a sufficient degree of consumer choice. We believe that adopting this more gradual approach, as opposed to directly limiting the number of non-standardized plan options to two in PY 2024, also facilitates this transition and reduces the risk of disruption for both issuers and enrollees.

We also believe that providing advance notice of the eventual transition to the limit of two non-standardized plan options in PY 2025 and subsequent plan years will allow issuers additional time to prepare for the two-plan limit. We further believe that permitting additional variations specifically for non-standardized plan options with the inclusion of dental and/or vision benefit coverage—instead of, for example, permitting additional variation for any single change in the product package, however small—decreases the likelihood that these limits will be circumvented. Permitting additional flexibility for any single change in the product package (such as only including one additional infrequently utilized benefit) would allow issuers to continue to offer as many non-standardized plan options as desired simply by adding a single benefit to these additional plans, which would run counter to the goal of reducing the risk of plan choice overload.

We also believe that permitting issuers to offer a total of at least five plans in PY 2024—four non-standardized and at least one standardized—per product network type, metal level, and inclusion of dental and/or vision benefit coverage, in any service area will allow issuers to offer at least five different networks per product network type, metal level, and inclusion of dental and/or vision benefit coverage, in any service area, a number we believe provides a sufficient degree of flexibility for issuers and choice for consumers.

Similarly, we believe that permitting issuers to offer a total of at least three plans in PY 2025 and subsequent plan years—two non-standardized and at least one standardized—per product network type, metal level, and inclusion of dental and/or vision benefit coverage, in any service area will allow issuers to offer at least three different networks per product network type, metal level, and inclusion of dental and/or vision benefit coverage, in any service area, a number we believe provides a sufficient degree of flexibility for issuers and choice for consumers.

Comment: Several commenters recommended either applying limits to non-standardized plan options or imposing a meaningful difference standard to issuers in SBEs in addition

to issuers in the FFEs and SBE–FPs. However, one commenter opposed applying limits to the number of non-standardized plan options and imposing a meaningful difference standard to issuers in SBE–FPs, explaining that SBE–FPs are similarly positioned to SBEs and should thus also be exempt from these requirements.

Response: Similar to our approach with respect to standardized plan options in the 2023 Payment Notice, we did not propose to limit the number of non-standardized plan options that issuers can offer through SBEs for several reasons, including that several SBEs already impose such limits. As such, we believe imposing duplicative requirements on issuers in SBEs that are already limited in the number of non-standardized plan options they can offer could create contradictory requirements that misalign with existing State requirements.

We also believe that SBEs are uniquely positioned to best understand the nature of their respective markets as well as the consumers in these markets. Furthermore, as we explained in the proposed rule, as well as in the 2023 Payment Notice, we believe States that have invested the necessary time and resources to become SBEs have done so in order to implement innovative policies that differ from those on the FFEs. We explained that we do not wish to impede these innovative policies so long as they comply with existing legal requirements.

However, as we explained in the proposed rule, as well as in the 2023 Payment Notice, because we impose this requirement in the FFEs, and because the SBE–FPs use the same platform as the FFEs, we believe it is appropriate to apply these requirements equally on FFEs and SBE–FPs. We believe that changing the platform to permit distinction on this policy between FFEs and SBE–FPs would require a very substantial financial and operational burden to HHS that we believe outweighs the benefit of permitting such a distinction. Finally, States with SBE–FPs that do not wish to be subject to these requirements may investigate the feasibility of transitioning to an SBE.

Comment: Many commenters who were concerned with the proliferation of seemingly similar plans and the consequent increased risk of plan choice overload but were opposed to limits on non-standardized plan options recommended implementing a meaningful difference standard. These commenters explained that implementing a meaningful difference standard would strike a more appropriate balance in reducing the risk of plan choice overload while simultaneously preserving a sufficient degree of consumer choice. These commenters also explained that adopting this approach would be a more effective mechanism in ensuring that plans are not duplicative and are instead meaningfully different from one another without inhibiting issuer innovation in plan design.

Commenters also had a range of recommendations for a meaningful difference standard. Several commenters suggested decreasing the deductible dollar difference threshold from the proposed $1,000 to $500, explaining that requiring a deductible difference of $1,000 would be too high to account for consumer preference. Several commenters recommended adopting a version of the meaningful difference standard more closely aligned with the previous iteration of the meaningful difference standard. Several commenters recommended taking more factors into account when determining whether plans are meaningfully different from one another, such as differences in covered specific benefits (such as dental or vision benefits), differences in product packages, differences in cost-sharing (such as the percentage of pre-deductible services), differences in provider network (such as if there is a reasonable difference in the size of the network or a reasonable percentage of providers who are different between networks), differences in network ID, differences in product network type, and HSA-compatibility.

Response: We believe that directly limiting the number of non-standardized plan options to four for PY 2024 and two for PY 2025 and subsequent years per issuer, product network type, metal level, and inclusion of dental and/or vision benefit coverage, in any service area, is a more effective mechanism at this particular time to reduce plan choice proliferation and to reduce the risk of plan choice overload for several reasons.

First, we believe the increased complexity associated with a meaningful difference standard that effectively reduces duplicative plan offerings as well as the risk of plan choice overload would be more difficult for issuers to understand and operationalize. We believe that direct limits on the number of non-standardized plan options that issuers can offer is a more straightforward approach. We also believe that the increased complexity associated with creating and operationalizing a meaningful difference standard (that takes multiple factors into account when determining whether plans are meaningfully different from one another) creates the risk of unintentionally allowing circumvention, which would decrease the efficacy of this mechanism.

Furthermore, we do not wish to cause unintended consequences to plan designs by requiring plans to have deductible differences of $1,000 or more—which would influence issuers to systematically increase cost-sharing for particular benefits to meet such meaningful difference standards or to systematically subject particular benefits to the deductible, which could potentially increase the risk of discriminatory benefit designs. That said, we note that we intend to further investigate the feasibility and appropriateness of employing this mechanism in a future year.

Comment: Several commenters requested clarification that any product or plan mapping necessary due to non-standardized plan option discontinuations would satisfy the exception to guaranteed renewability for uniform modifications of coverage at renewal due to modification in Federal requirements under §§ 147.106(e)(2) and 148.122(g)(2).

Response: The guaranteed renewability requirements at section 2703 of the PHS Act and § 147.106 (as well as parallel provisions at §§ 146.152 and 148.122) generally require an issuer that offers health insurance coverage in the individual or group market to renew or continue in force such coverage at the option of the plan sponsor or individual, as applicable. These provisions also establish requirements for issuers that decide to discontinue offering a particular product in the individual or group market and for issuers that modify coverage at the time of coverage renewal. These requirements apply at the ''product'' level, and the terms ''product'' and ''plan'' are defined in § 144.103.

Removing a plan(s) from a product will not result in a product discontinuation, unless by removing the plan(s), the issuer exceeds the scope of a uniform modification of coverage at § 147.106(e).[291] If an individual's product remains available for renewal, including a product with uniform modifications, the issuer generally must provide the individual the option to renew coverage under that product (including any plan within the product) to satisfy the guaranteed renewability

[291] Center for Consumer Information and Insurance Oversight, Uniform Modification and Plan/Product Withdrawal FAQ (June 15, 2015), available at *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/uniform-mod-and-plan-wd-FAQ-06-15-2015.pdf.*

requirements. Further, issuers on the Exchange must adhere to the re-enrollment hierarchy at § 155.335(j) when auto re-enrolling enrollees in coverage through the Exchange.

The guaranteed renewability regulations provide that, in the individual and small group markets, modifications made pursuant to Federal or State requirements are a uniform modification of coverage. However, as nothing in this final rule requires an issuer to cease generally offering non-standardized plans (that is, outside the Exchange), a non-standardized plan discontinuation is not a change made pursuant to a Federal requirement.

Comment: Several commenters requested clarification that State-mandated plan designs would be excluded from the proposed limit on the number of non-standardized plan options.

Response: State-mandated plan designs will not be excluded from the limit of four non-standardized plan options in PY 2024 or two non-standardized plan options in PY 2025 and subsequent years per issuer, product network type, metal level, and inclusion of dental and/or vision benefit coverage, in any service area. We do not believe that State-mandated plan designs differ sufficiently from other non-standardized plan options and did not receive comments with substantive examples of such plan designs. Furthermore, we believe that if all issuers in a particular State are required to offer State-mandated plan designs through the Exchanges in that State, these limits will apply to these issuers equally. Finally, we believe that the flexibility permitted in this framework (in which issuers will have the ability to offer four non-standardized plan options per product network type, metal level, and inclusion of dental and/or vision benefit coverage, in any service area for PY 2024, and two for PY 2025) will allow issuers to comply with both these State-mandated plan designs and the limits finalized in this rule.

Comment: Several commenters requested that HHS clarify its definition of ''service area'' in the limit on the number of non-standardized plan options.

Response: We clarify that the ''service area'' component of the limit on non-standardized plan options refers to Federal Information Processing Series (FIPS) code.[292] A FIPS code is a five-digit code that is unique to every county in the country. The first two digits are the State code (for example, Georgia's State code is 13), and the remaining three digits identify the county. We are defining ''service area'' with FIPS codes in order to provide a standardized, widely utilized, comprehensive, and mutually exclusive geographic unit for assessing consumer choice overload and adherence to non-standardized plan option limits.

5. QHP Rate and Benefit Information (§ 156.210)

a. Age on Effective Date for SADPs

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78283), we proposed 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 proposed that this requirement apply to Exchange-certified SADPs, whether sold on- or off-Exchange. We clarify that an SADP, as noted at section 1302(d)(2)(B)(ii) of the ACA, is a type of QHP, which is Exchange-certified, and offers the pediatric dental EHB as specified at section 1302(b)(1)(J) of the ACA.

We explained in the proposed rule (87 FR 78283) that since PY 2014, the process the FFEs use in QHP certification allows SADP issuers seeking certification to enter multiple options to explain how age is determined for rating and eligibility purposes. We explained that 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 use the age as of the date of policy issuance or renewal for purposes of identifying the appropriate age rating adjustment, 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.[293]

We stated in the proposed rule that 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. We added that 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, and the rate will not change on the basis of age until the next plan year, even if the enrollee's age changes mid-plan year.

As further explained in the proposed rule (87 FR 78283), allowing SADPs to rate by other methods imposes unnecessary complexity, not only to us 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. Thus, we stated that we believe requiring SADP issuers to use the age on effective date methodology, and consequently removing the less commonly used and more complex age calculation methods, would reduce consumer confusion and promote operational efficiency.

We stated that, 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 stated that 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 sought 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 received one comment on the anticipated challenges this proposal could present for SBEs, which we address later in this section.

We sought comment on the proposal to require SADP issuers, as a condition of Exchange certification, 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. We refer readers to the proposed rule (87 FR 78283) for further discussion of our proposal. After reviewing the public comments, we are finalizing this provision at new § 156.210(d)(1) as proposed. We summarize and respond to public comments received on the

[292] *https://www.census.gov/library/reference/code-lists/ansi.html#county.*

[293] 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.*

proposed age on effective date policy below.

Comment: All commenters who commented on this provision supported the proposal. A few commenters expressed their general support of CMS's efforts to standardize the age calculation method and to select age on effective date as the only method for calculating the enrollee's age for rating and eligibility purposes. A majority of commenters supported the proposal because it would reduce or eliminate confusion among consumers and improve consumer understanding of SADPs. One commenter agreed this policy would eliminate unnecessary complexity for both consumers and the Navigators and assisters who help them.

Response: We agree with commenters that requiring SADP issuers to use age on effective date as the sole method to calculate an enrollee's age for rating and eligibility purposes will help reduce or eliminate confusion among consumers, improve consumer understanding of SADPs, and eliminate unnecessary complexity for consumers and those who assist them. As we mentioned in the proposed rule (87 FR 78283), not only is age on effective date the most commonly used age rating method, but it is also the most straightforward methodology for consumers to understand. Since consumers can more easily understand the premium rate they are charged when the age on effective date method is used, it reduces consumer confusion. As we also mentioned, allowing SADPs to rate by other methods imposes unnecessary complexity, not only to HHS 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. From the consumer standpoint, the more complicated alternative age calculation methods currently in use make it more difficult to understand the premium rate they are charged. Therefore, we believe requiring SADP issuers to use age on effective date as the sole age rating method, and removing the less commonly used and more complex age calculation methods, will reduce consumer confusion and promote operational efficiency.

Comment: Several commenters supported this proposal because it promotes consistency between issuers, as well as between medical QHPs and QHPs that are SADPs. One commenter agreed with CMS that standards for medical QHPs and QHPs that are SADPs should be aligned wherever possible, including rating methodologies. Similarly, one commenter supported the proposal because it aligns with consumer expectations and current industry practices. Another commenter noted that the other age reporting options are not widely used, and therefore, they agreed it is appropriate for CMS to no longer offer issuers the ability to choose the less common age reporting methods. Lastly, one commenter noted that SBEs that do not currently use the age on effective date method may need more time for implementation.

Response: We agree with commenters that requiring SADP issuers to use age on effective date as the sole age calculation method promotes consistency between issuers and between medical QHPs and QHPs that are SADPs as well. We also agree that this policy aligns with consumer expectations and industry practices. As we mentioned in the proposed rule (87 FR 78283), the vast majority of individual market SADP issuers have used the age on effective date method since PY 2014. Given that most SADP issuers are already using this method, and based on the current availability of such plans in all service areas, we anticipate that most consumers or other Exchange-certified plans will not experience notable changes. As we also mentioned, market rules at § 147.102(a)(1)(iii) require medical QHP issuers to use the age as of the date of policy issuance or renewal for purposes of identifying the appropriate age rating adjustment, however, SADP issuers were not subject to the same requirement. Implementing this policy change will help align the requirements for SADPs with the requirements applicable to other QHPs. We also acknowledge that the SADP issuers that do need to implement this change will need time for implementation, but we do not anticipate this will be a significant operational burden and believe this is feasible to implement for QHP certification in PY 2024.

b. Guaranteed Rates for SADPs

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78284), we proposed 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 proposed that this requirement apply to Exchange-certified SADPs, whether they are sold on- or off-Exchange.

In the proposed rule (87 FR 78284), we explained that 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.[294] In particular, because issuers of Exchange-certified SADPs are not required to comply with the premium rating requirements under section 2701 of the PHS Act applicable to non-grandfathered individual and small group health insurance coverage, we have permitted issuers of Exchange-certified SADPs in the FFEs and SBE–FPs to comply with the rate information submission requirements at § 156.210 under a modified standard.[295] Specifically, we have historically granted issuers of SADPs 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. We explained in the proposed rule that 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. We noted that 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 the accurate collection of dental rating rules without forced operational limits in most reasonable circumstances.

In the proposed rule (87 FR 78284), we stated that 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. We explained that if SADP issuers submit estimated rates and

[294] See PHS Act sections 2722(b) and (c) and 2763(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.

[295] 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.

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. We also noted that since low-income individuals may qualify for APTC, 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 acknowledged in the proposed rule that requiring guaranteed rates presents a small risk that SADP issuers that offer estimated rates could cease offering SADPs on the Exchanges. While we recognized this risk, we stated that we believe the benefits of this proposal far exceed the disadvantages. Specifically, as discussed previously, we stated that 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.

As we explained in the proposed rule, because we believe this proposed policy would significantly benefit enrollees by ensuring that enrollees in SADPs 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 sought 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 did not receive any comments on the anticipated challenges this proposal could present for SBEs, or whether or to what extent we should limit or delay this proposed certification requirement.

We sought comment on 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. We refer readers to the proposed rule (87 FR 78284) for further discussion of our proposal. After reviewing the public comments, we are finalizing this provision at new § 156.210(d)(2) as proposed. We summarize and respond to public comments received on the proposed policy to require guaranteed rates below.

Comment: All commenters addressing this provision supported the policy proposal. A few commenters expressed their general support of CMS's efforts to require the submission of guaranteed rates for SADPs. More specifically, a few commenters supported this proposal because it promotes consumer understanding and helps reduce or eliminate consumer confusion. One commenter stated that requiring SADPs to submit guaranteed rates promotes consumer understanding by ensuring that consumers and those who assist them will better understand their coverage and the actual premium costs they will incur. Another commenter noted that this proposal will help people make informed decisions when shopping for their health coverage. Another commenter explained that guaranteed rates add transparency and clarity for consumers.

Response: We agree with the commenters that requiring SADP issuers to submit guaranteed rates will benefit consumers by promoting consumer understanding and helping to reduce or eliminate consumer confusion. We prioritize the development and implementation of consumer-centric policies, and will continue to direct our efforts towards promoting consumer understanding and improving consumer transparency.

Comment: A few commenters supported this proposal because it results in a better consumer experience and helps eliminate complexity. One commenter noted requiring SADP issuers to submit guaranteed rates will eliminate the practice of providing estimated rates to consumers, which typically requires the enrollee to contact the insurance issuer directly to determine a final rate.

Response: We agree with the commenters that requiring guaranteed rates will result in an improved consumer experience. We also agree that eliminating the practice of providing estimated rates, which requires the enrollee to contact the insurance issuer directly to determine a final rate, is beneficial because it helps eliminate complexity and reduces the burden on the consumer. As we noted in the proposed rule (87 FR 78284), by indicating a guaranteed rate, the SADP issuer commits to charging the consumer the approved premium rate, which has been calculated using the consumers' geographic location, age, and other permissible rating factors. Therefore, a guaranteed rate provides consumers with more certainty, resulting in a more positive consumer experience.

Comment: A few commenters supported the guaranteed rates proposal because it is consistent with current industry practices. In particular, one commenter stated that since the estimated rate option is not widely used by SADP issuers, it is appropriate for CMS to no longer offer this option.

Response: We agree with the commenters that the guaranteed rates proposal aligns with current industry practices. As we mentioned in the proposed rule (87 FR 78284), the vast majority of issuers offering on-Exchange and off-Exchange Exchange-certified SADPs already elect to submit guaranteed rates. Therefore, the majority of SADP issuers are unlikely to be impacted by this policy.

Comment: A few commenters supported the guaranteed rates proposal because it allows for accurate APTC calculation of the pediatric dental EHB portion of premiums, and protects consumers from both unexpected costs and unnecessary financial burden. One commenter explained that because the portion of APTC attributable to pediatric dental coverage can be applied to SADPs, after-purchase rate information changes could affect APTC calculation, resulting in unnecessary financial burden and uncertainty for enrollees selecting SADPs. Another commenter also emphasized that guaranteed rates protect consumers from unnecessary tax reconciliation.

Response: We agree with the commenters that requiring guaranteed rates will promote accurate APTC calculation of the pediatric dental EHB portion of premiums, and protect consumers from unnecessary financial burden and uncertainty. As we explained in the proposed rule (87 FR 78284), if an SADP issuer submits an estimated rate and subsequently modifies their actual rate, the Exchanges, including SBEs, SBE–FPs, and FFEs, could incorrectly calculate APTC for the pediatric dental EHB portion of a consumer's premium,[296] which could result in consumer harm. This may also disproportionately impact low-income individuals who may qualify for APTC, who are already disproportionately impacted by limited access to affordable health care. Therefore, we believe this policy will also help advance health equity by ensuring that low-income individuals who qualify for APTC are charged the

[296] Consistent with §§ 156.440(b) and 156.470, APTC may be applied to the pediatric dental EHB portion of SADP premiums.

correct premium amount when enrolling in SADPs on the Exchange.

Comment: One commenter requested clarity on whether the proposed policy also applies to small group SADPs. This commenter explained that as a State, it does not have the authority to review dental rates for small group issuers on- or off-Exchange, and thus it cannot enforce this proposed certification requirement for such issuers. The commenter further explained that if plans cannot be certified without meeting this requirement, that CMS should certify the off-Exchange-only SADPs.

Response: We clarify that the guaranteed rates policy does not apply to SADPs that are not Exchange-certified. SADPs that are not seeking Exchange certification, in either an individual market Exchange or SHOP, will not need to use guaranteed rates under this policy. States will therefore not need to enforce this requirement, but State Exchanges will be required to only certify SADPs that comply with the requirement.

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

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78284 through 78285), we proposed to add a new paragraph (c) to § 156.225 to require that QHP plan and plan variation [297] marketing names include correct information, without omission of material fact, and do not include content that is misleading. We stated that, if this policy is finalized, we would review plan and plan variation marketing names during the annual 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. As we stated in the proposed rule (87 FR 78285), 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. We also stated that in PY 2022, we received complaints from consumers in multiple States who misunderstood cost-sharing information in their QHP's marketing name. We also stated that upon further investigation, CMS and State regulators determined that language in a number of plan and plan variation marketing names was 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.[298]

As we explained in the proposed rule (87 FR 78285), CMS' review of QHP data for PY 2023 indicates continued use of cost-sharing information in plan and plan variation marketing names. We explained in the proposed rule that this proposed policy would address the issues we observed during PY 2022 and again in PY 2023 by requiring all information in plan and plan variation marketing names that relates to plan attributes to align with 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. Also, we stated that 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. We refer readers to the proposed rule (87 FR 78284 through 78285) for further discussion of this proposed requirement, including examples illustrating the kinds of information in plan and plan variation marketing names that could mislead consumers through inaccurate information or omission of material facts.

We sought comment on this proposal and whether there are additional methods of preventing consumer confusion and market disruption related to this issue. In particular, we sought comment on the potential to identify components of plan and plan variation marketing names that could be uniformly structured and defined across QHPs for consistency and to 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 sought comment on whether, to address this, we 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.

After reviewing the public comments, we are finalizing, as proposed, § 156.225(c) to require that QHP plan and plan variation marketing names include correct information, without omission of material fact, and not include content that is misleading. We will review plan and plan variation marketing names during the annual QHP certification process in close collaboration with State regulators in States with Exchanges on the Federal platform. We summarize and respond to public comments received on the proposed policy below.

Comment: Almost all commenters supported the proposal. A number of commenters agreed that requiring marketing names to be accurate and not misleading would help consumers make more informed plan selections, and choose a QHP that they are ultimately satisfied with. Some commenters added that, like HHS and States, they also heard concerns and complaints from consumers applying for Exchange coverage about inaccurate or misleading marketing names, or marketing names that included extensive detail that they found confusing. One commenter noted that while confusion about marketing names has not been an issue in all States, it would be helpful to have clear Federal policy should the issue arise. Many commenters expressed strong support for continued collaboration between HHS and States in plan and plan variation marketing name oversight. Some commenters requested that HHS not impose any requirements on marketing names in excess of what States already require, or that HHS not make requirements that contradict requirements already in place within a State.

Response: We agree with commenters that requiring plan and plan variation marketing names to be accurate and not misleading will help applicants for Exchange coverage make more informed

[297] 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).

[298] 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.

decisions, and have greater confidence that they are choosing the plan that is best for themselves and their families. Moving forward, we will continue working closely with States to review plan and plan variation marketing names by providing information and technical assistance and regularly scheduled calls and coordinating shared review of marketing names during the annual QHP certification process. We will also take existing State requirements into account when overseeing marketing names to prevent contradictory requirements and ensure an efficient plan and plan variation marketing name review process.

Comment: A few commenters opposed the proposal, stating that they generally supported its intent, but disagreed that additional regulation was necessary to achieve its purpose. One commenter stated that States are in a better position than HHS to regulate marketing names, and voiced concern that there could be conflicting recommendations between State and Federal regulators. Another commenter stated that issuers should continue to have the ability to uniquely position their plans in a market through plan marketing names, noting that this practice is often descriptive in nature, and therefore, is not possible to do through other methods of data submission. As examples, the commenter cited terms like ''Freedom plans,'' implying broad access or ''Virtual plans,'' implying enhanced telehealth benefits. This commenter added that they offered Exchange plans with the same marketing convention for the past ten years, and expressed concern about any requirements to change it. Other commenters supportive of the proposal made similar points. For example, other commenters cited terms like ''elite'' or ''premium'' as being important marketing tools to convey advantages of a particular plan. Another recommended exempting marketing names that have been used for three or more years from required correction, with the exception of changes to cost-sharing amounts. The commenter noted that many plans have been offered for five or more years under the same name, and it would be confusing for enrollees to see a new marketing name for the same plan.

Response: We agree with commenters that States are well-positioned to oversee plan and plan variation marketing names. However, based on other public comments and our experiences over the last several years, we believe that Federal partnership is helpful and necessary to ensure that marketing names include only information that is accurate and not misleading. As noted earlier, we will continue to work closely with States to prevent contradictory requirements and ensure State input. We note that certain Federal requirements may exceed those that States currently have in place, such as prohibiting a plan from including in its marketing name ''$0 cost-sharing'' without specifying that it only applies to a limited number of visits, or listing ''$0 deductible'' for a plan that offers a $0 medical deductible but a greater than $0 drug deductible. However, we believe such requirements are important to address the more recent marketing name practices causing problems and we do not anticipate that any such requirements will contradict existing State rules.

We also acknowledge that some issuers have consistently offered plans and plan variations with marketing names that are clear and include correct information. This policy applies to all plan and plan variation marketing names. We will not exempt any marketing names that include errors, such as contradictions with plan benefit information, from required corrections. However, our goal is not to prevent issuers from using marketing names that have not proven problematic in the past. Because inclusion of detailed and sometimes incorrect or misleading plan benefit information in marketing names is a relatively recent practice, we do not anticipate issuers needing to make extensive changes to marketing names already in use for a number of years.

Finally, this policy does not prohibit the use of descriptive language including the terms the commenter cited, such as ''Freedom Plans'' and ''Virtual Plans''; because these terms do not directly correlate with or intend to describe a specific service or benefit, it is unlikely that they would be considered incorrect. However, we encourage issuers to consider this language carefully to ensure it is not misleading. In particular, we encourage issuers to ensure that a plan or plan variation marketing name does not mislead consumers regarding the nature and cost-sharing for telehealth services and in person services, when there are differences between the two.

Comment: Multiple commenters shared concerns about the specific types of inaccurate or confusing marketing name information, some of which we identified in the proposed rule (87 FR 78285). One commenter recommended that issuers not be required to include the term ''deductible'' in marketing names that included a deductible dollar amount, because issuers had long included these dollar amounts in marketing names, and adding an additional term could cause confusion. Some commenters expressed general concerns about lengthy, detailed marketing names, stating that they cause confusion because they are difficult for consumers to understand. One of these commenters made several recommendations to decrease the length of marketing names, such as prohibiting issuers from including the company name in the marketing name because it is already displayed in the *HealthCare.gov* plan compare section, and imposing a character limit to prevent issuers from creating long and complicated plan names. Another commenter recommended limiting marketing names to including only one cost-sharing feature to avoid overwhelming consumers with too much information. One commenter raised the concern that some marketing names advertise features available under all QHPs, such as no restrictions for consumers with pre-existing conditions or full coverage of preventive care free of charge, which increases the length of the marketing name without providing valuable information.

Some commenters also expressed concern about using terms like ''choice'' or ''star'' network to refer to a narrow network, based on the belief that these terms implied an enhanced benefit when the reality was that the plan might provide access to fewer providers than a plan with a broader network that it did not advertise. Commenters also expressed concern about including information in a marketing name that leads consumers to believe that one of more benefits will be covered free of charge, when in fact certain conditions and limitations apply and enrollees cannot access such benefits without incurring significant cost sharing. Commenters also observed that marketing names for CSR variants of silver plans often retain the dollar amount of the deductible or copay of the non-CSR variant plan. In addition, commenters noted that some consumers find it difficult to confirm benefit information with a Summary of Benefits and Coverage (SBC); they cannot determine which SBC corresponds to a plan they have or are considering, because plan and plan variation marketing names do not match the plan name used in the SBC. This commenter recommended that HHS require plan and plan variation marketing names to match the plan name in the corresponding SBC at the level of individual CSR variations.

Response: We appreciate the comments regarding the concerns we cited in the proposed rule about specific

types of incorrect or misleading marketing name information, and appreciate additional issues that commenters raised. We confirm that under this policy, at minimum, we will generally flag for revision plan and plan variation marketing names that include the issues listed in the proposed rule (87 FR 78285) to help ensure consumers are not misled about plans' cost-sharing and coverage implications. However, while we suggested in the proposed rule that dollar amounts that do not specify what they refer to (for example, deductible, maximum out-of-pocket, or something else) could be misleading, based on comments that cited the importance of allowing issuers to continue using longstanding plan and plan variation marketing names, and that encouraged us not to require issuers to include the term ''deductible'' in marketing names that include a deductible dollar amount, we will not require issuers to include cost-sharing terms such as deductible in marketing names that list numbers or dollar amounts. Specifically, while we believe that some consumers might benefit from additional detail about what numbers in a marketing name reference, we are aware that requiring issuers to label all numbers in a marketing name could be counterproductive by lengthening an otherwise concise plan marketing name and requiring that some issuers change marketing names that have long been in use and that comply with existing State rules. Nevertheless, we strongly encourage issuers to carefully consider the information that numbers and dollar amounts are meant to convey. Further, in cases where marketing names specify the type of cost sharing that a number or dollar amount refers to, our review will confirm that this information is accurate. For example, plan and plan variation marketing names that list a deductible amount must be clear whether that amount refers only to medical, drug, or another type of benefit, or simply lists a deductible amount that is inclusive of all these categories to ensure that potential enrollees understand the full cost-sharing requirement.

Additionally, we share concerns that consumers are not always able to fully understand a plan's benefits because of inconsistencies between a plan name used in an SBC and the corresponding plan or plan variation marketing name displayed on *HealthCare.gov.* Moving forward, we will require that these names be consistent and clearly resemble each other, even if a plan or plan variation marketing name includes cost-sharing or other benefit detail that the plan name listed in the SBC does not. This requirement exemplifies the intent of the final policy that we discussed in the proposed rule: by requiring marketing names to be correct, not omit material fact, and not include content that is misleading, we expect that consumers will be able to refer to marketing names as a source of information that supports them in their plan selection process by facilitating their ability to learn more about a potential plan, which includes being able to look up information in other plan materials, instead of exacerbating confusion or making it more difficult to understand plan benefit details. We will also prohibit marketing names from advertising benefits that the ACA requires all Exchange plans to cover as though they were unique to that plan to prevent this information from unnecessarily extending marketing names' length and from implying that certain plans are uniquely advantageous because they provide benefits that in fact all QHPs are required to cover. This requirement mirrors requirements in widely adopted North American Industry Classification (NAIC) model regulations, and therefore, reflects longstanding rules and practice.[299]

Additionally, we have also observed cases of incorrect information in plan variation marketing names for CSR variations that occur because the marketing name retains cost-sharing information from the non-CSR variation plan. Our goals moving forward as part of our review of plan and plan variation marketing names will include making sure that this does not happen. We strongly encourage issuers to proactively update cost sharing information in marketing names to accurately reflect information for CSR plan variations to ensure that their initial QHP application includes accurate information.

We share concerns about the use of potentially misleading terms to refer to narrow networks; while we do not currently plan to prohibit use of general descriptive terms in marketing names, we encourage issuers to carefully consider whether in certain instances, use of these terms could cause or exacerbate existing consumer confusion or mislead consumers regarding a particular plan benefit. We also do not currently plan to prohibit inclusion of issuer names because this could prevent continuity in some marketing names that are not otherwise problematic. We note that current QHP certification instructions already impose a character limit on plan and plan variation marketing names of 255 characters.[300] Moving forward, we will consider whether decreasing this character limit starting in PY 2024 would help to reduce consumer confusion and improve plan data accuracy and the efficiency of the QHP certification process. For example, a character limit of 150 would have permitted more than 90 percent of plan and plan variation marketing names in plan year 2022, while providing a cap to shorten some of the lengthiest marketing names and reduce the risk of unnecessary and confusing information. Finally, we will consider for future PYs the additional recommendations to limit confusion related to plan and plan variation marketing names.

Comment: Some commenters supported the proposal but expressed concern or confusion about the extent and nature of its requirements. Multiple commenters expressed concern about language in the proposed rule noting that information in plan and plan variation marketing names should correspond to benefit information in other plan documents, including the Plans & Benefits Template, *HealthCare.gov* plan selection information, and other applicable QHP certification materials. Some commenters, including several that supported the proposal and one that did not, noted that not all plan information that issuers include in plan marketing names is included in the Plans & Benefits Template. Multiple commenters cited examples of information on benefits that they noted may help to mitigate negative impacts of certain Social Determinants of Health, such as medical transportation and telehealth coverage. One commenter requested that the Plans & Benefits Template not be used as a marketing name generator. Several commenters requested that HHS release guidance on specific requirements for plan and plan variation marketing names under this policy, to mitigate issuer confusion and ensure efficient submission of plan information during the QHP certification process for the coming PY.

Response: We clarify that this policy does not restrict plan and plan variation marketing name content to information only from the Plans & Benefits

[299] See ADVERTISEMENTS OF ACCIDENT AND SICKNESS INSURANCE MODEL REGULATION, Section 6.A(14), which prohibits ''An advertisement that exaggerates the effects of statutorily mandated benefits or required policy provisions or that implies that the provisions are unique to the advertised policy.''

[300] See PY2023 QHP Issuer Application Instructions: Plans & Benefits, Section 4.10: page 2D–17: *https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits.*

Template, or any other template that issuers submit as part of the QHP certification process. However, information about benefits or any other plan attribute included in a marketing name should not be the sole source of information about that benefit, and it must not conflict with information that appears in other plan documents. In other words, issuers must only include benefit or other plan attribute information in a marketing name that is from other plan documents, such as the Plans & Benefits Template, the SBC, or the plan policy document. For example, references to telehealth coverage, a medical transportation benefit, or to any other plan information in a plan marketing name should be based on, correspond to, and not imply that they are more generous than, information about that benefit from plan policy documents. Further, as previously discussed, information in the plan marketing name should not imply more generous coverage or lower cost sharing than what is true in practice for that plan, including by omitting key benefit details or related restrictions. For example, we have received complaints about plan and plan variation marketing names advertising ''free'' or ''$0'' primary care provider visits, when in fact only virtual or telehealth visits are free of charge. Omission of that limitation on the type of visits that are free can mislead consumers and make it less likely that they will choose a plan based on an accurate understanding of its benefits. Finally, we understand the need for guidance on permitted plan and plan variation marketing name characteristics, and strongly support issuer efforts to ensure that marketing name content is accurate prior to submitting an application for QHP certification.

Comment: One commenter suggested that because applicants for Exchange coverage can view plan and benefit information in a standardized format on the *HealthCare.gov* website, there is no need for standardizing plan and plan variation marketing names. Other commenters stated that because plan and benefit information is available on *HealthCare.gov,* there is no need for plan or plan variation marketing names to include benefit information at all, and CMS should prohibit doing so. Other commenters recommended that rather than impose overly restrictive standards on plan and plan variation marketing names, CMS should work to improve the consumer shopping experience on *HealthCare.gov* to maximize consumer understanding of benefits available through and cost sharing required by different QHP options.

Response: We agree that characteristics of the consumer shopping experience in *HealthCare.gov's* Plan Compare section play an important role in helping consumers to choose a plan that is best for themselves and their family. We also agree that consumers are generally better served by comparing plan benefit information on *HealthCare.gov* Plan Compare, because Plan Compare displays corresponding information for different plans in a comparable way (for example, plan deductibles and other cost sharing information is listed in the same format for each available plan). We disagree that the consistency that Plan Compare offers makes it unnecessary to require that plan and plan variation marketing names be correct and not misleading, because incorrect or misleading information has the potential to harm consumers regardless of whether accurate information is also available. In fact, information from a marketing name that conflicts with or does not match corresponding information on *HealthCare.gov* or another Exchange enrollment platform could create consumer confusion that an Exchange could mitigate with a standard marketing name format designed to complement information from *HealthCare.gov* Plan Compare or another Exchange's enrollment platform. With regard to the suggestion that availability of plan and benefit information on *HealthCare.gov* means there is no need for issuers to include this information in marketing names, we will not prohibit that practice at this time, because our goal for PY 2024 is to ensure that marketing names are accurate and not misleading while permitting issuers, to the extent possible, to continue using marketing names that they have in prior years in order to mitigate issuer burden and avoid consumer confusion. Further, we know that some State rules related to plan and plan variation marketing names include some cost sharing information, and we want to establish rules that complement and do not contradict State policy. Relatedly, as further discussed below, we do not plan to require a specific plan marketing name format for PY 2024, but do view it as a useful potential tool to improve the consumer shopping experience wherever possible, which we will continue to work to do.

Comment: Many commenters supported developing specific standards for plan and plan variation marketing names either for PY 2024 or in future plan years. Some offered suggestions for information that issuers should be permitted or required to include. Commenters also supported establishing a defined format that all marketing names would be required to follow, several citing examples of issuers and States that had already adopted specific formats with success. For example, one commenter noted that Washington's Exchange requires issuers to follow a naming format for standard plans, known as ''Cascade Care'' plans. Specifically, Washington adopted the standard plan naming format of ''[Issuer Name] + Cascade + [Metal Level]'' when implementing standard plans for PY 2021, and found it simplified comparisons for consumers by making it easier for them to use standard plans' comparable plan designs to evaluate the distinctions. Commenters that recommended standardizing plan and plan variation marketing names and that recommended specific types of information generally recommended all or some combination of issuer name, plan metal level, limited cost-sharing information, network type, and HSA eligibility if applicable. Some commenters offered specific suggestions about network information in marketing names with several recommending requiring issuers to include network information in marketing names for similar plans with different networks. Others emphasized that network information in marketing names should not be misleading, and one stated that availability and relative cost of out-of-network benefits is important to some consumers and an indication in the plan name would be a prominent way to signal plan differences in this area.

However, other commenters opposed the development of specific standards, based on concerns that this would limit issuers' ability to convey important plan information about plan characteristics through a marketing name and uniquely position products in the market based on this information. Some commenters raised further concerns that a standard format for plan marketing names that specified permitted types of information could result in the same marketing name for multiple plans, which would cause consumer confusion. Other commenters added that requirements for issuers to offer standardized plan options made it especially important for issuers to be able to use marketing names to illustrate what makes a particular QHP unique in a context of many available options, and that many issuers offer more than one network within a single product network type and use marketing names to make this distinction clear to consumers.

Response: We agree that clear and comparable information is most helpful for consumers during the plan selection process, and we appreciate recommendations on how to design plan marketing names to support consumer decision-making. However, we will not apply a required format for plan and plan variation marketing names for PY 2024, because we want to achieve a balance between overseeing plan marketing names to ensure that they are accurate and not misleading and providing issuers with flexibility to create plan marketing names with information they believe will be useful to consumers. Further, we want to continue to work with interested parties to understand the best methods for ensuring that a marketing name is accurate and clear, but also accounts as needed for distinctions between different plans. For example, we appreciate comments related to helping to ensure that consumers understand plans' provider network information, and will continue to investigate how to improve consumers' experiences in this area. Additionally, we agree with comments that it is important to prevent different plans from having the same plan variation marketing name, and will take this concern into account if we develop standardized requirements for plan and plan variation marketing names.

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

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78285), we proposed 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 Payment Notice (86 FR 6138), we added paragraph (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).

We stated in the proposed rule (87 FR 78286) that since 2016, only a single issuer has sought certification on an FFE for a plan that does not use a network. As we explained in the proposed rule, 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 proposed to revisit this policy.

Section 1311(c)(1) 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 include within health insurance plan provider networks those ECPs that serve predominantly low income, medically underserved individuals. We explained in the proposed rule (87 FR 78286) that HHS carries out this directive in part through establishing network adequacy and ECP requirements.

We stated in the proposed rule (87 FR 78286) that when we added paragraph (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. We explained that 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 providers to obtain certification, even though they are not currently subject to §§ 156.230 and 156.235. We also noted that whether a plan that does not use a network provides a sufficient choice of providers is a more nuanced inquiry than a simple assertion that an enrollee can receive benefits for any provider. We explained that 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 the care for a specific health condition from a single provider without incurring additional out-of-pocket costs. We stated that 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 and noted that 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.

We stated in the proposed rule (87 FR 78286) that to ensure more effectively 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). We explained that consistent standards also would allow for easier comparison across all QHPs in a more comprehensible manner for prospective enrollees. The benefits of easier comparison among 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 6154), and it is true that the ACA includes no standalone network requirement. However, we explained in the proposed rule (87 FR 78286) that, 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 explained that 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 noted that 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 stated that we now understand the statute's text to best support a reading that access to ECPs will be provided ''within health insurance networks.''

Additionally, we noted in the proposed rule (87 FR 78286) that 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. We further noted that § 155.1000 provides Exchanges with broad discretion to certify health plans that may otherwise meet the QHP certification standards specified in 45 CFR part 156. We explained that 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). We also explained in the proposed rule (87 FR 78286), that we believe 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.[301] For example, we stated that 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 comparison of standardized plan options. Furthermore, we noted that 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.[302] [303]

We stated in the proposed rule (87 FR 78286 through 78287) that the proposed revision would assure HHS that all plans certified as QHPs offer sufficient choice of providers in compliance with a consistent set of criteria for easier comparison across all QHPs and better ensure substantive consumer protections afforded by the ACA without undue barriers to access those protections. We explained that 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. We stated that this would 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, under the authority delegated to HHS to establish criteria for the certification of health plans as QHPs, we proposed 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. We explained in the proposed rule (87 FR 78287) that under this proposal, an Exchange could not certify as a QHP a health plan that does not use a network of providers. However, we solicited 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.

We explained in the proposed rule (87 FR 78287) that this proposed requirement would also generally apply to SADPs. We stated that since 2014, the FFEs have received, and approved, QHP certification applications for SADPs that do not use a provider network in every PY. However, we explained that the number of SADPs that do not use a provider network has never accounted for a significant number of Exchange-certified SADPs on the FFEs. We noted that at their most prevalent in PY 2014, only 50 of the 1,521 Exchange-certified SADPs on the FFEs were plans that do not use a provider network. We also noted that in PY 2022, only 8 of the 672 Exchange-certified SADPs on the FFEs were plans that do not use a provider network.

We further explained in the proposed rule (87 FR 78287) that the number of SADPs on the FFEs that did not use a provider network appears to be limited since 2017 to fewer and fewer States; while 9 FFE States had Exchange-certified SADPs that do not use a provider network in PY 2014, only 2 FFE States still had Exchange-certified SADPs that do not use a provider network in PY 2022. We noted that since PY 2021, only 85 counties in Alaska and Montana still have Exchange-certified SADPs that do not use a provider network. We stated that we assumed 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 further explained that 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 invited 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.

[301] As discussed below, some commenters asserted that the requirement to use a network of providers to obtain certification contravenes section 1311(e)(1)(B)(i) of the ACA, which states that an ''Exchange may not exclude a health plan . . . on the basis that such plan is a fee-for-service plan,'' and that ''fee-for-service plans'' are understood to be ''a type of non-network plan.'' While we respond to this comment in more detail below, we clarify that our reference here to section 1311(e)(1)(B)(i) of the ACA specifically pertains to our finding that—at least in an FFE that the agency operates—using a network of providers is generally in the interests of qualified individuals. It does not address whether fee-for-service plans are in the interests of qualified individuals.

[302] 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.*

[303] 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.

TABLE 11: Prevalence of Exchange-Certified 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.*

We explained in the proposed rule (87 FR 78288) that, 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 stated that 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 explained in the proposed rule (87 FR 78288 through 78289) that we were 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 were 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 11). We also expressed our awareness that having no Exchange-certified SADPs offered through an Exchange in an area would impact all non-grandfathered individual and small group health plans in such areas. We noted that 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 noted 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.

As we explained that in the EHB Rule (78 FR 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. We further explained in the proposed rule (87 FR 78289) that 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, we stated in the proposed rule that 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 solicited comment to confirm this understanding.

As we stated in the proposed rule (87 FR 78289), to prevent a situation where this proposal would require health plans in those areas to cover the pediatric dental EHB, we solicited 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; we also clarified that this exception would not be applicable to health plans. We explained that 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. We stated that other factors could include an attestation from the issuer about extreme difficulties in developing a dental provider network, or data provided in the ECP/network adequacy (NA) template or justification forms during the QHP application submission process that reflect such extreme difficulties. We sought 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 sought comment on this proposal, as well as on other topics included in this section.

After reviewing the public comments, for the reasons set forth in this final rule and those we explained in the proposed rule, subject to the exception discussed below, we are finalizing the proposal to revise the network adequacy and ECP standards at §§ 156.230 and 156.235 to require all individual market QHPs, including individual market SADPs, and all SHOP QHPs, including SHOP SADPs, across all Exchanges to use a network of providers that complies with the standards described in those sections. In addition, as proposed, we are also removing from the regulation text the exception at § 156.230(f) that these sections do not apply to plans that do not use a provider network. Finally, we are finalizing a limited exception at § 156.230(a)(4) for certain SADP issuers that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers. Specifically, under this exception, an area is considered ''prohibitively difficult'' for the SADP issuer to establish a network of dental providers based on attestations from State departments of insurance in States with at least 80 percent of their counties classified as Counties with Extreme Access Considerations (CEAC) that at least one of the following factors exists in the area of concern: a significant shortage of dental providers, a significant number of dental providers unwilling to contract with Exchange issuers, or significant geographic limitations impacting consumer access to dental providers.

We summarize and respond to public comments received on this proposal below.

Comment: A majority of commenters supported the proposal to require plans to use a network of providers that complies with the standards in §§ 156.230 and 156.235. Commenters agreed that such a requirement is consistent with statutory requirements at section 1311(c)(1)(B) and (C) of the ACA. Some commenters indicated that the proposal would allow easier comparison across all QHPs in a more comprehensible manner for prospective enrollees. Commenters agreed that the proposal would ensure consumer choice and access to care, as it would ensure that QHPs do not impose excessive burden on enrollees to understand whether they would incur additional out-of-pocket costs by their plan or to identify which providers within a reasonable distance from their residence accept the plan's benefit amount as payment in full. Other commenters agreed with the proposal, asserting that health plans that do not use a network of providers are not in consumers' interests, as they are more likely to subject consumers to increased medical costs. Other commenters agreed that this requirement should apply to SADPs. Some commenters supported the proposal, stating that plans that do not use a provider network have historically presented a barrier to consumers' ability to access care and control their health care costs, unnecessarily expose people to potential medical debt, and are not in the interests of consumers shopping for QHPs.

Response: Subject to a limited exception described below applicable to SADPs, we are revising the network adequacy and ECP standards at §§ 156.230 and 156.235 to state that all individual market QHPs, including individual market SADPs, and all SHOP QHPs, including SHOP SADPs, across all Exchanges must use a network of providers that complies with the standards described in those sections, and to remove the exception at § 156.235(f) that these sections do not apply to plans that do not use a provider network. We are finalizing this requirement, agreeing with commenters that subjecting all plans that apply for certification to the network adequacy and ECP standards at §§ 156.230 and 156.235 allows for proper oversight of the statutory requirements at section 1311(c)(1)(B) and (C) of the ACA. As discussed below, while plans that use a network of providers may present certain access issues for consumers,

their compliance with §§ 156.230 and 156.235 ensures that consumers have reasonable access to a set of providers that accept the plan's payment as payment in full, which limits consumers' out-of-pocket costs. In addition, we are not aware of any administrable regulatory standard that would ensure that plans that do not use a network comply with those sections of the ACA. Commenters responding to this proposal also did not identify a regulatory standard that we believe that we could administer to ensure compliance with the ACA, as further discussed below.

Comment: A minority of commenters, including one health insurance issuer, opposed the proposal and asserted that the exception at § 156.230(f) should be retained. These commenters asserted that the proposal to require QHPs to utilize a provider network contravenes section 1311(e)(1)(B)(i) of the ACA, which states that an ''Exchange may not exclude a health plan . . . on the basis that such plan is a fee-for-service plan,'' and they state that ''fee-for-service plans'' are understood to be ''a type of non-network plan.'' Commenters also asserted that HHS impermissibly justifies the requirement that QHPs must use a network of providers because only plans with networks can satisfy section 1311(c)(1)(C) of the ACA regarding the ECP requirement for certification. One commenter stated that HHS should develop alternative regulatory standards for plans that do not use a network to demonstrate compliance with section 1311(c)(1)(B) and (C) of the ACA, recommending that HHS should look to Medicare Advantage program standards as an example.

Response: We do not agree that the requirement for QHPs to utilize a provider network conflicts with section 1311(e)(1)(B)(i) of the ACA. Section 1311(e)(1) and (e)(1)(B)(i) of the ACA states that an Exchange may certify a health plan as a QHP if such plan meets the requirements for certification as promulgated by the Secretary under section 1311(c)(1) of the ACA and the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State in which such Exchange operates, except that the Exchange may not exclude a health plan, among other reasons, on the basis that such plan is a fee-for-service (FFS) plan. In requiring all plans to use a network, we are exercising the authority granted to the Secretary at section 1311(c)(1)(A) of ACA to establish requirements for the certification of health plans as QHPs, though we are also informed by the requirement for certification at section 1311(e) of the ACA, which states that an Exchange must determine that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, and which we determine when evaluating plans for QHP certification on an FFE.

In so doing, we are not excluding FFS plans from obtaining certification on the basis that such plans are FFS plans and categorically not in the interests of qualified individuals and qualified employers. We are establishing that plans that do not use a network of providers are inherently unable to comply with the statutory requirement at section 1311(c)(1)(C) of the ACA because that section requires health plans certified as QHPs to ''include [ECPs] within health insurance plan networks.'' That health plans must include ECPs within health insurance plan networks as one of the criteria for certification is a straightforward reading of the language at section 1311(c)(1)(C) of ACA. This statutory language does not provide an exception for plans that do not use a network of providers or FFS plans; it simply states, ''. . . to be certified, a plan shall, at a minimum—(C) include [ECPs] within health insurance plan networks . . .'' Our interpretation that this language requires health plans to use a network of providers to obtain certification is supported by statute. We believe that section 1311(c)(1)(B)'s requirement that plans must provide a ''sufficient choice of providers'' on which the commenter relies in fact provides additional legal support for our regulation. As discussed below, section 1311(c)(1)(B) of the ACA encompasses the burden of accessing providers, and our experience with health plans that do not use a network of providers seeking QHP certification suggests that such plans impose significant burdens on enrollees seeking access to providers.

Commenters' suggestion is based on equating FFS plans to plans that do not use a network of providers. We disagree that FFS plans never use a network of providers. For example, while commenters rely on the Office of Personnel Management's subregulatory definition of ''non-PPO'' FFS plans—which are indeed FFS plans that do not involve a network—they overlook the definition of ''Fee-for-Service (FFS) with a Preferred Provider Organization (PPO)'' plan that follows, which acknowledges that there are FFS plans that use a network.[304] Similarly, the commenters' citation to our 1997 statement in the **Federal Register** suggesting that Medicare private FFS plans often lacked networks overlooks that even then, section 1852(d) of the Social Security Act (the Act) *allowed* private FFS plans to include a network [305]—and that provision has since been amended to encourage and sometimes require that Medicare private FFS plans use a network.[306] Because FFS plans include plans with and without networks of providers, we disagree that a statutory prohibition on not certifying plans based on the fact that they are FFS plans impliedly prohibits not certifying plans on the basis that they lack a provider network.

Thus, we find that commenters are incorrect that FFS plans never use a network of providers. However, even if the commenters' assertions were accurate, section 1311(e)(1)(B)(i) of the ACA would not prevent finalization of this requirement. First, we principally proposed this rule under our authority to set requirements under section 1311(c) of the Act, and we do not believe section 1311(e)(1)(B)(i) of the ACA—directed at the authority of Exchanges—necessarily limits our general rulemaking authority under section 1311(c) of the ACA. Nor does section 1311(e)(1)(B)(i) of the ACA override our interpretation of the requirement at section 1311(c)(1)(C) of the ACA that all plans must use a network as a requirement for certification. In addition, even if section 1311(e)(1)(B)(i) of the ACA also limited section 1311(c) of the ACA, the prohibition at section 1311(e)(1)(B)(i) of the ACA is based on how the plan pays providers for services rendered, and not on the absence or presence of a network of providers.

In addition, even if we did not interpret the ACA to require the use of a network of providers for certification, we are not aware of any administrable regulatory standard to assess whether a plan that does not use a network of providers ensures a sufficient choice of providers, including ECPs, as required by sections 1311(c)(1)(B) and (C) of the ACA. While it may be true that enrollees in plans that do not use a network may visit any provider (and thus all ECPs)

[304] *https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-types/#:~:text=Fee%2Dfor%2DService%20(FFS)%20Plans%20with%20a%20Preferred,to%20file%20claims%20or%20paperwork.*

[305] See Public Law 105–33, section 4001, 111 Stat. 290–91 (1997).

[306] See Public Law108–173, section 211, 117 Stat. 2180 (2003); Pub. L. 110–275, section 162, 122 Stat. 2569–70 (2008).

and receive some reimbursement from the plan, the possibility of the enrollee receiving *some* reimbursement for any benefit from any provider is not the same as the plan providing enough reimbursement for those benefits, such that the enrollee has reasonable access to sufficient providers that would accept the plan's payment amount as payment in full. As discussed in the proposed rule (87 FR 78286), for a prospective enrollee, the analysis of whether a plan ensures a sufficient choice of providers, and thus provides sufficient protection against additional out-of-pocket costs, involves factors like the burden of accessing those providers, including whether there are providers nearby that they can see without unreasonable delay that will accept such a plan's benefit amount as payment in full. Thus, we cannot conclude that such a plan *de facto* complies with these statutory requirements simply because it provides *some* reimbursement to its enrollees for any benefit.

Further, we are unaware of an administrable regulatory standard that would allow us to determine whether such a plan's benefit amount would be accepted as payment in full by any provider, such that an enrollee's out-of-pocket costs may be limited by receiving services from that provider. Such a plan cannot impose on providers any obligation to set a certain price for a specific service, and there is no requirement imposed by the plan on providers to accept the plan's payment as payment in full. The plan cannot prevent a provider from changing the price for a specific service, nor can it require that a provider communicate the price change to the enrollee or their plan. Likewise, no Federal requirements prohibit such individual market plans from changing the amount the plan pays for a given service or require the plan to communicate the change to the enrollee or their provider, even mid-plan year. As a result, the enrollee is subject to a plan that can change its benefit amount, and there is no assurance that any provider will actually accept the payment amount as payment in full; these changes could occur frequently and without any notice to the enrollee. To attempt to ascertain whether there are sufficient providers (including ECPs) who will accept the plan's benefit amount as payment in full, one would need to accurately understand what services are medically necessary, continuously contact every provider in the State to determine what services they perform and what amount they charge for every specific service, *and* continuously contact the plan to determine the amount they pay for every specific service. Such an exercise is prohibitively difficult for a consumer to perform, and we have been unable to devise an administrable regulatory standard to ensure compliance with the ACA's network adequacy and ECP requirements.

Further, even if it were theoretically possible to devise such a requirement, we are not aware of any statutory authority to require providers continuously to report what amount they would accept as payment in full, either to an Exchange, a plan, or individuals—significantly inhibiting an Exchange's ability to enforce such a standard. And, even if we had such statutory authority, there is insufficient demand that HHS dedicate the significant resources necessary to devise a regulatory standard for plans that do not use a network to demonstrate compliance with section 1311(c)(1)(C) of the ACA. We are aware of a single health plan that does not use a network of providers in one State that seeks to obtain certification for the State's Exchange. No other issuer has expressed interest to us in obtaining certification for such a plan, and the majority of comments on this rule supported the proposal to require health plans to use a network to obtain certification.

One commenter suggested that we consider implementing a regulatory standard that considers Medicare Advantage private FFS plan requirements. We do not find Medicare Advantage private FFS plans to be comparable to plans without networks seeking QHP certification under the ACA. Section 1852(d) of the Act requires Medicare Advantage private FFS plans to demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. Further, Medicare Advantage private FFS plans are defined in section 1859(b)(2) of the Act as a plan that, among other things, ''does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan.'' As a result, in the Medicare Advantage context, private FFS enrollees are more protected from unexpected out-of-pocket costs.[307] This may not hold true in the Exchange context. The one issuer that has previously sought QHP certification for a plan that did not use a network of providers would not have required any provider to agree to any particular terms or conditions of payment. Unlike Medicare Advantage private FFS plans, then, we are concerned that Exchange plans without networks leave uncertainty as to whether any provider accepts a plan's benefit amount as payment in full and potentially opens up the enrollee to additional out-of-pocket costs.

Comment: Some commenters asserted that the proposed rule fails to provide a balanced discussion of the data on provider network strengths and weaknesses or acknowledge the merits of plans that do not use a provider network.

Response: In requiring plans to use a network of providers to obtain QHP certification, we are not representing that plans that use a network of providers do not present certain access issues. For example, we recognize that such plans place the burden on enrollees to ensure that specific providers are in-network, while a plan that does not use a network of providers does not place a such a burden on its enrollees to receive some benefit under the plan. We also recognize that some networks are narrower than some enrollees may prefer, which can result in enrollees needing to travel further or wait longer to receive care from an in-network provider, while enrollees in a plan that does not use a network of providers may not need to travel as far or wait as long to receive some benefit under their plan. However, unlike plans that do not use a network of providers, there is an administrable regulatory standard to ensure that plans that use a network of providers comply with sections 1311(c)(1)(B) and (C) of the ACA; to that end, since 2014, we have required that plans that use a network of providers comply with the network adequacy and ECP standards at §§ 156.230 and 156.235. Plans that comply with these standards ensure that their enrollees have access to sufficient providers who are contractually obligated to accept the plan's payment amount as payment in full. This is a consumer protection that plans that do not use a network cannot provide to its enrollees, and one that we believe is consistent with core tenets of the ACA—

[307] Because sections 1852(k)(1) and 1866(a)(1)(O) of the Act require health care providers and hospitals to accept Medicare-established amounts as payment in full, Medicare Advantage private FFS plans can rely on the availability of providers that accept Medicare as one way to demonstrate access to services for their enrollees. In addition, since 2011, Medicare Advantage (MA) private FFS plans that are offered in areas where there are at least two other MA plans that are network-based plans, must use contracts or agreements with providers as the only way to demonstrate that the private FFS plan provides adequate access to services. See 42 CFR 422.114.

that consumers have access to a plan that provides a reasonable method to limit their out-of-pocket costs for health care to the annual limitation on cost sharing.

Comment: One commenter requested that HHS clarify whether the definition of ''provider'' includes pharmacies in the context of network adequacy and ECP standards.

Response: While we have not defined the term ''provider'' in the context of the network adequacy standards, we provide a list of the individual provider and facility specialty types that are included in the network adequacy reviews within the 'Specialty Types' tab of the respective plan year ECP/NA template. If an issuer does not see a specific specialty type listed in the 'Specialty Types' tab, it should refer to the 'Taxonomy Codes' tab of the ECP/NA template to select the correct specialty type to which the taxonomy code crosswalks. If a specific taxonomy code is not listed in the 'Taxonomy Codes' tab, such as in the case of pharmacies, the provider type has not been included in the FFE network adequacy reviews. In the context of the ECP standards, although we have not defined the term ''provider,'' we list the provider types that are included in the ECP categories at § 156.235(a)(2)(ii)(B), which does not include pharmacies.

Comment: Some commenters, including two State departments of insurance (Alaska and Montana), were in favor of a limited exception to this requirement for SADPs that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers. These commenters confirmed our analysis that it may be currently prohibitively difficult for SADP issuers to establish a network of dental providers in Alaska and Montana, and that without an exception to the proposed requirement, consumer access to any SADP would be in jeopardy. Commenters supported the use of the list of non-exhaustive factors that we would consider in determining whether it is prohibitively difficult for SADP issuers to establish a network of dental providers, 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. In addition, commenters specifically mentioned as barriers geographic barriers and providers' unwillingness to enter into provider contracts. A handful of commenters suggested that State regulators should decide whether to allow non-network plans to be certified as QHPs on an Exchange. One commenter recommended that we implement this ''prohibitively difficult'' approach for allowing certain SADPs to not use a provider network with a pre-approved form for SADPs to request the exception and permit an abbreviated filing for subsequent years if a SADP filed the full request in a prior year. This commenter also requested clarification that the ''prohibitively difficult'' exception does not require an attestation, as well as clarification as to the meaning of ''extreme difficulties'' in developing a dental provider network.

Response: We are finalizing this proposal with a limited exception for SADPs that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers. This limited exception follows logically from how the requirements in sections 1311(c)(1)(B) and (C) of the ACA that plans ensure a sufficient choice of providers, including ECPs, apply in the unique SADP context. As commenters point out, if creating a network of dental providers is prohibitively difficult for SADPs in certain areas, it is foreseeable that there may be some areas where SADPs could not be Exchange-certified (in Alaska and Montana, for example). That risks there being no SADPs in that area and thus no choice of dental providers through SADPs at all. Thus, in this limited context, requiring a network would defeat the purpose of sections 1311(c)(1)(B) and (C) the ACA to ensure that enrollees have a sufficient choice of providers.

We find additional support for this exception in section 1302(b)(4)(F) of the ACA, which states that if 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 for pediatric services, including pediatric dental benefits. Without an Exchange-certified SADP available on the Exchange in those areas, all non-grandfathered individual and small group health insurance plans in impacted areas would be required to cover the pediatric dental EHB, and would be required to develop a network of pediatric dental providers in accordance with the policy finalized in this rule. Imposing this certification requirement on these health plans would likely cause health plans in the area to fail this certification requirement, as SADPs would have already established the difficulty in creating pediatric dental networks in this area. The ultimate result would be that QHPs may not be available on the respective Exchange in those areas, as all non-grandfathered individual and small group health insurance plans in the State would not be permitted to omit coverage of the pediatric dental EHB.

This limited exception will be codified at § 156.230(a)(4). Under this exception, we will consider an area to be one where it is ''prohibitively difficult'' for the SADP issuer to establish a network of dental providers based on attestations from State departments of insurance in States with at least 80 percent of their counties classified as CEAC that at least one of the following factors exists in the area of concern: a significant shortage of dental providers, a significant number of dental providers unwilling to contract with Exchange issuers, or significant geographic limitations impacting consumer access to dental providers. For purposes of its network adequacy standards, CMS uses a county type designation method that is based on the population size and density parameters of individual counties. These parameters are foundationally based on approaches used by the U.S. Census Bureau in its classification of ''urbanized areas'' and ''urban clusters,'' and by the Office of Management and Budget (OMB) in its classifications of ''metropolitan'' and ''micropolitan.'' The CEAC county type designation is based on a U.S. Census Bureau population density estimate of fewer than 10 people per square mile.

This approach was informed by comments submitted in response to our solicitation for comments regarding if and/or how we should design a limited exception for SADP issuers. The States of Alaska and Montana were the only two States that expressed a need for this limited exception in their public comments, and are the only two States with FFEs that have had SADPs without a provider network for the past two years. The State of Alaska noted that out of the 2,200 people in the country enrolled in SADPs without provider networks in 2021, approximately 1,000 of those individuals resided in Alaska. The State of Alaska requested in its public comment that if HHS proceeds with requiring SADPs to use a provider network that we include a limited exception for SADPs in areas where it is prohibitively difficult to establish a network, noting that 90 percent of counties in Alaska with Exchange-certified SADPs without provider networks have no Exchange-certified SADPs with provider networks. Furthermore, the State of Montana stated in its public comment that they have unique challenges as it pertains to health care delivery and access, including geographic barriers to care and a limited number of dentists

practicing in Montana who are willing to contract with issuers. The State of Montana strongly supported HHS establishing an exception to the provider network requirement for SADPs in areas where it is difficult for issuers to establish SADPs with provider networks based on information supporting such an exception, including data provided in an issuer's ECP/NA template.

These comments submitted by the States of Alaska and Montana, combined with data provided in issuers' ECP/NA templates or justification forms, demonstrate that in States with 80 percent or more of their counties classified as CEAC (that is, Alaska, Montana, North Dakota, and Wyoming), it is prohibitively more difficult for issuers to establishing a network of dental providers compared with issuers in States with fewer than 80 percent of their counties classified as CEAC, as evidenced by the limited availability of SADPs that use a provider network in these States and/or the limited number of contracted dentists. Given that our network adequacy time and distance standards allow for an issuer to receive credit for a provider across county/State lines so long as the provider is within the requisite time and distance of consumers in the respective county, issuers operating in States with fewer than 80 percent of their counties classified as CEAC have performed better overall with respect to meeting network adequacy standards than issuers in Alaska, Montana, North Dakota, and Wyoming, demonstrating that States with fewer than 80 percent of their counties classified as CEAC are not in need of this exception. Therefore, limiting this SADP exception to States with 80 percent or more of their counties classified as CEAC aligns with our solicitation for comments regarding whether we should consider the availability of other SADPs that use a provider network in the service area and prior years' network adequacy data submitted in issuers' ECP/NA templates or justification forms to identify counties in which SADP issuers have struggled to meet standards due to a shortage of dental providers.

We expect that States, in determining whether an area has been impacted by at least one of the above factors to the degree of being considered ''prohibitively difficult'' for SADP issuers to establish a network of dental providers, will take 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 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, and geographic barriers. Where we have determined that an area is one where it is ''prohibitively difficult'' for the SADP issuer to establish a network of dental providers based on attestations from State departments of insurance, all SADPs that are seeking Exchange certification and that are offering coverage in that area will be exempt from the requirement to use a provider network. In areas for which we have not made such a determination, SADP issuers may still avail themselves of the written justification process at § 156.230(a)(2)(ii).

We also believe that this limited exception is justified for SADPs in part because, unlike health plans, dental-only coverage constitutes an excepted benefit under section 2791(c)(2)(A) of the PHS Act. In addition, there is limited exposure to unanticipated out-of-pocket costs for pediatric dental EHB in SADPs that do not use a network of providers, and there are a relatively small number of pediatric dental EHBs that are covered by such a plan. Collectively, these factors significantly limit the potential that those receiving pediatric dental EHB will experience excessive out-of-pocket costs. Thus, we are not extending this limited exception to health plans. No commenters indicated that it is prohibitively difficult for health plans to establish a network of providers that complies with §§ 156.230 and 156.235 (or sections 1311(c)(1)(B) or (C) of the ACA) or that such a requirement may result in the inability for health plans to be certified as QHPs in specific areas. As a result, we are codifying the limited exception for SADPs only at this time.

We will operationalize this limited exception beginning with certification for PY 2024 and anticipate that States will apply for this exception and include a justification for requiring an exception. We envision providing SADP issuers and States ample guidance in advance of PY 2024, and in any event, envision working closely with State regulators in these areas. We considered allowing issuers to apply for an exception, but we believe that State regulators are better positioned to make recommendations to HHS, as they know the challenges of their markets. We also believe that the conditions for granting or not granting an exception would not exist at an issuer level, but instead at a county or service area level, such that issuer-specific applications would be inappropriate.

Compliance With Appointment Wait Time Standards

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78289), we noted that in the 2023 Payment Notice, we finalized the requirement that issuers demonstrate compliance with appointment wait time standards via attestation, beginning in PY 2024.

We received numerous comments in response to the finalized policy from the 2023 Payment Notice raising concerns regarding the implementation of appointment wait time standards for QHP issuers beginning in PY 2024. In response to the public comments, we are amending § 156.230(a)(2)(i)(B) to delay applicability of this standard until PY 2025. We summarize and respond to public comments received below.

Comment: Most commenters opposed applying appointment wait time standards beginning in PY 2024 and requested delayed implementation to PY 2025. Several commenters highlighted the need for HHS to issue additional guidance necessary for issuers to comply with appointment wait time standards, and to allow the industry time to comment on that guidance. Many commenters noted the lack of specificity around how appointment wait times would be assessed and how issuers could attest without a standard metric. Other commenters were concerned that States do not have the tools to assess compliance or additional resources to conduct compliance activities. A few commenters were concerned with the following barriers to implementation: the burden on providers to report data to issuers; the operational challenges in monitoring contracted providers; the difficulty in receiving accurate wait time data from providers; and fluctuations in appointment wait times during the PY. Other commenters noted workforce staffing, recruiting, and retention challenges as additional barriers. By contrast, a few commenters supported implementing the appointment wait time policy on the finalized schedule so that consumers have access to timely necessary care. Others supported the standard but requested that the methodology for assessing compliance include additional methodologies other than issuer attestation.

Response: As noted above, we agree with the many commenters that implementation of the appointment wait

time standards should be delayed by one PY. We are amending the regulation to delay the applicability of the appointment wait time standards until PY 2025. We are also aware of other HHS initiatives to define and implement appointment wait times standards for other program areas. The additional PY delay will allow HHS to ensure that these wait time standards are implemented in a holistic, logical way across programs. Accordingly, QHP issuers in FFEs will have one additional PY before being required to attest to meeting appointment wait time standards.

As we noted in the 2023 Payment Notice, specific guidelines for complying with appointment wait time standards will be released in later guidance. This will allow us additional time to develop specific guidelines for how issuers should collect the requisite data from providers, how the metrics should be interpreted, and for public comment on the proposed guidance. Issuers that do not yet meet the appointment wait time standards once implemented in PY 2025, will be able to use the justification process to update HHS on the progress of their contracting efforts for the respective plan year.

We encourage issuers that have implemented monitoring and data collection of provider appointment wait times to continue to do so. However, under this new timeline, we will not be actively collecting or requiring submission of any data or attestations for compliance with the standards for purposes of QHP certification for PY 2024.

Comment: Some commenters noted the proposed rule would require QHPs on all Exchanges to comply with network adequacy standards but that appointment wait time criteria would only apply to issuers in FFEs. Others requested that HHS establish Federal appointment wait time standards that would be applicable to issuers in all Exchanges, including State Exchanges.

Response: As we noted in the 2023 Payment Notice (87 FR 27334), we appreciate these comments and understand that there are diverse opinions regarding the appropriate regulator for network adequacy standards in State Exchanges. We will monitor existing network adequacy standards in State Exchanges relative to the Federal standards and will consider whether applying Federal standards to issuers in State Exchanges in future PYs is warranted.

Comment: One commenter requested revisions to the wait time standards for dental issuers and to reduce the required wait time standard compliance percentage from 90 percent to 80 percent during the first 3 years. A few commenters requested that the appointment wait time standards be applicable to pediatric providers separately.

Response: We appreciate the detailed recommendations around appointment wait times and we will take these comments under advisement as we continue to specify the Federal appointment wait time standards.

8. Essential Community Providers (§ 156.235)

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78289), we proposed 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 proposed 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 SUD Treatment Centers) would be recategorized within these new proposed stand-alone ECP categories. We proposed 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 proposed to add Rural Emergency Hospitals (REHs) as a provider type in the Other ECP Providers ECP category (87 FR 78289). We stated in the proposed rule that this addition would reflect the fact that on or after January 1, 2023, REHs may begin participating in the Medicare program. As we noted in July 2022, ''[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.'' [308] We stated in the proposed rule that we believe 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 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. We explained in the proposed rule (87 FR 78289) that each plan year, we release 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. We noted that the list is not exhaustive and does not include every provider that participates or is eligible to participate in the 340B Drug Pricing 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. We explained that we endeavor to continue improving the ECP list for future years and that 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 noted in the proposed rule (87 FR 78289) 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, we stated that 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 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

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

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).

We stated in the proposed rule (87 FR 78290) that the 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.

As we explained in the proposed rule (87 FR 78290), given that the ECP standard is facility-based, 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) or CMS as providing such services, in addition to fulfilling other ECP qualification requirements as specified at § 156.235(c).

We stated in the proposed rule (87 FR 78290), that if this proposal is 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 12 (as discussed below, we are finalizing these as proposed).

TABLE 12: ECP Categories and Provider Types in FFEs 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, we proposed 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, we proposed 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, we proposed 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 noted that we would retain the 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.

We proposed that only two ECP categories, FQHCs and Family Planning Providers, be subject to the additional 35 percent threshold in PY 2024 and beyond. We stated in the proposed rule (87 FR 78291) that these two categories were selected, in part, because they represent the two largest ECP categories; together, these two categories comprise a significant majority of all facilities on the ECP List. As we explained in the

proposed rule, 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. We stated that we may consider applying a specified threshold to other ECP categories in future rulemaking, if we find 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.

We explained that, 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, we stated that 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. We further stated that 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.

In the proposed rule (87 FR 78291), we acknowledged challenges associated with a general shortage and uneven distribution of SUD Treatment Centers and Mental Health Facilities. However, we noted that the ACA requires that a QHP's network include ECPs where available. As such, we explained that 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, we explained that, 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. We noted that, as a result, issuers are not disadvantaged if their service areas contain fewer ECPs. We explained that we anticipate 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. We stated that 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 sought comment on these proposals.

After reviewing the public comments, we are finalizing, as proposed, for PY 2024 and subsequent PYs, the establishment of two additional stand-alone ECP categories at § 156.235(a)(2)(ii)(B), Mental Health Facilities and SUD Treatment Centers, and the addition of REHs as a provider type in the Other ECP Providers category. In addition, we are finalizing, as proposed, revisions to § 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, we are finalizing that QHPs must 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 for PY 2024 and subsequent PYs. Furthermore, we are finalizing, as proposed, revisions to § 156.235(a)(2)(i) to clarify that these threshold requirements will be in addition to the existing provision that QHPs must satisfy the overall 35 percent ECP threshold requirement in the plan's service area. As stated earlier, we noted in the proposed rule (87 FR 78289) that the proposal establishing two additional ECP categories and the proposed threshold requirements 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), but we stated that 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). However, we omitted corresponding regulation text amendments in the proposed rule. We are including regulation text amendments at § 156.235(b)(2)(i) to codify this policy as proposed.

We summarize and respond to public comments received on the proposed policies, below.

Comment: The majority of commenters supported the proposal to create the standalone ECP categories for SUD Treatment Centers and Mental Health Facilities, noting that the new categories will expand access to mental health services and SUD treatment. One commenter urged HHS to further define what types of facilities are included in the SUD Treatment Centers and Mental Health Facilities categories. One commenter recommended that HHS use the language ''mental health organizations'' because ''mental health organizations'' is a broader term and can include peer-run organizations and other community-based mental health centers. They indicated that these organizations receive funding and technical assistance from SAMHSA and that they would be able to service more individuals if they were ECPs. Two commenters requested that HHS establish an additional ECP category for ''pediatric mental health facility.''

Response: We are finalizing the creation of standalone ECP categories for SUD Treatment Centers and Mental Health Facilities as proposed. As noted by commenters and explained in the proposed rule (87 FR 78290), we believe that establishing these new standalone categories will expand access to mental health services and SUD treatment. Regarding the suggestion to use the broader term ''mental health organizations,'' the commenter noted that this term can include the use of peer-run organizations. CMS partners with SAMHSA to ensure that a range of providers providing mental health and SUD care appear on the HHS ECP list in order to increase access for all consumers who need these types of care. HHS may consider additional ECP categories or provider types, including pediatric mental health providers and other types of mental health organizations, in future rulemaking, if analysis suggests that there is a sufficient number and distribution of such providers.

Comment: Two commenters opposed HHS' proposal to establish these ECP categories. One of these comments urged HHS to delay implementation of the standalone categories until PY 2025 to allow issuers more time to prepare and to evaluate the impact of the proposal. One commenter did not

specifically state whether they supported or opposed the proposal but stated that regulation should be left to the States. Two commenters recognized that issuers may have difficulty meeting the requirements due to inadequate provider supply. One of these two commenters recommended delaying the implementation of the two categories until further analysis can be conducted to determine the best way to contract with quality SUD treatment and mental health providers.

Response: In response to concerns raised about potential difficulties meeting the increased standard because of a provider supply shortage, we note that the standard does not penalize issuers that lack certain types of ECPs within a service area. First, section 1311(c)(1)(C) of the ACA requires that a QHP's network include those ECPs, *where available,* that serve predominantly low income and medically-underserved populations. As such, as we explained in the proposed rule (87 FR 78291), 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. In addition, 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.[309] As a result, issuers are not disadvantaged if their service areas contain fewer ECPs. Further, as in prior years, there will be mechanisms in place to assist issuers who encounter difficulty meeting any element of the ECP standard during certification, including the ECP Justification Form and the ECP Write-in Worksheet.[310] We reflect this in our regulations (§ 156.235(a)(3) and (b)(3)) by permitting issuers that cannot meet the contracting standards to satisfy the QHP certification standard by submitting a justification. Therefore, the standard does not penalize issuers that cannot meet the ECP standard because of a lack of certain types of ECPs within a service area. Moreover, we anticipate implementing these categories for PY 2024 will increase consumer access to vitally important mental health and SUD care, enhancing health equity for low-income and medically underserved consumers. Thus, we are not delaying implementation until PY 2025.

Comment: One commenter supported the proposal but expressed patient access concerns, as many mental health and SUD facilities are religious in nature, and LGBTQIA+ and racial and ethnic minority groups have frequently expressed discomfort with religiously affiliated programs. The commenter urged HHS to ensure that the ECP list also includes secular mental health and SUD facilities.

Response: We acknowledge the commenter's concern and remain committed to continuously improving the ECP list such that it includes a wide range of providers that can provide care for all consumers, recognizing that diverse patient populations may have varying needs and preferences for their care, including mental health and SUD care.

Comment: Several commenters supported the proposal to add REHs to the Other ECP Providers category, citing expanded access to care in rural areas.

Response: We agree that including REHs in the Other ECP Providers category may increase access to needed care for low-income and medically underserved consumers in rural communities, and are finalizing the addition of REHs to the Other ECP Providers category as proposed. As we noted in the proposed rule (87 FR 78289), REHs are a new provider type established to address the growing concern over closures of rural hospitals, and as such, there may initially be few REHs on the ECP list. We anticipate that the number of REHs on the ECP list will grow in future years as some current ECPs, such as critical access hospitals, may potentially convert to REHs to avoid closure.

Comment: Two commenters opposed the addition of REHs to the Other ECP Providers category. They recommended that HHS delay the proposal until PY 2025 to allow more time for issuers to prepare and because States, hospitals, providers, and other interested parties are in the process of implementing new REH standards.

Response: We are finalizing our proposal to add REHs to the ''Other ECP Providers'' category. This will increase the likelihood that issuers will include REHs in their networks, thereby increasing access to needed care for low-income and medically underserved consumers in rural communities. However, we note that issuers will often have the option to satisfy the ECP requirement by contracting with another provider type. If no REHs are available in a service area, the issuer will not be penalized.

Comment: Many commenters supported the proposal to apply the 35 percent threshold to FQHCs and Family Planning Providers, citing enhanced access to care for low-income, medically underserved consumers. One commenter stated that its support for the extension of the 35 percent requirement threshold to FQHCs was contingent on HHS' ECP justification process remaining the same.

Response: We agree that the application of the 35 percent threshold to FQHCs and Family Planning Providers will enhance access to care for low-income, medically underserved consumers, and are finalizing the 35 percent thresholds for FQHCs and Family Planning Providers as proposed. As we stated in the proposed rule, these thresholds will apply to all issuers regardless of whether they are subject to the General ECP standards under § 156.235(a) or the Alternate ECP Standards under § 156.235(b). We note that SADP issuers will only be subject to such requirements as applied to provider types that offer dental services, as reflected in § 156.235(a)(2)(ii)(B). Apart from some enhancements to the ECP Justification Form to facilitate issuers' reporting to CMS when provider facilities have closed or are no longer interested in contracting, or when issuers have encountered other contracting barriers beyond their control, the justification process remains broadly the same as in PY 2023.

Comment: Some commenters opposed the proposed categorical threshold requirements (that is, the proposed threshold requirements that would apply to specific categories of ECPs), stating that they do not account for regional variations in provider availability, enrollee needs, and geographic features. Commenters also stated that categorical thresholds may lead to inflexibility in contracting with high-quality providers and increased administrative costs. Two of the opposing commenters expressed concerns about not being given enough time to negotiate new contracts with providers. However, one commenter acknowledged that issuers that fall short of the requirement could submit ECP write-ins and justification forms.

Response: We recognize commenters' concerns given that issuer network participation negotiations are a tool that issuers use to manage costs, which are

[309] HHS also endeavors to continue improving the ECP list for future plan years, and invites issuers to encourage any mental health or SUD provider in that issuer's service area to submit an ECP petition for potential inclusion on the list.

[310] See *https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy* and *https://www.qhpcertification.cms.gov/s/Essential%20Community%20Providers%20and%20Network%20Adequacy%20FAQs for more information.*

generally reflected in lower premium rates. Reducing issuers' ability to limit the scope of their networks could reduce the utility of that cost management tool and potentially cause premiums to increase. In considering these factors, we elected not to propose to extend the 35 percent threshold to each of the major ECP categories. Rather, we proposed that only two major 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 a significant majority 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. As we explained in the proposed rule (87 FR 78291), because there is already a robust number of these two types of facilities on the ECP list, we do not anticipate that it will be unduly burdensome for issuers to contract with 35 percent of available providers of these types in the plan's service area. We acknowledge that extending the 35 percent threshold to those ECP categories that contain fewer total providers, on the other hand, could potentially lead to decreased contracting flexibility for issuers.

If issuers encounter difficulty meeting the 35 percent thresholds for FQHCs and/or Family Planning Providers due to insufficient time, provider availability, or flexibility to carry out contracting activities, we remind issuers that the ECP Justification Form, the ECP Write-in Worksheet, and the ECP/NA Post-certification Compliance Monitoring (PCM) program are available as tools to assist issuers with their good faith efforts toward compliance with the applicable ECP standard.

Comment: Several commenters noted support for HHS' proposal to increase the contracting threshold for FQHCs from 30 to 35 percent.

Response: We did not make such a proposal in the proposed rule. We proposed, and are finalizing, the application of a 35 percent ECP threshold to both FQHCs and Family Planning Providers (in addition to the existing overall 35 percent ECP threshold requirement in the plan's service area). In prior years, the threshold percentage applied overall across categories and did not apply specifically to any individual ECP category.

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

a. Establishing a Timeliness Standard for Notices of Payment Delinquency

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78291), we proposed to amend § 156.270(f) by adding a timeliness standard to the requirement for QHP issuers in Exchanges to send enrollees notice of payment delinquency. Specifically, we proposed to revise § 156.270(f) to require issuers to send notice of payment delinquency promptly and without undue delay.

We stated in the proposed rule that 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. We noted in the proposed rule (87 FR 78291) that enrollees who are not receiving APTC may also be entitled to a grace period under State law, if applicable.

As we explained in the proposed rule (87 FR 78291), we have an interest in helping enrollees maintain coverage by establishing basic standards of communication between the QHP issuer and enrollees 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, we stated that 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.[311] At § 156.270(f), we have also regulated on communicating to an enrollee when they have become delinquent on premium payment and when their coverage has been terminated. But we noted that while the regulation at § 156.270(f) requires that issuers notify enrollees when they become delinquent on premium payments, we currently set no timeliness requirements for issuers. We stated that, in conducting oversight of issuers, we are aware that in some instances, issuers have delayed notifying enrollees of delinquency, and are 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. We noted that in extreme cases, an enrollee may not become aware that they have become delinquent until termination of coverage has already occurred. For example, we noted that 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 will not have an opportunity to restore it. We acknowledged that there may also be uncertainty among issuers regarding their requirement to send notices of delinquency, since we have not provided guidance on when this notice must be sent.

As we explained in the proposed rule (87 FR 78292), modifying § 156.270(f) to require issuers operating in Exchanges 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). We noted that it would also provide clarity to issuers regarding their obligation to send a notice when an enrollee becomes delinquent on premium payment. Finally, we stated that 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. We sought comments on this proposal.

In addition, to further help ensure that notices are sent in a timely and uniform manner, we stated that we believe 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. Thus, we also solicited comment on what a reasonable timeframe would be for sending notices of delinquency to enrollees.

After reviewing the public comments, we are finalizing our proposal to revise § 156.270(f) to require QHP issuers in

[311] See § 155.400(e).

Exchanges on the Federal platform to send notices of payment delinquency promptly and without undue delay. We are also finalizing that such notices must be sent within 10 business days of the date the issuer should have discovered the delinquency. In addition, we clarify that this timeliness requirement only applies to QHP issuers operating in Exchanges on the Federal platform. We summarize and respond below to public comments received on the proposal to require issuers to send notice of payment delinquency promptly and without undue delay, and on the comment solicitation regarding a reasonable timeframe for sending notices of delinquency to enrollees.

Comment: Most commenters who addressed the proposal to add a timeliness standard for sending notices supported it, stating that the proposal would help better ensure continuity of coverage and access to health care services for enrollees. One commenter stated that the proposal would help ensure issuers do not arbitrarily terminate coverage without providing the enrollee a chance to make a payment that may be needed to maintain their coverage.

Response: We agree with commenters that adding the timeliness standard will help ensure continuity of coverage and access to health care services, as well as help ensure issuers do not arbitrarily terminate coverage without providing the enrollee a chance to make a payment that may be needed to maintain their coverage. As discussed further below, we are finalizing the timeliness standard with modification.

Comment: One commenter opposed the proposal, stating that such rules are already included and enforced at the State level. In addition, one commenter who supported the proposal suggested that HHS could deem issuers compliant with the policy in States that have existing time frames for sending notices to enrollees with premiums in arrears.

Response: While we acknowledge some States have their own rules, as we noted in the proposed rule (87 FR 78291), HHS has observed instances in which issuers significantly delayed sending delinquency notices, limiting enrollees' ability to pay past due premium prior to termination of coverage. It is thus important to establish a minimum standard for when issuers must send notices of payment delinquency so that enrollees consistently receive such notices in a timely manner. Under this approach, in States that do not have requirements or that have less stringent requirements, issuers of QHPs in Exchanges on the Federal platform would at least be required to meet this new Federal standard, though States may establish a timeliness standard that is more protective. However, we clarify that this timeliness requirement does not apply to SBEs. Unlike the Exchanges on the Federal platform, some SBEs collect and aggregate premium on behalf of issuers, or send delinquency notices to consumers, and thus it is appropriate to avoid extending this requirement to issuers in SBEs.

Comment: Two commenters supported adding a timeliness standard to the requirement for QHP issuers to send enrollees notice of payment delinquency but did not recommend including a specific timeframe for this requirement. These commenters encouraged CMS to allow issuers to maintain their best practices for sending delinquency payment notices, and cautioned that issuers need sufficient time to process enrollee payments received in the few days before and after a payment due date to ensure consumers do not unnecessarily receive a notice of payment delinquency.

Response: We acknowledge that issuers have historically had a variety of practices for sending delinquency notices, and that they need sufficient time to process enrollee payments to ensure consumers do not unnecessarily receive a notice of payment delinquency. However, we also believe it is important that enrollees are given adequate time to make payments before any applicable grace period expires. To balance providing issuers sufficient time to process payments around the payment due date and ensuring that enrollees timely receive notice of payment delinquency, we are finalizing a standard that requires issuers to send delinquency notices within 10 business days of the date the issuer should have discovered the delinquency.

Comment: One commenter recommended that taglines (including large print taglines) be added to delinquency notices to address the needs of consumers with LEP and/or sight issues.

Response: Although this comment is not within the scope of our proposals on the timeliness standard presented in the proposed rule, we appreciate that consumers with disabilities may have a need for reasonable accommodations with regard to the notices they receive. Issuers are required to provide such accommodations under State and Federal law. Regulation on meaningful access to qualified health plan information can be found at § 156.250, and on accessibility requirements at § 155.205(c). Enrollees who need a particular accommodation should reach out to their issuer to make the request.

Comment: Twenty commenters suggested time frames for sending notices of delinquency to enrollees. One commenter recommended the earliest timeframe that is reasonably possible and most protective of enrollees. Nine commenters recommended insurers send notice of payment immediately after the deadline. Two commenters recommended that issuers send delinquency notices to enrollees within 5 business days following the due date of the unpaid premium. One commenter recommended one week, and another commenter recommended 7 calendar days, both following the due date of the premium. Two commenters recommended 10 business days after the discovery of the delinquency, with one commenter adding that this would provide flexibility for situations in which an issuer is not initially aware that an enrollee has become delinquent on premium payments. This commenter also noted that there were cases in which issuers did not receive notice of insufficient funds until 20 days after payment was due.

One commenter recommended 12 days, with no specification of when that time period would begin, or whether they meant business or calendar days. One commenter recommended a minimum of 12 business days or 15 calendar days, with no specification of when that time period would begin. One commenter recommended that an issuer send an initial delinquency notice within two calendar weeks of the initial delinquency. One recommended that 30 days from the original payment due date would be a sufficient timeline for sending such notices, but did not specify whether they meant business or calendar days.

Response: We agree with the two commenters who suggested that 10 business days would be a reasonable timeframe for sending notices of payment delinquency. However, in order to ensure that issuers are promptly sending notices, we are finalizing a time frame of 10 business days from when the issuer ''should have'' discovered the delinquency. This means that there is an expectation that issuers will promptly send notices of delinquency once they discover the delinquency. We believe that requiring notice to be sent within 10 business days of the date an issuer should have discovered the enrollee's delinquency appropriately balances the need to ensure enrollees receive timely notice of delinquency, while providing issuers with adequate time to send the notices. Adopting a standard of 10 business days also allows time for

issuers to ensure information regarding enrollee delinquency is accurate and to communicate with enrollees. In addition, as some commenters noted, there are situations in which an issuer is not initially aware that an enrollee has entered delinquency. For example, one commenter noted that there were cases in which issuers did not receive notice of insufficient funds until 20 days after payment was due. Thus, the standard we are finalizing in this rule requires issuers to send notice to enrollees within 10 business days of the date the issuer should have discovered the delinquency so that issuers are not required to send the notices until they should have become aware that an enrollee is delinquent on payment.

Other timeframes suggested by commenters, such as 30 days after the payment due date or immediately after the deadline for payment, are either too long to ensure that enrollees are timely notified of delinquency and have an opportunity to rectify it, or too short to give issuers time to process an enrollee's delinquency and send a notice. We believe that defining ''promptly without undue delay,'' as 10 business days of the date the issuer should have discovered the delinquency provides issuers with the flexibility to process premium payments that arrive late, and enough time for enrollees to make late payments before the expiration of a grace period.

Comment: One commenter recommended that HHS institute a minimum requirement that issuers include notice of delinquency on their monthly invoices as soon as the first missed payment and allow issuers to continue to send additional notices using additional methods.

Response: Issuers have flexibility to implement additional notices, and nothing prevents issuers from sending additional notices if they would like to do so.

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

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78292), we proposed to amend § 156.1210(c) to remove, beginning with adjustments to APTC and user fee payments and collections for 2015 PY coverage, 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 for the PY to which such inaccuracy relates has been completed, for these data inaccuracies to be eligible for resolution.

In the proposed rule (87 FR 78292), we proposed to revise § 156.1210(c) to provide that to be eligible for resolution under § 156.1210(b), 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 PY to which the inaccuracy relates. As we stated in the proposed rule, under this proposal, beginning with the 2020 PY 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. Additionally, we proposed 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 PY coverage that are reported after December 31, 2023, which means an issuer must describe all inaccuracies identified in a payment and collections report for PYs 2015 through 2019 before January 1, 2024. We stated that this proposal would allow issuers some additional time after this rule is finalized to submit any inaccuracies for the 2015 through 2019 PY coverage, for which submissions would no longer be permitted upon the effective date of this rule if this proposal were effective upon finalization.

We did not propose 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 proposed 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).

For issuers in State Exchanges, we further affirmed that this proposal would not change the requirement that issuers promptly identify and report data inaccuracies to the State Exchange.[312] We stated that under the proposed revisions, 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 proposed that HHS would not make any payments to issuers in State Exchanges on data inaccuracies or payment errors for 2015 through 2019 PY coverage that are reported after December 31, 2023. In addition, we explained that 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 refer readers to the proposed rule for further discussion of these proposals (87 FR 78292 through 78293). We sought comment on these proposals.

After reviewing the public comments, we are finalizing our proposals without modification. Specifically, we are finalizing as proposed, removing the alternate deadline at § 156.1210(c)(2) beginning with the 2015 PY coverage,[313] so that issuers are required to describe all inaccuracies identified in a payment and collections report within 3 years of the end of the applicable PY to which the inaccuracy relates to be eligible to receive an adjustment to correct an underpayment.[314] Additionally, as proposed, we are finalizing at § 156.1210(c) that, for PYs 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, thus allowing issuers additional time to submit any inaccuracies for the 2015 through 2019 PY coverage. We summarize and respond below to public comments received on the proposed provisions.

Comment: A few commenters supported the proposal to remove the alternate deadline at § 156.1210(c)(2) to resolve data inaccuracies and report payment adjustments to HHS. Removal of the alternate deadline requires issuers to describe all inaccuracies in a payment and collections report within three years of the end of the applicable PY to which the inaccuracy relates. One of these commenters was concerned about permitting waiver of any user fees owed to an SBE–FP if inaccuracies are discovered after the deadline and indicated that some State-imposed user fees are determined by State law and HHS does not have the authority to waive them.

Response: We are finalizing these changes as proposed and clarify that

[312] As previously noted, the requirements captured in § 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 24258.

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

[314] Underpayment in this section 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.

this policy is not intended to waive the collection of user fees owed to SBE–FPs. Only payments to issuers to address underpayments that are identified several years after the applicable plan year are constrained under these changes—not incoming user fee or APTC overpayments owed by the issuer to either HHS or a State. As explained in the proposed rule and 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) states that if a payment error is discovered after the reporting deadline, the issuer is obligated to notify HHS and the State Exchange (as applicable) and repay any overpayment.

Comment: One commenter stated that removing the alternate deadline at § 156.1210(c)(2) puts issuers in a position in which they will be expected to return overpayment of APTCs but will not be reimbursed for underpayments when identified through an audit process, asserting that this is unnecessarily punitive to issuers. That commenter stated that audits are time-consuming, resource-heavy obligations to ensure accurate payments are made and paying issuers what they owed is a reasonable expectation.

Response: We believe the benefits of requiring inaccuracies identified in a payment and collections report to be described within 3 years of the end of the applicable plan year to which the inaccuracy relates outweigh any perceived inequities associated with establishing a deadline for receiving an adjustment to correct discovered underpayments but not for payment of amounts owed to the Federal government. First, 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. In addition, finalizing these changes ensures that HHS and Exchange processes for handling payment and enrollment disputes for discovered underpayments are completed before the existing IRS limitation on amending a Federal income tax return. Second, prompt reporting 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. The 3-year window is intended to result in accurate reporting and timely resolution of data inaccuracies, and will 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. Further, we believe that requiring issuers to adhere to the 3-year deadline to submit all disputes and address all errors will incentivize proactive reporting of inaccuracies that will increase data integrity, and will discourage a reactive approach of utilizing the audit process to identify inaccuracies and utilizing the end of the audit process as an alternative timeframe to receive additional APTC or reimbursement of user fee payments. For all of these reasons, we therefore generally disagree that this approach is unnecessarily punitive.

This policy requires that issuers describe all inaccuracies identified in a payment and collections report within three years of the end of the applicable PY to which the inaccuracy relates to be eligible to receive an adjustment to correct an underpayment. We will continue to take action that results in an outgoing payment on data inaccuracies or payment errors identified through an audit process when those errors are identified within the 3 years of the end of the applicable PY to which the inaccuracy relates. However, under this new framework, we will not accept or take action that results in an outgoing payment on data inaccuracies or payment errors for the 2015 through 2019 PY coverage that are not reported before January 1, 2024.

To assist in the transitioning to this new framework, we are affording issuers additional time to report data inaccuracies or payment errors for the 2015 through 2019 PY coverage for discovered underpayments, providing at § 156.1210(c) that all such inaccuracies must be reported before January 1, 2024. This one-time window is intended to afford issuers time to address concerns with their submissions and any discovered underpayments for these PYs before full implementation of this policy change. We will make outgoing payments for additional APTC or reimbursement of user fee overpayments associated with reported errors during this one-time window, which we believe affords ample opportunity for issuers to report any data inaccuracies or payment errors related to discovered underpayments for 2015 through 2019 PY coverage.

Finally, we note that it is the False Claims Act (31 U.S.C. 3729, *et seq.*) [315] *that obligates* issuers to notify HHS and repay improper ''payments made by, through, or in connection with an Exchange . . . if those payments include any Federal funds,'' and prohibits an issuer from knowingly and improperly avoiding the obligation to pay. 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. The requirement at § 156.1210(c) that the issuer notify HHS and the State Exchange (as applicable) and repay any overpayment (regardless of when the payment error is discovered), aligns with obligations under the False Claims Act. Further, we reiterate that safeguarding Federal funds is a primary reason for APTC and user fee audits (78 FR 65087 through 65088),[316] even if a historic, ancillary benefit under the prior framework had been providing issuers a mechanism to receive additional outgoing payments after the 3-year reporting deadline in situations involving late discovery and identification of underpayments. After consideration of comments, we are finalizing the amendments to § 156.1210(c) as proposed.

11. Administrative Appeals (§ 156.1220)

As discussed in section III.A.7.d. of this preamble, (HHS–RADV Discrepancy and Administrative Appeals Process), we are finalizing the amendments to § 156.1220(a)(4)(ii) to add a reference to new proposed § 153.630(d)(3) to align with the changes to shorten the SVA attestation and discrepancy reporting period. As discussed in section III.A.7.d of this preamble, under new § 153.630(d)(3), we are retaining 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. The cross-reference to § 153.630(d)(2) in § 156.1220(a)(4)(ii)

[315] ACA section 1313(a)(6) explicitly subjects payments made by, through, or in connection with an Exchange to the False Claims Act, if the payments include any Federal funds.

[316] The 2014 Payment Notice that included financial oversight, maintenance of records and reporting requirements, ''safeguard[s] the use of Federal funds provided as cost-sharing reductions and advance payments of the premium tax credit and provide[s] value for taxpayers' dollars.'' See 78 FR 65088; *see also* CMS. The Center for Consumer Information & Insurance Oversight: Audit Reports. *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/AuditReports* (''The goals of [APTC] audits are to: Safeguard Federal Funds'').

will be maintained and will capture the new proposed 15-calendar-day window to confirm, or file a discrepancy, for SVA findings (if applicable).

In addition, in the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78293), we proposed 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 by extending the deadline to request an informal hearing to the next applicable business day. We solicited comment on this proposed amendment.

After reviewing the public comments, we are finalizing the amendment to § 156.1220(b)(1), as proposed, to extend the deadline to request an informal hearing to the next applicable business day in situations when the last day of the period to request an informal hearing does not fall on a business day. We summarize and respond below to the public comment received on the proposed amendment to § 156.1220(b)(1).

Comment: One commenter supported the proposal to clarify that when the last day to request an informal hearing does not fall on a business day, the deadline is the next business day.

Response: We are finalizing the amendment to § 156.1220(b)(1), as proposed, extending the deadline to request an informal hearing to the next applicable business day when the last day to request an informal hearing does not fall on a business day. As we noted in the proposed rule (87 FR 78293), this provision is consistent with our policy for other risk adjustment deadlines that do not fall on a business day.[317]

For a discussion of the comments related to the shortening of the SVA window to confirm, or file a discrepancy for SVA findings to 15 days, see the preamble discussion in section III.A.7.d. of this rule (HHS–RADV Discrepancy and Administrative Appeals Process).

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. 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 solicited public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs). The public comments and our responses appear in the applicable ICR sections that follow.

A. Wage Estimates

To derive wage estimates, we generally use 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.[318] Table 13 in this final 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 13: 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 are finalizing the repeal of the ability for 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 are finalizing several amendments to § 153.320(d).

The burden currently associated with this option is the time and effort for the State regulator to submit its request(s), supporting evidence, and analysis to HHS. Burden for this option is currently approved under OMB control number: 0938–1155. In that Paperwork Reduction Act (PRA) package, we estimate that it will take a business operations specialist 40 hours (at a rate of $76.20 per hour) to prepare the request, supporting evidence, and analysis, and 20 hours for a senior

[317] See, for example, § 153.730.

[318] 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.*

operations manager (at a rate of $110.82 per hour) to review the request, supporting evidence, and analysis and transmit it electronically to HHS. In that PRA package, we further estimate that each State seeking a reduction will incur a total burden of 60 hours at a cost of approximately $5,264.40 per State to comply with this reporting.

Since this policy will eliminate the ability of the one prior participating State (Alabama) to request a reduction in risk adjustment transfers beginning with benefit year 2025, we proposed to rescind this information collection and the associated burden beginning with the 2025 benefit year in the proposed rule. Therefore, there will be a reduction in burden on States seeking reductions of 60 hours at a cost of approximately $5,264.40 per State due to the repeal of this policy.

We sought comment on the information collection requirements related to this policy and the proposed rescission of this information collection beginning with the 2025 benefit year. We did not receive any comments. Therefore, we are finalizing this information collection as proposed, and HHS will rescind the associated information collection once the policy is no longer in effect.

C. ICRs Regarding Risk Adjustment Issuer Data Submission Requirements (§§ 153.610, 153.700, and 153.710)

We are finalizing a requirement for issuers to collect and make available for HHS' extraction from issuers' EDGE servers a new data element, a QSEHRA indicator. To implement this policy, we are adopting the same transitional approach and schedule for the QSEHRA indicator as was finalized for the ICHRA indicator in the 2023 Payment Notice. Under this approach, for the 2023 and 2024 benefit years, issuers will be required to populate the QSEHRA indicator using 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 will be required to make a good faith effort to collect and submit the QSEHRA indicator for these enrollees. We are also finalizing the proposed extraction of this data element beginning with the 2023 benefit year and are also finalizing the inclusion of the QSEHRA indicator in the enrollee-level EDGE limited data sets available to qualified researchers upon request, once available.

We will begin collection of the QSEHRA indicator with the 2023 benefit year, and we estimate that approximately 650 issuers of risk adjustment covered plans will be subject to this data collection. We will 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 will 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 associated with collecting this new data element for issuers, we are adopting 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.[319] For successful EDGE server data submission, each issuer will need to update their file creation process to include the new data element, which will 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 these estimates, we estimate $62,829 in total annual labor costs for 650 issuers (650 total hours per year for all issuers). We believe that this 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 extraction of the new 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. As this policy is being finalized in this rule, we will revise the information collection request to account for the burden associated with this policy, and will provide the applicable comment periods.[320]

We are also finalizing the amendment to 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, we estimate that the extraction of these data elements will 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 is to limit the burden on issuers for us to collect and extract the plan ID and rating area data elements from these additional prior benefit year data. Therefore, while we broadly solicited comment on these data collections, we specifically solicited 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.

We did not receive any comments in response to the information collection requirements related to these policies. We are finalizing these requirements as proposed.

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–

[319] 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.

[320] Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment (OMB control number 0938–1155).

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 are finalizing, beginning with 2022 benefit year HHS–RADV, a change to 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 policy will not significantly impact issuer burden relative to previous estimates for HHS–RADV and the current materiality threshold. In particular, the new threshold will not significantly alter the anticipated number of issuers that will 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. Assuming one-third of issuers below the materiality threshold will 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 will remain fairly constant. We believe that the number of issuers participating in HHS–RADV for any given benefit year under the finalized 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. We will revise the information collection currently approved under OMB control number: 0938–1155 to account for the changes to the HHS definition for the materiality threshold in § 153.630(g)(2).

We did not receive any comments in response to the information collection requirements related to this policy. We are finalizing these requirements as proposed.

E. ICRs Regarding Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210 and 155.225)

We are finalizing amendments to §§ 155.210 and 155.225 to permit enrollment assistance on initial door-to-door outreach by Navigators, non-Navigator assistance personnel, or certified application counselors. This policy will not impose any new information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Though we require Navigator grantees to track enrollment numbers on weekly, monthly, and quarterly progress reports, burden is already accounted for under OMB control number: 0938–1205, and grantees are not required to specifically track enrollments completed for door-to-door enrollments.

We did not receive any comments in response to the information collection requirements related to this policy. We are finalizing these requirements as proposed.

F. ICRs Regarding Providing Correct Information to the FFEs (§ 155.220(j))

We are finalizing 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 policy will 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 will 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 policy, including those related to documenting, maintaining, and producing the documentation. This policy will 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 will be up to the agents, brokers, and web-brokers to determine the best way to meet these regulatory requirements.

Costs related to requiring the agent, broker, or web-broker 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 and to maintain that documentation for a period of 10 years are as follows. We estimate it will 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 $5.56 additional cost associated with it based on extra time commitment. In PY 2022, agents submitted 4,947,909 policies. This makes the yearly total cost associated with the extra 412,326 hours of burden approximately $27,493,898 (412,326 total hours × $66.68 per hour).

Costs associated with maintaining consumer's or their authorized representative's documentation will 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 will be incurred. If an agent, broker, or web-broker opts to use paper for documentation, they will bear the costs of paper, ink and filing cabinets to store the paperwork.

HHS will 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, we typically request documentation associated with approximately 10 different applications, generally from the past 2 to 3 years. We estimate it will take an agent approximately 2 hours to gather consumer documentation for 10 applications. Each year, we generally investigate approximately 120 agents, brokers, or web-brokers. Therefore, we estimate the yearly cost of producing documentation for HHS to be approximately $16,002 (($66.68 hourly rate × 2 hours) × 120). The documentation will be able to be mailed electronically, so there will 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, we will request that the agency produce a certain number of records from the past 10 years. As this policy is being finalized in this rule, we will request to account for the associated information collection burden under OMB control number: 0938–NEW—(CMS–10840—Agent/Broker Consent Information Collection).

After a review of the comments received, we are finalizing this information collection requirement as proposed. We summarize and respond to public comments received on the burden estimates associated with the proposal 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 and to maintain that documentation for a period of 10 years.

Comment: One commenter suggested we did not estimate these costs properly. This commenter believed we underestimated these burden estimates by as much as six times. Specifically, the commenter asserted the time to produce client specific documentation for each client and unique factors such as individuals with limited English proficiency or without means to sign electronically and the estimated 30 minutes the process takes for Medicare applications is indicative the burden may be underestimated.

Response: After reviewing the regulatory changes and potential costs associated, we disagree with this commenter's suggestion that we underestimated these costs. We believe 5 minutes per enrollment interaction is a reasonable timeframe to meet these requirements. Under current § 155.220(j)(2)(ii), agents, brokers, and web-brokers must ''Provide the Federally-facilitated Exchanges with correct information . . .'' As such, these new requirements are simply building on the existing requirement to provide the FFEs with correct information, which we believe will alleviate the burdens and costs associated with these new requirements for agents, brokers, and web-brokers.[321] Requesting that a consumer respond to a text message, email, verbal question posed by the assisting agent, broker, or web-broker, etc., stating they have reviewed their application information and it is accurate should not add a significant amount of time to the enrollment process. As discussed in the proposed rule (87 FR 78252), we did not propose to specify a method for documenting that eligibility application information has been reviewed and confirmed to be accurate by the consumer or their authorized representative. This flexibility will allow each individual agent, broker, or web-broker to establish protocols and methods that will meet their needs in the most efficient manner. We believe this flexibility will allow agents, brokers, and web-brokers to meet the requirements of § 155.220(j)(2)(ii) within the estimated 5 minutes per enrollment interaction instead of the 30 minutes associated with Medicare applications.

Additionally, we only plan on requesting this documentation when investigating potentially fraudulent or noncompliant behavior. As agents, brokers, and web-brokers establish storage methods that best suit their needs, the costs associated with obtaining and submitting such documentation to HHS should be minimal. We believe that a 2-hour time window for submitting requested documentation is a reasonable assumption.

Comment: A few commenters suggested the proposed record retention period of 10 years is too long for agents, brokers, and web-brokers to maintain the documentation required by § 155.220(j)(2)(ii)(A). Another commenter stated HHS should have the record retention period align with the required record retention period of the State where the consumer is enrolled.

Response: We have considered these comments but continue to believe 10 years is an appropriate length of time to maintain the documentation required by § 155.220(j)(2)(ii)(A). As discussed in the proposed rule (87 FR 78253), this aligns with other Exchange maintenance of records requirements, including § 155.220(c)(3)(i)(E), which states internet websites of web-brokers used to complete QHP selections must ''[m]aintain audit trails and records in an electronic format for a minimum of ten years and cooperate with any audit under this section.'' We believe being consistent within the regulation and with other Exchange maintenance of records requirements is important. Enforcement actions may encompass non-compliance with different parts of the regulations making standardized timeframes for retention important for relevant document collection and review during investigations. Additionally, we do not agree that aligning with State record retention requirements is beneficial in this instance given the variability in retention periods that this approach would introduce. Many agents, brokers, and web-brokers assist consumers in multiple States and as a result, we often speak with consumers from multiple States during the course of a single investigation into potential noncompliance by an agent, broker, web-broker. If these agents, brokers, and web-brokers were retaining documents based on State laws, investigations may be hindered by one State's record retention law being shorter than another's due to records being legally discarded by the agent, broker, or web-broker under investigation. Mandating a standard 10-year retention period for all agents, brokers, and web-brokers assisting consumers in the FFEs and SBE–FPs will help mitigate these concerns when reviewing agent, broker, or web-broker responses to monitoring, audit, and enforcement activities conducted consistent with § 155.220(c)(5), (g), (h), and (k).

Comment: Some commenters stated this documentation should be part of the application process and maintained by the Federal government, making the documentation readily accessible and minimizing burden on agents, brokers, and web-brokers.

Response: We appreciate commenter's suggestions and agree there is merit to these ideas. However, it is not currently feasible to implement systematic changes of this nature. There are no plans to create a system that would allow the Federal government to store documentation for all enrollees. This type of systematic change would likely take years to implement, which would mean the protections we hope to implement with these new requirements would be severely delayed. Delaying these requirements means a longer time period during which consumers may be vulnerable to potentially fraudulent behavior by agents, brokers, and web-brokers. 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 attested to be accurate will help avoid these situations, which is why we are requiring the consumer or their authorized representative to take an action to produce a record that is retained by the assisting agent, broker, or web-broker. We believe the consumer is in the best position to project their future income. To determine if a consumer is eligible for financial assistance, such as APTC, prior to enrollment, an estimate for income must be entered prior to the eligibility determination process. As many consumers enroll in health coverage prior to a new calendar year, the income amount they enter is an estimate based on available data, including income in prior years, as well as what consumers believe their income will be in the upcoming plan year. If we remove the consumer action from this process, which may happen if the system is changed in ways these commenters are suggesting, it may circumvent the

[321] See § 155.220(j)(2)(ii).

purpose of these new requirements (that is, consumers reviewing their information to ensure accuracy).

G. ICRs Regarding Documenting Receipt of Consumer Consent (§ 155.220(j))

We are finalizing amendments to § 155.220(j)(2)(iii) to require agents, brokers, and web-brokers to document the receipt of consumer consent prior to facilitating enrollment in coverage through the FFEs or SBE–FPs or assisting an individual in applying for APTC and CSRs for QHPs. This policy will require the consumer or their authorized representative to take an action that produces a record that they provided consent. Agents, brokers, and web-brokers will be required to maintain the documentation for a minimum of 10 years and produce it upon request in response to monitoring, audit, and enforcement activities.

We estimate costs will be associated with this policy, including those related to documenting, maintaining, and producing the records of consumer consent. This policy does not mandate any method or prescribe a template for documenting receipt of consumer consent. It will be up to the agents, brokers, and web-brokers to determine the best way to meet these regulatory requirements.

Costs related to requiring that agents, brokers, and web-brokers document the receipt of consumer consent and maintain such documentation for a period of 10 years are as follows. We estimate it will take about 5 minutes for an enrolling agent, broker or web-broker to obtain a consumer's, or their authorized representative's, record of their consent. Using the adjusted hourly wage rate of $66.68 for an Insurance Sales Agent, each enrollment will have approximately $5.56 in additional cost associated with it based on the extra time commitment from these proposed policy changes. In PY 2022, agents submitted 4,947,909 policies. Based on this number of enrollments, the total annual burden is approximately 412,326 hours with a total annual cost of approximately $27,493,898.

We will 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, we typically request consent records of approximately 10 different applications, generally from the past 2 to 3 years. We estimate it will take an agent, broker, or web-broker approximately 2 hours to gather consent documentation for 10 applications.[322] Each year, we generally investigate approximately 120 agents, brokers, or web-brokers. Therefore, we estimate the yearly cost of producing consumer consent documentation to HHS to be approximately $16,002 (($66.68 hourly rate × 2 hours) × 120). These records are able to be mailed electronically, so there will 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, we will request that the agency produce a certain number of records from the past 10 years.

The estimated total annual cost of documenting of consumer consent is $27,493,898 and the estimated total cost of producing the retained consent records is $16,002. This cost is captured in the new information request related to requiring 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. Therefore, the total annual cost of the information collection requirements associated with this policy is $27,493,898. As this policy is being finalized in this rule, we will request to account for the associated information collection burden under OMB control number: 0938–NEW (CMS–10840—Agent/Broker Consent Information Collection).

After a review of the comments received, we are finalizing the information collection requirements as proposed. We received similar comments on this proposal as we did on the policy 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 and to maintain that documentation for a period of 10 years. There were no comments that were unique to the documentation of consumer consent. Therefore, we request that you please see the prior information collection section for our responses to these comments.

[322] We note that we generally expect that producing retained documentation of consumer consent and documentation that a consumer has reviewed and confirmed the accuracy of their application information will occur as part of a single audit in most cases, so the estimate for this activity in section IV.F is inclusive of the costs for this activity in this ICR.

H. ICRs Regarding Failure To File and Reconcile Process (§ 155.305(f))

We are finalizing amendments to § 155.305(f)(4) to provide that an Exchange must determine an enrollee ineligible for APTC if the enrollee has FTR status is for two consecutive tax years as opposed to one tax year (specifically, years for which tax data will be utilized for verification of household income and family size). This change will ensure that consumers are complying with the requirement to file their Federal income tax returns and reconcile past years' APTC, while also ensuring continuity of coverage in Exchange QHPs. The finalized FTR rule will impact APTC eligibility determinations for PY 2025 and beyond.

On Exchanges on the Federal platform, FTR will be conducted in the same as manner it had previously been conducted with respect to collection of information, with minimal changes to the language of the Exchange application questions necessary to obtain relevant information; as such, we anticipate that the finalized amendment will not impact the information collection OMB control number: 0938–1191 burden for consumers.

We did not receive any comments in response to the information collection requirements related to this policy. We are finalizing these information collection requirements as proposed, with a correction that there is not an option for Exchanges to remove APTC after a consumer has been in an FTR status for 1 year.

I. ICRs Regarding Income Inconsistencies (§§ 155.315 and 155.320)

We are finalizing amendments to § 155.320 to require Exchanges to accept attestations, and not set an Income DMI, when the Exchange requests tax return data from the IRS to verify attested projected annual household income, but the IRS confirms there is no such tax return data available.

Based on historical DMI data, we estimate that HHS will 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 revisions to § 155.320 will 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 change will 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 will decrease burden on consumers by 1.2 million hours per year.

We will revise the information collection currently approved under OMB control number: 0938–1207 to account for this decreased burden.

We did not receive any comments in response to the information collection requirements related to this policy. We are finalizing these information collection requirements as proposed.

J. ICRs Regarding the Improper Payment Pre-Testing and Assessment (IPPTA) for State-Based Exchanges (§§ 155.1500 through 155.1515)

As described in the preamble to § 155.1510, IPPTA will replace the previous voluntary State engagement initiative with mandatory participation and related requirements. 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 state that State Exchanges will 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 will be no more than 22 hours.

In the preamble to § 155.1510(a)(2), we state that HHS will provide State Exchanges with the pre-testing and assessment data request form. We will 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 will be the time it will 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 sought 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) will take 265 hours per respondent at an estimated cost of $28,493.24 per respondent on an annualized basis. To compile our estimates, we referenced our experience collecting data in our FFE pilot initiative and in working with State Exchanges in the previous voluntary State engagement initiative. We identified specific personnel and the number of hours that will 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 4,770 hours for a total cost of up to $512,878 on an annualized basis. As this policy is being finalized in this rule, we will request to account for the associated information collection burden under OMB control number: 0938–1439 (CMS–10829—Improper Payment Pre-Testing and Assessment (IPPTA)).

We did not receive any comments specific to the collection of information and are finalizing these requirements as proposed. We did receive and respond to related general comments of financial burdens in the earlier preamble section associated with this policy.

K. ICRs Regarding QHP Rate and Benefit Information (§ 156.210)

a. Age on Effective Date for SADPs

We are finalizing requiring 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 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 will create any additional costs or burdens for issuers seeking QHP certification. This information collection is currently approved under OMB control number: 0938–1187.

We did not receive any comments in response to the information collection requirements related to this policy. We are finalizing these requirements as proposed.

b. Guaranteed Rates for SADPs

The policy 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.

We did not receive any comments in response to the information collection requirements related to this policy. We are finalizing these requirements as proposed.

L. ICRs Regarding Establishing a Timeliness Standard for Notices of Payment Delinquency (§ 156.270)

The policy to add a timeliness standard to the requirement for QHP issuers to send enrollees notice of payment delinquency will 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 policy will not require any additional information collection. We are merely finalizing the addition of a requirement that issuers in the Exchanges on the Federal platform send these notices promptly and without undue delay, within 10 business days of the date the issuer should have discovered the delinquency. This information collection is currently approved under OMB control number: 0938–1341.

After a review of the comments received, we are finalizing the information collection requirements as proposed. We summarize and respond below to public comments received on the information collection requirements

related to the proposed addition of the timeliness standard to the requirement for QHP issuers to send enrollees notice of payment delinquency.

Comment: One commenter was neutral on the proposal as long as it did not require another letter to be sent to consumers.

Response: To clarify, this policy adds a timeliness requirement to the existing required notice of payment delinquency, so issuers will not be required to send another letter to consumers.

M. Summary of Annual Burden Estimates for Finalized Requirements

TABLE 14: Final 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)(2)(ii) and (iii)	0938-NEW	120	120	2	240	$16,002	$16,002
§ 155.220(j)(2)(ii)	0938-NEW	4,947,909	4,947,909	0.08	412,326	$27,493,898	$27,493,898
§ 155.220(j)(2)(iii)	0938-NEW	4,947,909	4,947,909	0.08	412,326	$27,493,898	$27,493,898
§ 155.320	0938-1207	-1,200,000	-1,200,000	-0.2	-240,000	-$11,208,000	-$11,208,000
§ 155.1510	0938-1439	18	18	265	4,770	$512,878	$512,878
TOTAL		8,696,605	8,696,605		590,252	$44,366,240.60	$44,366,240.60

This final rule includes one policy—repealing the ability of States to request a reduction in risk adjustment transfers (§ 153.320(d))—with information collection requests being rescinded. HHS will rescind the associated information collection once the policy is no longer in effect.

The following information collection requests will be submitted for OMB 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 policies do not impact any of the information collections under the following OMB control numbers: 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: 0938–1187; and Establishment of Qualified Health Plans and American Health Benefit Exchanges, OMB control number: 0938–1156. After a review of the comments received, we are finalizing the information collection requirements as proposed. We summarize and respond to public comments received on information collection requirements for the proposals related to agent/broker standards in the ICR sections earlier in this rule (sections IV.F and IV.G).

V. Regulatory Impact Analysis

A. Statement of Need

This rule finalizes improvements to risk adjustment and HHS–RADV policies to use more recent data to recalibrate the risk adjustment models and to refine operational HHS–RADV processes, and to update Navigator standards to permit door-to-door and other unsolicited means of direct contact. The rule also finalizes requirements that agents, brokers, and web-brokers provide correct consumer information and document consumer consent; and requirements that Exchanges on the Federal platform accept an applicant's or enrollee's attestation of projected annual household income when IRS data is not available and determining 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 finalizes the implementation of the IPPTA, reduced 2024 user fee rates of 2.2 percent of premiums for FFE issuers and 1.8 percent of premiums for SBE–FP issuers, and minor updates to standardized plan options and limiting the number of non-standardized plan options issuers can offer. Finally, the rule finalizes requirements for QHP plan marketing names to include correct information, without omission of material fact, and to not include content that is misleading; revisions to the network adequacy and ECP standards at §§ 156.230 and 156.235 to state that all QHP issuers, including SADPs, subject to limited exceptions, must use a network of providers that complies with the standards described in those sections; expanded access to care for low-income and medically underserved consumers by strengthening ECP standards for QHP certification; revisions to the Exchange re-enrollment hierarchy; the addition of a timeliness standard to the requirement for QHP issuers to send enrollees notice of payment delinquency; and revisions to the final deadline 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, requiring that issuers describe all such inaccuracies within three years of the end of the applicable plan year to which the inaccuracy relates to be eligible to receive an adjustment.

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), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). The April 6, 2023 Executive order on Modernizing Regulatory Review [323] amends section 3(f) of Executive Order 12866 to define a ''significant regulatory action'' as an action that is likely to result in a rule that may: (1) have an annual effect on the economy of $200 million or more (adjusted every 3 years by the Administrator of the Office of Information and Regulatory Affairs (OIRA) for changes in gross domestic product), or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impacts of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise legal or policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in the Executive order, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

A regulatory impact analysis (RIA) must be prepared for rules that are significant under section 3(f)(1) of the Executive order. Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is ''significant'' as measured by the $200 million threshold under section 3(f)(1). 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 final 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 15 showing the classification of the impact associated with the provisions of this final rule.

This final rule finalizes 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 final rule. The effects in Table 15 reflect qualitative assessment of impacts and estimated direct monetary costs and transfers resulting from the provisions of this final rule for health insurance issuers and consumers.

We are finalizing the risk adjustment user fee of $0.21 PMPM for the 2024 benefit year to operate the risk adjustment program on behalf of States,[324] which we estimate will 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 finalizing FFE and SBE–FP user fee rates of 2.2 and 1.8 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 the implementation of the IPPTA program, we estimate recordkeeping costs for data submission to be approximately $1,025,756 beginning in PY 2024.

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[323] Available at *https://www.govinfo.gov/content/pkg/FR-2023-04-11/pdf/2023-07760.pdf.*

[324] As noted previously in this final 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 15: 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 revisions to income DMIs beginning in 2024.

Qualitative:

- Improved review of rebuttal evidence and reconsideration requests based on the policy to increase the review period for agent, broker, or web-broker suspensions or terminations to 45 days and 60 days, respectively.
- 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 limiting the number of non-standardized plan options that issuers can offer through the FFEs and SBE-FPs.
- 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 allowing 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-based Exchanges, through implementation of the IPPTA.
- Reduced burden on consumers and assisters due to requiring 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 adding 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 policies, that will 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)	$676.57 Million	2022	7 percent	2023-2027
	$691.07 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 2025 due to the increased coverage as a result of the policy to determine an enrollee ineligible for APTC only after two consecutive years of FTR.
- 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-based Exchanges related to IPPTA, estimated to be a total annual cost of approximately $512,878 across all 18 State Exchanges.
- 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 increased coverage as a result of the income DMI policies.
- Increased costs of $161 million per coverage year beginning in 2023 associated with increased APTC expenditures due to modifying 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 adding 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 associated with increased APTC expenditures due to amending 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.
- Cumulative additional cost of approximately $27,509,900 per year associated with a new information collection related to requiring agents, brokers, and web-brokers to document the receipt of consumer consent and retaining eligibility and consent records documentation.
- Cumulative additional costs of approximately $27,493,898 per year with a new information request related to requiring 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.
- Lost revenue of approximately $3,674,735 annually for the top one percent of enrolling agents during open enrollment period due to time constraints related to the requirement to document consumer consent.

Qualitative:

- Under the 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 17,532 of the total 101,453 non-standardized plan option plan-county combinations (17.3 percent) will be discontinued as a result of this limit in PY 2024. Relatedly, we estimate that approximately 0.81 million of the 12.2 million enrollees on the FFEs and SBE-FPs (6.6 percent) will be affected by these discontinuations in PY 2024. Finally, we estimate an average reduction of 0.03 network IDs per issuer, product network type, metal level, and service area, meaning we anticipate network IDs will remain largely unaffected by this limit for PY 2024.
- Termination of these non-standardized plan options may affect issuers' balance of enrollment across plans and the premium rating for each of those plans, and may require issuers to send discontinuation notices for enrollees whose plans are being discontinued.
- Increase in administrative burden to State Exchanges that choose to adopt the option to prohibit issuers from terminating coverage mid-plan year for child dependent enrollees because they reached the maximum allowable age.
- Potential administrative burden on issuers to comply with new plan marketing name standards in Exchanges on the Federal platform, and in any State Exchanges that choose to update specific plan marketing name standards based on the new rule; potential burden in these State Exchanges 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 requirement that all QHPs and SADPs use a network and comply with the network adequacy standards at § 156.235 beginning with PY 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 requirement that all QHPs and SADPs use provider networks beginning with PY 2024.
- Potential short-term impact of reallocated resources for issuers resulting from need to reallocate staffing or resources to attest or file a discrepancy of its SVA within the compressed 15-day window.

Transfers:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	-$400.62 Million	2022	7 percent	2023-2027
	-$410.73 Million	2022	3 percent	2023-2027

Quantitative:

- Reduction in FFE and SBE-FP user fee transfers from issuers to the Federal Government of $404 million for benefit year 2024 compared to if the user fee level from the prior benefit year were maintained in 2024. We estimate additional reductions in FFE and SBE-FP user fee transfers from issuers to the Federal Government of $563 million in 2025, $562 million in 2026, and $563 million in 2027 if the 2024 user fee level were maintained in subsequent years.

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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

spending, revenue collections, and insurance enrollment. Table 16 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 final rule discussed in this RIA. We do not expect the provisions of this final rule to significantly alter CBO's estimates of the budget impact of the premium stabilization programs that are described in Table 16.

TABLE 16: Estimated Federal Government Outlays and Receipts for the Risk Adjustment and Reinsurance Programs from Fiscal Year 2024-2028, in billions of dollars[325]

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 proposed 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 proposed 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. However, we are finalizing that we will use the 2018, 2019, and 2020 benefit year enrollee-level EDGE data to recalibrate the 2024 benefit year risk adjustment models, for all coefficients without exception, including the adult age-sex coefficients. Consistent with the approach outlined in the 2020 Payment Notice to no longer rely upon MarketScan® data for recalibrating the risk adjustment models, as finalized in this rule, we will continue to recalibrate the risk adjustment models for the 2024 benefit year using only enrollee-level EDGE data, and will continue to use blended, or averaged, coefficients from the 3 years of separately solved models for the 2024 benefit year model recalibration. This approach seeks to maintain stability in the markets by capturing some degree of year-to-year cost shifting without over-relying on any factors unique to one particular year. Additionally, we anticipate that the recalibration of the HHS risk adjustment models using 2018, 2019, and 2020 EDGE data for the blending of all HHS risk adjustment model coefficients will have a minimal impact on risk scores and transfers for issuers in the individual and small group (including merged) markets because our analysis found that the 2020 enrollee-level EDGE data is largely comparable to previous years' data sets.

We did not receive any comments in response to the burden estimates associated with the proposed policy or any of the alternatives presented in the proposed rule. We are finalizing these estimates with the modification discussed in the above paragraph. We note that although the age-sex coefficients for the adult risk adjustment models differ slightly from their proposed values, we anticipate that these changes will have a 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 are finalizing the elimination of the ability for 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 will have a minimal impact as only one State, Alabama, is considered a prior participant State and will no longer be able to request reductions in risk adjustment transfers beginning with the 2025 benefit year.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

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

We are finalizing 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 will 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 will end, and issuers will 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 will provide additional guidance 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.C of this final 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 are finalizing the extraction of the plan ID and rating area data elements from issuers' EDGE servers that issuers already make

[325] Reinsurance collections ended in FY 2018 and outlays in subsequent years reflect remaining payments, refunds, and allowable activities.

accessible to HHS as part of the required risk adjustment data for additional prior benefit years of data. Specifically, we are finalizing an amendment to 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.

We did not receive any comments in response to the burden estimates for these policies. We are finalizing these estimates as proposed.

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

For the 2024 benefit year, HHS will operate risk adjustment in every State and the District of Columbia. As described in the 2014 Payment Notice (78 FR 15416 through 15417), HHS' operation of risk adjustment on behalf of States is funded through a risk adjustment user fee. For the 2024 benefit year, we are using the same methodology to estimate our 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 [326] and section 12001 of the IRA,[327] which extended the enhanced PTC subsidies in section 9661 of the ARP through the 2025 benefit year. We estimate that the total cost for HHS to operate the risk adjustment program on behalf of all 50 States and the District of Columbia for the 2024 benefit year will be approximately $60 million, and therefore, the proposed risk adjustment user fee will 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 risk adjustment user fee for the 2024 benefit year to reduce the transfer amounts collected or paid by issuers of risk adjustment covered plans.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

[326] Public Law 117–2.

[327] Public Law 117–169.

5. Risk Adjustment Data Validation Requirements When HHS Operates Risk Adjustment (HHS–RADV) (§ 153.630)

We are finalizing, beginning with 2022 benefit year HHS–RADV, changes to 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 initial validation audit (IVA) over the years and to ensure the materiality threshold is not eroded as costs increase. We quantified this increase in IVA cost in the Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment PRA package (OMB Control Number 0938–1155), which we updated in 2022.[328] We believe the number of issuers exempt from HHS–RADV for any given benefit year under the new 30,000 BMM materiality 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 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 are finalizing, beginning with 2021 benefit year HHS–RADV, the removal of 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. With this policy, exiting and non-exiting outlier issuers are treated the same, and HHS is applying 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 the number of negative error rate outlier exiting issuers in any given benefit year will be very small, and therefore, we believe changing this policy will not significantly increase burden.

We are also finalizing a change to the attestation and discrepancy reporting window to file a discrepancy report or confirm second validation audit (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 will improve our ability to finalize SVA findings results prior to release of the HHS Risk Adjustment Data Validation (HHS–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. This change will 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). The shortened window also does not change the underlying burden for an issuer to attest or file a discrepancy of its SVA results as those tasks generally remain the same. Instead, this change only relates to the timeframe to complete these activities. Although there may be a potential increase in administrative burden to issuers resulting from the need to reallocate staffing or resources to attest or file a discrepancy of its SVA within the compressed 15-day window, the existing overall burden hours and associated resource expenditures to complete this task remains unchanged. Further, we believe that this shortened reporting window will not be overly burdensome to the few impacted issuers, and that any disadvantages of this shortened reporting window will be outweighed by the benefits of timely resolution of any discrepancies before the release of the applicable benefit year HHS RADV Results Memo and the Summary Report of Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers for the applicable benefit year.

After reviewing the public comments, we are finalizing the burden estimates as proposed. We summarize and respond to public comments received regarding the impact of the change to the HHS–RADV materiality threshold definition below.

Comment: One commenter agreed that the proposed materiality threshold of 30,000 BMM will continue to ease the administrative burden associated with HHS–RADV audits. Another commenter encouraged HHS to consider changing the materiality threshold for HHS–RADV participation to a percentage of Statewide member months to reduce the burden of HHS–RADV on issuers that do not materially impact risk adjustment transfers.

[328] Available at *https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202207-0938-001.*

Response: As explained in section III.A.7 of this final rule, we believe that a materiality threshold of 30,000 BMM appropriately balances the goals of the HHS–RADV process and the burden of the process on smaller issuers. As stated above, we do not anticipate that a materiality threshold of 30,000 BMM will change the current estimated burden of the annual HHS–RADV requirements on issuers. The burden of annual HHS–RADV requirements may decrease over time as a materiality threshold of 30,000 BMM will result in a more consistent pool of issuers subject to random and targeted sampling than a threshold of $15 million in total annual premiums, which could increase the number of issuers subject to annual HHS–RADV audits over time as premiums grow. We did not consider or propose using a percentage of Statewide member months as the metric for the materiality threshold as that metric does not have a relationship with the costs to conduct the audit. We therefore decline to adopt use of such a metric as part of this final rule.

6. EDGE Discrepancy Materiality Threshold (§ 153.710)

We are finalizing an amendment to 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 or exceed $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 updated materiality threshold definition for EDGE discrepancies will 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).

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

7. Exchange Blueprint Approval Timelines (§ 155.106)

As discussed in section III.B.1 of this final rule, the proposed regulatory amendments will not eliminate the requirement for States seeking to transition to a different Exchange operational model (FFE to SBE–FP or State Exchange, or SBE–FP to State Exchange) to submit an Exchange Blueprint or for HHS to approve, or conditionally approve, a State's Exchange Blueprint. It will only impact the timeline, by providing additional time for HHS to provide approval, or conditional approval.

We do not anticipate any additional burden associated with this policy 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 did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

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

As discussed in section III.B.2, new rules will 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 change will not impose any new or additional opportunity costs on Assisters, and we do not anticipate any estimated burden associated with this proposal. The benefits of this proposal will 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 will 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 sought comment on these assumptions, specifically about any reduction in costs, benefits, or burdens on Assisters and consumers as related to this policy.

After reviewing the public comments, we are finalizing the burden estimates as proposed. We summarize and respond to public comments received regarding the impact of the proposed change to repeal the provisions that currently prohibit Assisters from going door-to-door or using other unsolicited means of direct contact to provide enrollment assistance to consumers below.

Comment: We received many comments expressing appreciation that we are striving to build-in more flexibility for Assisters to go into the community and reach the patients who need the most support. These commenters stated that Assisters being able to travel to an enrollee's residence enhances the opportunity to get more people enrolled in health insurance coverage and that this provision will allow Navigators and other types of Assisters to better meet patients where they are, hopefully allowing more people to receive health coverage.

Response: We agree that additional flexibility will help reduce burden not only for Assisters but for consumers experiencing chronic illness, inflexible schedules, lack of child care, lack of transportation, and other adverse social determinants of health.

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

As discussed in section III.B.3 of this final rule, the regulatory amendments we are finalizing will 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 these amendments, 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 noncompliance against them or who have exhibited a pattern of noncompliance or abuse that may pose imminent consumer harm will be impacted.

As discussed in the preamble, this policy will 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 will not change. While we will be increasing the amount of potential time the review process will 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 will 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 policy.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

10. Providing Correct Information to the FFEs and Documenting Receipt of Consumer Consent (§ 155.220(j))

As discussed in section III.B.3 of this final rule, the regulatory amendments we are finalizing will require agents, brokers, and web-brokers assisting with and facilitating enrollment in coverage 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. The policy will require the consumer or their authorized representative to take 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 upon request in response to monitoring, audit, and enforcement activities.

In addition, we are finalizing regulatory amendments that will 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 policy will require the consumer or their authorized representative to take an action that produces a record of consent that must be maintained by the assisting agent, broker, or web-broker and produced upon request in response to monitoring, audit, and enforcement activities. As we anticipate these two documentation processes will likely be occurring as part of the same consumer interaction,[329] the two policies are discussed together below.

A potential cost to consider is the additional time it will take to process and submit each consumer's eligibility application. It currently takes approximately 30 minutes for an assisting agent, broker, or web-broker to submit a consumer's eligibility application. These finalized requirements may add approximately five minutes additional time, per the new requirement, to each application, making each application submission take 40 minutes under the new finalized policies. This means that for every six policies submitted under the new finalized 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.[330] Therefore, the finalized regulatory text may result in $66.68 lost per day per agent, broker, or web-broker ($16.67 × 4 fewer applications submitted).

However, there will 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[331] submitted 1,159,608 policies during PY 2021, which equals approximately 7 submitted policies per day.[332] As it was determined under the new policies that an agent could submit approximately 12 applications per day, there is no clear impact associated with these policies as far as the number of applications being submitted. However, this could be different during the Open Enrollment Period (OEP) as there is generally more enrollment activity during OEP than regular business days. During PY 2022 Open Enrollment, agents submitted 2,572,341 applications, which translates to 38 applications per agent. The top selling 1 percent of agents submitted 689,146 applications during Open Enrollment, which is approximately 18 applications per day.[333] Under the finalized 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 week for 8 hours per day, an agent may 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). For the 668 agents in the top selling 1 percent, the total potential commission loss may be approximately $3,674,735 (668 agents × $5,501.10). It is likely these agents are working more hours than we accounted for, meaning the 330 fewer applications and $3,674,735 in lost commissions is an estimate such that the actual loss of commission will be less than we estimated.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

11. Failure To File and Reconcile Process (§ 155.305)

We are finalizing a requirement that Exchanges 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 policy will benefit both Exchanges and consumers by ensuring that consumers are complying with the requirement to file their Federal income tax returns and reconcile past years' APTC, while also providing continuity of coverage for consumers who might otherwise go uninsured after losing ATPC.

[329] 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 and prior to application submission. However, we generally expect that the documentation that will be required before and after the completion of the application, will occur as part of a single interaction in most cases.

[330] This was derived using the Insurance Sales Agent mean hourly wage from the above wage estimate table of $33.34 and dividing in half.

[331] The current number of agents registered with the Exchange is 66,893. We looked at data from the 668 top-selling agents.

[332] This assumed an agent worked 250 days per year (50 weeks at 5 days per week).

[333] This assumed an agent worked 5 days per week at 8 hours per day, which is likely a low estimate.

We anticipate that this policy will increase APTC expenditures by promoting continuous enrollment of consumers with APTC, who, absent this policy, would likely choose to terminate their coverage altogether after losing their APTC eligibility due to having an FTR status. Based on our 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 without APTC. Assuming the same enrollment numbers for Open Enrollment 2025 with the new 2-year FTR policy, if the 102,000 enrollees who ended their QHP coverage after losing APTC were given another year of APTC eligibility to confirm compliance or come into compliance with the requirement to file and reconcile, we estimate that all 102,000 likely enrollees would have retained coverage for another coverage year. However, based on our experience running FTR since 2015, we anticipate that about 20,400 (20 percent) of these enrollees would have likely received a second, consecutive FTR flag and would be re-enrolled into coverage without APTC due to their failure to file and reconcile for two consecutive tax years. Therefore, we estimate that this 2-year FTR policy is likely to increase APTC expenditures by approximately $373 million per year beginning in plan year 2025 for those consumers who have not filed and reconciled for only one tax year (approximately 81,600) and retain their APTC eligibility (using average APTC amount of approximately $508 per month multiplied by the average retention rate in an Exchange QHP of 9 months).

We are 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 PHE. 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 the annual costs to maintain FTR operations to be approximately $10 million.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

12. Income Inconsistencies (§§ 155.315 and 155.320)

We anticipate that the finalized revision to § 155.315 will 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 change to grant a 60-day extension to applicants with income DMIs will 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 will be $9 million to comply with the requirement to grant the 60-day extension, and the total cost to the Federal Government will be $500,000.

We anticipate that the revisions to § 155.320 will 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 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 will 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 policy, due to applicants remaining enrolled through the end of the plan year instead of losing eligibility for APTC for failing to provide sufficient documentation to verify their projected household income.

However, we do anticipate that the revisions to § 155.320 will also result in some decreases in ongoing administrative costs for the Exchanges using the Federal platform and State Exchanges. The change will 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, based on historical DMI data, we anticipate that this will result in 1.2 million fewer households receiving an income DMI, which will result in $66 million in annual cost savings to the Federal Government. Additionally, State Exchanges using their own platform will also experience annual cost savings of $37 million due to this change.

We do not anticipate that these changes will impose a cost or regulatory burden on issuers. However, the changes will have a financial impact on issuers via the continued enrollment of consumers who otherwise would have experienced APTC adjustment and thus would have been likely to disenroll.

After reviewing the public comments, we are finalizing the burden estimates as proposed. We summarize and respond to public comments received regarding the impact of the change to accept household income attestation when IRS is contacted but does not return data and to provide an automatic 60-day extension for Income DMIs below.

Comment: One commenter noted concerns that these calculations would result in increased spending for the Federal Government.

Response: We agree that Federal Government spending will increase, but this will be primarily due to more consumers appropriately maintaining eligibility for financial assistance that they need to stay enrolled in coverage, which positively impacts health equity, continuous coverage, and the risk pool. We note that these consumers are still subject to the reconciliation process when filing their taxes, which may result in repayment of APTC and help account for any potential excess financial assistance beyond what they were eligible for. Additionally, households are required to provide true answers to application questions under penalty of perjury.

13. Annual Eligibility Redetermination (§ 155.335(j))

In the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule (87 FR 78206, 78259), we proposed changes to allow Exchanges, beginning in PY 2024, to direct re-enrollment for enrollees who are eligible for CSRs in accordance with § 155.305(g) from a bronze QHP to a silver QHP, if certain conditions are met (''bronze to silver crosswalk policy''), and to require all Exchanges (Exchanges on the Federal platform and State Exchanges) to incorporate provider network considerations into the re-enrollment hierarchy. After reviewing public comments, we are finalizing proposed changes to the re-enrollment hierarchy with modifications. Specifically, we are amending the proposed regulations to clarify that Exchanges implementing the bronze to silver crosswalk policy will compare net monthly silver plan premiums for the future year with net monthly bronze plan premiums for the future year, as opposed to net monthly bronze plan premiums for the current year (where net monthly premium is the enrollee's responsible amount after

applying APTC). Additionally, we changed the structure and some content of the regulation to simplify the regulatory text and to clearly characterize the rule's provider network continuity protections for enrollees whose QHP is no longer available, compared to enrollees eligible for the bronze to silver crosswalk policy under paragraph (j)(4).[334]

As discussed in the proposed rule, we anticipate that the inclusion of additional criteria in the auto re-enrollment process will increase costs and burden for issuers and Exchanges, although we are unable to quantify this increase. However, we believe initially limiting the scope of the bronze to silver crosswalk policy to only CSR-eligible enrollees who are currently in a bronze QHP and have a lower or equivalent after APTC cost silver QHP available will allow issuers and Exchanges to incrementally update their processes, as opposed to including 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 plans with lower or equivalent premium after APTC will facilitate enrollment into silver CSR plans and help reduce CSR forfeiture. Notwithstanding these burdens, we believe changes to the re-enrollment process finalized in this rule, in combination with improved consumer notification, will 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 cost of an enrollee's current plan. 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 will be promoting consumer access to affordable, quality coverage.

We sought 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 policy. We summarize and respond in preamble and below to public comments received regarding the impact of the changes to the auto re-enrollment policy.

Comment: Some commenters raised concerns that implementing this policy for the 2024 plan year would be difficult for issuers and cause confusion for consumers. Some commenters with this concern requested that HHS delay the policy if it were finalized, and that HHS not change the auto re-enrollment system until after the implementation of other proposed policies including the proposals to require plan and plan variation marketing accuracy and to limit the number of non-standardized plan options that issuers may offer through the Exchanges. These commenters expressed concerns that auto re-enrolling consumers into a different plan than their current QHP would exacerbate potential confusion related to these other policies. They requested that HHS wait to implement any changes related to auto re-enrollment until issuers have finalized their product decisions in accordance with new plan variation marketing requirements so that plan and plan variation marketing names are accurate, consistent, and understood by consumers before consumers are mapped into new plans they are unfamiliar with.

Response: As noted in section III.B.6. of the preamble, Exchanges on the Federal platform will implement the new policy at § 155.335(j)(4) by incorporating network ID into existing requirements for issuer submissions through the crosswalk process, which, per existing rules at § 155.335(j)(2), already requires that if no plans under the same product as an enrollee's current QHP are available for renewal, the Exchange will auto re-enroll the enrollee in the product most similar to their current product with the same issuer.[335] We believe that plan network ID will be an effective method of network comparison for Exchanges on the Federal platform because QHP Certification Instructions specify that if specific providers are in-network for some of an issuer's products but not others, the issuer must establish separate network IDs to enable mapping the plans to the applicable network IDs. We will also work closely with State Exchanges to share best practices for implementing this policy. Further, based on experience from past years, a majority of enrollees who were crosswalked into a different product with the same issuer had the same network ID and product type (for example, HMO, PPO), and so we anticipate that this policy will reinforce and not disrupt current auto re-enrollment processes.[336] Finally, we believe that issuer implementation burden will be mitigated because, as discussed in the proposed rule, Exchanges, not issuers, will be responsible for identifying enrollees eligible for the bronze to silver crosswalk policy under paragraph (j)(4).[337] Given the benefits that this policy will provide to consumers who will be enrolled in more generous coverage for no greater cost, we will not delay its effectuation. We will work closely with all interested parties to ensure smooth implementation and mitigate any adverse effects such as consumer confusion.

Comment: As also discussed in the preamble, many commenters supported this proposal, agreeing that it would help limit CSR forfeiture and increase the likelihood that more consumers would be enrolled in more generous coverage without additional cost. One commenter expressed support but suggested that the policy could be limited in its impact for individuals and families with household incomes above 150 percent FPL because of the difference in bronze and silver plans' monthly premiums. Commenters also raised concerns that auto re-enrolling consumers into a different plan for the coming year could disrupt consumers' provider network, prescription drug availability, and HSA eligibility that had informed their original choice of plan selection.

Response: We agree that this policy will help to prevent CSR forfeiture. Also, we agree with the comment that most enrollees who Exchanges can crosswalk from a bronze to a silver plan under paragraph (j)(4) will be those who have access to a silver plan with a $0 monthly net premium because their household income does not exceed 150 percent of the FPL. Nevertheless, we believe that the importance of auto re-enrolling enrollees in a plan within the same product and with the same provider network that they would have if they were auto re-enrolled under § 155.335(j)(1) or (2) outweighs concerns that this will result in fewer bronze enrollees being crosswalked to a silver plan. In response to concerns that Exchanges will be shifting CSR eligible consumers auto re-enrolled from a bronze to a silver plan under paragraph (j)(4) into different benefits and provider networks, we note that by making this change only for consumers who have a

[334] Please see the preamble for § 155.335(j) at section III.B.6. for a full description of and explanation for these modifications.

[335] See § 155.335(j)(2), and *see* ''Plan Crosswalk'' on the QHP Certification Information and Guidance website at *https://www.qhpcertification.cms.gov/s/Plan%20Crosswalk* for more information on the Crosswalk Template.

[336] Based on internal CMS analysis, for the 2023 plan year, 86 percent of crosswalks to a different product with the same issuer had the same network ID and the same network type (that is, HMO, PPO, EPO).

[337] See 87 FR 78263.

plan in their same product with a network ID that matches that of their future year bronze plan, the policy ensures that consumers will not experience network changes that they would not otherwise experience had they been auto re-enrolled into their bronze plan. Also, we will perform additional research to ensure that we are able to provide appropriate support and technical assistance to enrollees who may have chosen a bronze plan HSA, and we encourage State Exchanges, agents and brokers, and enrollment assisters to do the same.

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

We are finalizing the amendment to paragraph (b)(2)(iv) to § 155.420 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, and select a plan between 60 days before such loss of MEC and the last day of the month preceding the month in which the loss of MEC occurs. 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 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 at section III.B.7.a., ensuring smooth and quick transitions into Exchange coverage will be especially critical during Medicaid unwinding when a large number of consumers are expected to lose their Medicaid or CHIP coverage and transition to Exchange coverage.

Based on our 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 on 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. 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 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 occurs assuming a similar volume of consumers will choose to enroll in an Exchange QHP based on PY 2021 data. We estimated this amount by multiplying the number of consumers in PY 2021 who attested to a future loss of MEC and chose not to enroll (approximately 45,000) and multiplied this by average APTC (about $508 per month for PY 2021 and assuming an average enrollment of 7 months). However, the actual number could be lower, given that we are unable to estimate what proportion of consumers will still elect to not enroll in an Exchange QHP. We also anticipate additional costs for consumers whose monthly premium after APTC (if applicable) is greater than $0, as they would likely have to pay premiums for both MEC and Exchange coverage in the month over overlapping coverage, depending on the type of prior MEC involved. Conversely, our estimate may also be low because it does not account for the one additional month of coverage and APTC that consumers may receive if they would have already chosen to enroll in Exchange coverage under the existing policy, but may do so earlier under the new rule. We note that, to mitigate adverse selection and the related burden on issuers, we did not propose that Exchanges permit consumers to select a coverage date such as the first of the month following plan selection. We sought comment on this policy, specifically about any additional costs, benefits, or burdens on State Exchanges, issuers, and consumers as related to this policy. We also sought comment from issuers regarding any additional or remaining risk regarding mid-month coverage effective dates.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

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

We are finalizing the addition of paragraph (c)(6) to § 155.420 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. In addition, if a State Medicaid Agency allows or provides for a Medicaid or CHIP reconsideration period greater than 90 days, then the Exchange in that State may elect to provide a qualified individual or their 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 additional time to select a QHP, up to the number of days provided for the applicable Medicaid or CHIP reconsideration period. We believe that this 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 minimal coverage gaps.

Based on our own analysis, in plan year 2019, about 60,000 consumers seeking coverage on Exchanges using the Federal platform attested to a Medicaid or CHIP loss or denial between 60 to 90 days prior to submitting or updating a *HealthCare.gov* application. We estimate that this 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 will increase APTC expenditures by approximately $98 million per year. This number may be slightly higher given the additional flexibilities for State Exchanges, but we are unable to estimate that because we do not know which State Exchanges may choose to implement this special rule earlier than January 1, 2024, or which State Exchanges operate in States whose State Medicaid Agency allows or provides for a Medicaid or CHIP reconsideration period greater than 90 days whereby the Exchange in that State may elect to provide more than 90 days to select a QHP under § 155.420(c)(6).

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

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

We anticipate that revisions to § 155.420(d)(12) will maintain current regulatory burden and cost on issuers. As discussed earlier in preamble at section III.B.7.d., these revisions will make necessary changes to the text of § 155.420(d)(12) 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. This policy will 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 in 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.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

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

We do not anticipate any burden related to the policy to expressly 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, or the issuer's business rules. Because this prohibition has already been operationalized 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 policy and have not previously done so, but we do not have adequate data to estimate these costs.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

18. Improper Payment Pre-Testing and Assessment for State-Based Exchanges (§ 155.1500)

This policy will prepare HHS to implement the Payment Integrity Information Act of 2019 (PIIA) requirements for State Exchanges. As described in the preamble in this final rule, the PIIA requires that agencies measure the improper payments rate for programs susceptible to significant improper payments. We already undertake annual measurements for Medicare, Medicaid, FFEs, and SBE–FPs. This final rule will 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 policy will test State Exchanges' readiness to provide the information necessary to measure the rate of improper payments. Even slight decreases in this rate will accrue large taxpayer savings. As discussed in section IV.J, the IPPTA incurs approximately $28,500 in annual costs per State Exchange for a total annual cost of $512,878 for all 18 State Exchanges. Nevertheless, we believe that the potential benefits of this regulatory action justify the present costs.

This policy will 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 policy. Neither this IPPTA nor any follow-on program should affect transfers between parties.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

19. FFE and SBE–FP User Fee Rates for the 2024 Benefit Year (§ 156.50)

We are finalizing an FFE user fee rate of 2.2 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 are also finalizing an SBE–FP user fee rate of 1.8 percent of monthly premium 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, increased Open Enrollment numbers and anticipated Medicaid redeterminations), premiums for the 2024 benefit year, and user fee rates, we are estimating that FFE and SBE–FP user fee transfers from issuers to the Federal Government will be $404 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.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

20. Standardized Plans

a. Standardized Plan Options (§ 156.201)

At § 156.201, for PY 2024 and subsequent PYs, we are finalizing minor updates to our approach to standardized plan options. Specifically, in contrast to the policy finalized in the 2023 Payment Notice, we are finalizing, for PY 2024 and subsequent PYs, to no longer include a standardized plan option for the non-expanded bronze metal level. Accordingly, we are finalizing 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.

As we explained in the proposed rule, we believe 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. We also explained that we believe 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, we explained that if these standardized plan options 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 that 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, we are finalizing standardized plan options that continue to resemble the most popular QHP offerings that millions of consumers are already enrolled in. Accordingly, these 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.

We are maintaining an approach to standardized plan options that is similar to that taken in the 2023 Payment Notice, such that issuers will 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 we are finalizing requirements that QHP issuers 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 for which 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 will not be required to extend plan offerings

beyond service areas and metal levels in which they currently offer plans.

Furthermore, as discussed earlier in the preamble, we will continue to differentially display standardized plan options on *HealthCare.gov* per the existing authority at § 155.205(b)(1). Since we will continue to assume the burden for differentially displaying standardized plan options on *HealthCare.gov,* FFE and SBE–FP issuers will not be subject to this burden.

In addition, as noted in the preamble, we will 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. We believe that continuing the enforcement of these differential display requirements will 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 [338] or when enforcement of these requirements resumed beginning with the PY 2023 open enrollment period.

Furthermore, since we will 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 will continue to be minimized. We intend 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).

Finally, since we are not finalizing the proposed requirement for issuers to place all covered generic prescription drugs in the generic prescription drug cost-sharing tier and all covered brand drugs in the preferred or non-preferred brand prescription drug cost sharing tiers (or the specialty prescription drug tier, with an appropriate and non-discriminatory basis) in these standardized plan options, issuers of these plans will not be subject to this additional burden.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

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

At § 156.202, we are finalizing limiting the number of non-standardized plan options that issuers of individual market medical QHPs can offer through the FFEs and SBE–FPs to four in PY 2024 and two in PY 2025 and subsequent plan years per product network type, metal level, and inclusion of dental and/or vision benefit coverage, in any service area.

By finalizing the proposed policy with modifications to increase the limit on the number of non-standardized plan options that issuers can offer to four instead of two for PY 2024, and to also factor the inclusion of dental and/or vision benefit coverage into this limit, we estimate (based on PY 2023 enrollment and plan offering data) that the weighted average number of non-standardized plan options available to each consumer will be reduced from approximately 89.5 in PY 2023 to 66.3 in PY 2024, while the weighted average total number of plans (which includes both standardized and non-standardized plan options) available to each consumer will be reduced from approximately 113.7 in PY 2023 to 90.5 in PY 2024.

We also note that phasing in the reduction in the number of non-standardized plan options that issuers can offer, beginning with four for PY 2024, will also significantly reduce the number of plan discontinuations and affected enrollees for PY 2024. Specifically, based on PY 2022 data, we originally estimated that a limit of two non-standardized plan options would result in the discontinuation of approximately 60,949 of a total 106,037 non-standardized plan option plan-county combinations (57.5 percent), and would affect approximately 2.72 million of the 10.21 million enrollees in the FFEs and SBE–FPs (26.6 percent). That said, under the limit of four non-standardized plan options we are finalizing for PY 2024, based on PY 2023 data, we estimate that approximately 17,532 of the total 101,453 non-standardized plan option plan-county combinations (17.3 percent) will be discontinued as a result of this limit, and approximately 0.81 million of the 12.2 million enrollees on the FFEs and SBE–FPs (6.6 percent) will be affected by these discontinuations in PY 2024. Finally, in terms of the impact on network availability, we estimate an average reduction of only 0.03 network IDs per issuer, product network type, metal level, and service area, meaning we anticipate network IDs will remain largely unaffected by this limit for PY 2024.

As discussed in the preamble to this rule, we note that we are unable to provide meaningful estimates at this time for the weighted average number of non-standardized plan options available to each consumer; the weighted average number of total plans available to each consumer; the number of plan-county discontinuations; the number of affected enrollees; and the average reduction of network IDs per issuer, product network type, metal level, and service area under the limit of two non-standardized plan options per issuer, product network type, metal level, inclusion of dental and/or vision benefit, and service area for PY 2025 and subsequent plan years.

This is because for these estimates to be meaningful, they would need to be based on plan offering and enrollment data for PY 2024, which will not be available until the end of the current QHP certification cycle for PY 2024 and the end of the 2024 OEP, respectively. We anticipate that the broader landscape of plan offerings as well as the composition of individual issuers' portfolios of plan offerings will undergo significant changes as a result of the limit of four non-standardized plan options in PY 2024, and that any estimates based on data sourced from a plan year before this limit is enacted would not be meaningfully predictive of the landscape of plan offerings or individual issuers' portfolios of plan offerings for a plan year after this limit is enacted.

Furthermore, as we discussed in the preamble to this rule, we note that in the 2025 Payment Notice proposed rule, we intend to propose an exceptions process, as well as the specific criteria and thresholds that would be included in this exceptions process, that would, if finalized, allow issuers to offer non-standardized plan options in excess of the limit of two for PY 2025 and subsequent plan years.

Regardless, we acknowledge that the termination of these non-standardized plan options would entail burden in several forms, such as by affecting issuers' balance of enrollment across plans, by affecting the premium rating for each of those plans, and by requiring issuers to send discontinuation notices for enrollees whose plans are being discontinued. We are unable to quantify this burden, as the costs of discontinuing plans, reallocating enrollment among existing plans, and

[338] These differential display requirements were first effective and enforced beginning with PY 2018. See 81 FR 94117 through 94118, 94148.

recalculating the premium rating for each of these plans after these discontinuations and enrollee reallocations vary considerably due to a range of factors, including the current number of plan offerings per issuer, the number of plans that would be discontinued per issuer, the number of enrollees in those discontinued plans that would have to be re-enrolled in a different plan, and the composition of these remaining plan offerings.

That said, we believe that the advantages of enacting these changes outweigh the disadvantages of doing so. Specifically, with plan proliferation continuing unabated for several years, consumers have had to select from among record numbers of available plan options. Having such high numbers of plan choices to select from makes it increasingly difficult for consumers, especially those with lower rates of health care literacy, to easily and meaningfully compare all available plan options.

This subsequently increases the risk of suboptimal plan selection and unexpected financial harm for those who can least afford it. Thus, although we acknowledge the burden imposed on issuers subsequent to the imposition of a limit of four non-standardized plan options in PY 2024 and two non-standardized plan options in PY 2025 and subsequent plan years, we believe these changes align with the original intent of the Exchanges—to facilitate a consumer-friendly experience for individuals looking to purchase health insurance. We believe this change will continue to benefit consumers on the Exchanges over numerous years. We further note that we intend to offer the necessary guidance and technical assistance to facilitate this transition, such as through the 2024 Letter to Issuers and QHP certification webinars.

Relatedly, although issuers will be required to select another QHP to which to crosswalk affected enrollees from discontinued non-standardized plan options, we note that the existing discontinuation notices and process as well as the current re-enrollment hierarchy and corresponding crosswalk process outlined at § 155.335(j) will accommodate crosswalking these affected enrollees, and that no additional modification to these processes or to this re-enrollment hierarchy will be required. Finally, we note that no additional action will be required on behalf of consumers to complete this crosswalking process.

Finally, we believe burden is further meaningfully reduced given that we are phasing in the reduction in the number of non-standardized plan options that issuers can offer, beginning with four in PY 2024, which significantly reduces the number of necessary discontinuations in PY 2024 and subsequently reduces the number of affected enrollees that will need to be crosswalked.

We explained in the proposed rule that we did not have sufficient data to estimate the costs associated with these changes. As such, we sought comment from interested parties regarding cost estimates and data sources.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

21. QHP Rate and Benefit Information (§ 156.210)

a. Age on Effective Date for SADPs

We are finalizing standards related to the rate submission process for Exchange-certified SADPs during QHP certification. Specifically, we are finalizing modifications to 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 Classic DE and EDE partners) by promoting operational efficiency.

This 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 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 Classic DE and EDE partners). Therefore, this policy helps facilitate more informed enrollment decisions and enrollment satisfaction.

We also do not anticipate any negative financial impact as a result of this policy, given that it will be a small operational change. If anything, this policy has the potential to reduce financial burden on issuers and HHS, as removing the other age rating methods will reduce the added expense and slower development times that must account for test cases in the rating engine for the less commonly used and more complex methods.

Additionally, this policy change will not create any additional information submission burden, as it will apply to information that Exchange issuers already submit as part of the QHP certification process.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

b. Guaranteed Rates for SADPs

We are finalizing standards related to the rate submission process for Exchange-certified SADPs during QHP certification. Specifically, we are finalizing modifications to 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 will 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 policy change will 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 policy will also reduce the burden placed on consumers because it will 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.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

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

We are finalizing the addition of a new paragraph (c) to § 156.225 as proposed, to require that QHP plan and plan variation [339] marketing names include correct information, without omission of material fact, and do not include content that is misleading. We will review plan and plan variation marketing names during the annual

[339] 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.

By providing standards that help ensure plan and plan variation marketing names are clear and accurate, we anticipate this 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 policy will 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. We acknowledge that the policy might require additional effort during the QHP certification process on the part of Exchange issuers to comply with new plan marketing name standards, but believe it will 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.

Finally, we also believe that the policy will 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.

We sought comment on the burden that this policy would impose, and on the burden reduction it could provide. We also sought comment on how HHS can further alleviate any burden associated with this policy, such as through technical assistance to Exchange interested parties, including issuers and enrollment assisters.

We summarize and respond to public comments received regarding the impact of the policy below.

Comment: Many commenters supported the proposal and agreed that ensuring plan and plan variation marketing name accuracy would reduce burden on consumers, assisters, agents and brokers, and other stakeholders. Some commenters supported the policy but cautioned against imposing name requirements that were too detailed or restrictive, or that contradicted existing State requirements. A few commenters opposed the policy based on concerns that it would restrict issuers' ability to market unique characteristics of their plans.

Response: We respond to these public comments in the final rule preamble.

Comment: Several commenters recommended steps for CMS to take to reduce burden on issuers if this policy were finalized. One commenter requested that CMS delay the policy to 2025 because issuers would have already begun plan filings when the final rule is expected to be issued, and because marketing names are used in multiple materials, issuers would benefit from additional implementation time and more specific guidance regarding permitted naming practices to prevent having to revise consumer-facing materials. This commenter also suggested that this proposal be implemented prior to the proposed changes to the auto re-enrollment hierarchy to ensure that marketing names are first accurate, consistent, and understood by consumers, before some consumers are auto re-enrolled into a different plan than their current plan. Another commenter raised concerns about including additional requirements during the QHP certification process, stating that new requirements would add significant administrative burden during a time when issuers are working to implement several new standards and requirements.

Response: Given that the primary intent of this policy is to ensure that information in plan and plan variation marketing names is accurate and does not conflict with information included in other plan documents, we disagree that it is necessary or appropriate to delay it. In response to concerns about issuer burden, we expect that this rule, and the related requirements discussed in preamble, will permit the continued use of most plan and plan variation marketing names and that this will help mitigate burden on issuers. Further, the rule and related review process will likely result in improved stability in this area because it will allow us to work with issuers and States during the QHP Certification process to address marketing name errors prior to Open Enrollment, as opposed to addressing problems with and requiring changes to plan and plan variation marketing names based on consumer complaints during and after Open Enrollment. Over the past several years, the need to make changes to plan and plan variation marketing names after Open Enrollment to address incorrect or misleading information in marketing names has resulted in significant time and effort on the part of HHS and issuers. We expect that the requirement to make these corrections prior to Open Enrollment will result in a net reduction in burden, especially in cases where a marketing name error would otherwise have resulted in offering an SEP to enrollees whose plan selection may have been impacted by the incorrect or misleading marketing name information. The availability of accurate and clear marketing names during Open Enrollment will also reduce burden for consumers who would otherwise have to reassess their decisions based on information that was not clear when they enrolled.

For a discussion of why we do not plan to delay implementation of changes to the re-enrollment hierarchy, see the RIA section for annual eligibility redeterminations (§ 155.335(j)). We also note that as discussed in the preamble for this section, we will work with States to review plan and plan variation marketing names in advance of Open Enrollment, which will result in improved accuracy of marketing names prior to the auto re-enrollment process for PY 2024. Additionally, as we discussed in the proposed rule (87 FR 78309), we will proactively address 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.

Comment: Multiple commenters agreed that this policy would promote health equity by reducing the likelihood that consumers might misunderstand or be confused about QHP benefits based on information in marketing names. These commenters agreed that these challenges were especially burdensome for consumers with low health literacy, which is disproportionately experienced among low-income, underserved, and vulnerable populations.

Response: We agree with commenters and look forward to continuing to work with interested parties to advance health equity in the individual and small group health insurance markets.

23. Network Adequacy (§ 156.230)

HHS is finalizing the proposal to revise §§ 156.230 and 156.235 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, subject to a limited exception for certain SADPs as discussed previously in this final rule. 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.[340] [341] We expect any initial increased issuer costs to differ from the costs experienced once such provider contractual relationships have been established or pre-existing networks associated with their other plans have been leveraged. We requested 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 policy will 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, and we expect that a similarly small number of Exchange-certified SADPs that do not use a provider network would be affected on State Exchanges and SBE–FPs. As discussed further in Table 11 in the preamble for part 156, over the last few years, fewer than 100 counties on the FFEs 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 will 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.

As discussed previously in this final rule, these impacts will be mitigated, as we are finalizing 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 (we refer readers to section III.C.7 of the preamble of this final rule for further discussion of this exception).

Finally, we do not anticipate any impact as a result of this policy 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 we solicited comment to inform that understanding.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

24. Essential Community Providers (§ 156.235)

We are finalizing the proposal to strengthen the ECP standards under § 156.235(a)(2)(i) and (b)(2)(i) by requiring 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, we are 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 as proposed. 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 will 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.

We are also finalizing the proposal to strengthen the ECP standards under § 156.235(a)(2)(ii)(B) by establishing two additional stand-alone ECP categories—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 policy 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

[340] 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.*

[341] 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.*

(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 will be required to include as part of its application for QHP certification a satisfactory justification.

We did not receive any comments in response to the burden estimates for these policies. We are finalizing these estimates as proposed.

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

We are finalizing an amendment to § 156.270(f) to add a timeliness standard to the requirement for QHP issuers operating in Exchanges on the Federal platform to send enrollees notice of payment delinquency. Specifically, we are revising § 156.270(f) to require such issuers to send notice of payment delinquency promptly and without undue delay, within 10 business days of the date the issuer should have discovered the delinquency. We anticipate that this policy will 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 will 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 did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

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

We are finalizing an amendment to § 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 PY to which such inaccuracy relates has been completed, in order for these data inaccuracies to be eligible for resolution. We are retaining 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 PY to which the inaccuracy relates to be eligible to receive an adjustment to correct an underpayment of APTC or overpayment of user fees to HHS. Beginning with the 2020 plan year coverage, HHS will not pay additional APTC payments or reimburse user fee payments for FFE, SBE–FP, and State Exchange issuers for data inaccuracies reported after the 3-year deadline. For PYs 2015 through 2019, to be eligible for resolution under § 156.1210(b), an issuer must describe all inaccuracies identified in a payment and collections report before January 1, 2024. We anticipate that this change will 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 will be minimal, if any, as issuers have several opportunities to submit data inaccuracies prior to this 3- year deadline. Therefore, we anticipate no significant financial impact for this policy.

We did not receive any comments in response to the burden estimates for this policy. We are finalizing these estimates as proposed.

27. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this 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 assumed that the total number of unique commenters on last year's final rule (465) will be the number of reviewers of this final rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed 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 will 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 recognized that different types of entities are in many cases affected by mutually exclusive sections of this final rule, and therefore, for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. We sought comments on this assumption.

Using the wage information ($57.61 per hour) from the Bureau of Labor Statistics (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 a 100 percent increase for other indirect costs.[342] Assuming an average reading speed of 250 words per minute, we estimate that it will take approximately 6.67 hours for the staff to review half of this final rule (no more than 100,000 words). For each entity that reviews the rule, the estimated cost is $768.13 (6.67 hours × $115.22). Therefore, we estimate that the total cost of reviewing this regulation is approximately $357,180 ($768.13 × 465).

D. Regulatory Alternatives Considered

For 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 that were detailed in the proposed rule (87 FR 78216 through 78218). 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 fourth option, which was the proposed option, 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. 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

[342] *https://www.bls.gov/oes/current/oes_nat.htm.*

benefit year recalibration—only 2018 and 2019 data.

Our analyses found that the 2019 and 2020 enrollee-level EDGE recalibration data were largely comparable, however, there were observed anomalous decreases in the unconstrained age-sex coefficients for the 2020 enrollee-level EDGE. Specifically, whether a coefficient increased or decreased between the 2019 and 2020 enrollee-level EDGE data seemed to be related to the age and sex values for the age-sex factor, with older female enrollees being observed to have a greater likelihood of a decrease in their age-sex factor coefficient than other age and sex groups. However, we have noted that the magnitude of these coefficient changes is within the range of year-to-year changes that we have previously observed. Additionally, we agree with commenters to the proposed rule that removing only the 2020 enrollee-level EDGE data set age-sex factors from the blending of the coefficients may have disadvantages in that all coefficients in the model are interrelated and the removal of a subset of coefficients from blending as described in the proposed option 4 would not address any related coefficients that remained in the blending step. Therefore, although option 1 will not address the identified anomalous trend in the direction of changes to the age-sex factors, the small magnitude of the changes and the disadvantages of the proposed option have resulted in our decision to finalize option 1 in lieu of the proposed option. As such, we will maintain current policy, recalibrating the risk adjustment models using 2018, 2019, and 2020 enrollee-level EDGE data (without any adjustment).

We continue to believe the other options we considered are less appropriate than either the proposed option or the option finalized in this rule. For example, the second option we considered in the proposed rule represented a compromise between those who wish to include 2020 enrollee-level EDGE 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 are concerned this approach will require finding an appropriate weighting methodology, and we are further concerned that broadly dampening the effect of the 2020 enrollee-level EDGE data in the models defeats the purpose of adding the next available benefit year of data as part of model recalibration, because doing so will prevent the models from reflecting changes in utilization and cost of care that are unrelated to the impact of the COVID–19 PHE. We have 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 enrollee-level EDGE data. We do not believe that such a broad dampening is necessary because the anomalous coefficient changes identified from the 2020 enrollee-level EDGE data were largely limited to which adult model age-sex coefficients increased or decreased, and including an additional prior benefit year of data will dampen the impact of the 2020 data on other factors, preventing 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 involve the complete exclusion of 2020 enrollee-level EDGE data, because both of these options will result in reliance on data that may not be the most reflective data set of current utilization and spending trends. Furthermore, there are questions 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 as our analysis showed 2020 enrollee-level EDGE data to be largely comparable to 2019 benefit year enrollee-level EDGE data. 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) will 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 solicited 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 and responded to comments in the above preamble section entitled ''Data for Risk Adjustment Model Recalibration for 2024 Benefit Year''.

In developing the updated materiality threshold for HHS–RADV finalized in this rule, we sought to ensure the materiality threshold will 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 proposed 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 will fail to capture small issuers overtime as PMPM premiums grow and will require more regular updates to the materiality threshold to maintain the current balance. The use of a BMM threshold avoids this issue. We invited 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 invited comment on the applicability date for when the new materiality threshold should begin to apply. Based on comments received and discussed in the preamble section titled ''Materiality Threshold for Risk Adjustment Data Validation,'' we are finalizing this provision as proposed and are using the new materiality threshold beginning with the 2022 benefit year HHS–RADV.

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 amended our proposal and are finalizing as proposed a requirement 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, the policy we are finalizing will 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 IRS data would have their household income adjusted based on that data as opposed to those without IRS data who would lose eligibility for financial assistance.

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 believed this may slightly reduce operational complexity, we believed income-based CSR-eligible enrollees who have a *de minimis* or non-zero-dollar premium will 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 believed 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 will help issuers and Exchanges diligently and appropriately adjust their re-enrollment operations. We solicited comment on all aspects of the re-enrollment proposal at § 155.335(j) and responded to comments received in the associated preamble section. As discussed in that preamble section, we are finalizing this policy with minor modifications.

We considered taking no action related to the two technical corrections to the regulatory text at § 155.420(a)(4)(ii)(A) and (B). However, we believed 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 finalized 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 the revisions to § 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 will benefit from this finalized 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 will 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 will 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 the addition of new § 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 finalized change, especially during the period of unwinding the Medicaid continuous enrollment condition, 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.[343] Additionally, for other exceptional circumstances, there is flexibility under § 155.420(d)(9) that we 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 in a new application for enrollment (instead of losing eligibility for existing 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 the preamble.

We considered taking no action regarding the modifications to § 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, and we are therefore finalizing this policy as proposed.

In developing the IPPTA policies contained in this final rule (§ 155.1500), we requested to meet individually with each State Exchange that participated in the voluntary State engagement initiative in order to gather State-specific information regarding options for data collection that will 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 data collection option requests that the State Exchange provide no fewer than 10 sampled tax households that we proposed the State Exchange will 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 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 invited comment on this data collection option and potential alternative data collection options. We did not receive any comments on the data collection alternative option. We are finalizing the data collection option as proposed.

For standardized plan options, we considered a range of options for the 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 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 of the standardized plan options from PY 2023, as well as by increasing the maximum out-of-pocket (MOOP) values for these plan designs. We explained in the proposed rule that we believe this approach will strike the greatest balance in providing enhanced pre-deductible coverage while ensuring competitive premiums for these standardized plan options.

We invited comment on this proposed approach. As further discussed in the associated preamble section, we are finalizing the proposed standardized plan options policy, but with one modification. Specifically, we are not finalizing the proposed requirement for issuers to include all covered generic drugs in the generic prescription drug cost-sharing tier and all covered brand drugs in either the preferred brand or non-preferred brand prescription drug cost-sharing tiers (or the specialty tier, with an appropriate and non-discriminatory basis) in these standardized plan options, as is further discussed in the associated preamble section.

For non-standardized plan option limits, we considered a range of options for the 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.[344] 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.

In the proposed rule, we proposed to add § 156.202 to limit the number of non-standardized plan options that issuers of QHPs can offer through Exchanges on the Federal platform (including SBE–FPs) to two non-

[343] *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/8-9-natural-disaster-SEP.pdf.*

[344] 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.

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. We explained that we believed this would be the most effective mechanism to reduce the risk of plan choice overload, streamline the plan selection process, and enhance choice architecture for consumers on the Exchanges.

We invited comment on this proposed approach. As discussed further in the associated preamble section of this final rule, we are finalizing this policy with a modification. Specifically, we are finalizing a phased in approach to limiting the number of non-standardized plan options such that a QHP issuer in an FFE or SBE–FP in PY 2024 is limited to offering four non-standardized plan options per product network type, as the term is described in the definition of ''product'' at § 144.103, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage, in any service area. For PY 2025 and subsequent plan years, a QHP issuer in an FFE or SBE–FP 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, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage, in any service area.

We believe this policy strikes an appropriate balance in reducing the risk of plan choice overload and preserving a sufficient degree of consumer choice. As we explain in the corresponding section of the preamble to this final rule, we believe that permitting additional variations specifically for non-standardized plan options with the inclusion of dental or vision benefit coverage—instead of, for example, permitting additional variation for any single change in the product package, however small—decreases the likelihood that these limits will be circumvented.

For plan and plan variation marketing names, we considered issuing sub-regulatory guidance in lieu of rulemaking to require that marketing names include correct information, without omission of material fact, and not include content that is misleading. However, as explained in the proposed rule, given the important role that plan and plan variation marketing names play in facilitating plan competition through consumer education on Exchanges, we proposed this requirement in regulation to allow interested parties the opportunity to comment. As discussed in that preamble section, we are finalizing this policy as proposed.

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. In the proposed rule, we invited comment on these proposed changes and respond to those comments in the associated preamble section of this final rule. As discussed in that preamble section, we are finalizing these changes as proposed.

We considered not proposing to require all QHP issuers, including SADPs, 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. In the proposed rule, we invited comment on this proposal and respond to those comments in the associated preamble section of this final rule. As discussed in that preamble section, we are finalizing this policy but providing 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 (we refer readers to section III.C.7 of the preamble of this final rule for further discussion of this exception).

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, as we stated in the proposed rule, 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 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 declined to propose such a regulation, 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. As discussed in the associated preamble section of this final rule, we are finalizing this timeliness standard with modifications, such that beginning in PY 2024, QHP issuers in Exchanges operating on the Federal platform will be required to send notices of payment delinquency promptly and without undue delay, within 10 business days of the date the issuer should have discovered the delinquency.

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 will 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 will 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 will be $35 million or less.[345] 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 2021 MLR reporting year, approximately 78 out of 480 issuers of health insurance coverage nationwide had total premium revenue of $41.5 million or less.[346] 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

[345] *https://www.sba.gov/document/support--table-size-standards.*

[346] Available at *https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.*

small companies are likely to have non-health lines of business that will result in their revenues exceeding $41.5 million.

In this final rule, we are finalizing 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 did not believe that an initial regulatory flexibility analysis is required for such firms and therefore do not believe a final regulatory flexibility analysis is required. 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 final rule. Therefore, the Secretary has certified that this final 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 rule will not affect small rural hospitals. Therefore, the Secretary has certified that this final 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 2023, that threshold is approximately $177 million. Although we have not been able to quantify all costs, we expect that the combined impact on State, local, or Tribal governments and the private sector does not meet the UMRA definition of 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 final rule will not impose substantial direct requirement costs on State and local governments, this regulation has federalism implications due to potential direct effects on the distribution of power and responsibilities among the State and Federal Governments relating to determining standards relating to health insurance that is offered in the individual and small group markets. For example, the repeal of the ability for States to request a reduction in risk adjustment State transfers 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 policies in this rule related to IPPTA will 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 final 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 this final rule should not conflict with State law, HHS does not anticipate any preemption of State law. We invited State Exchanges to submit comments on this section of the proposed rule if they believe it will conflict with State law and did not receive any such comments.

In addition, we believe this final rule does have federalism implications due to the finalized policy that Exchanges offer earlier effective dates for consumers attesting to future mid-month coverage losses. However, the federalism implications are mitigated as Exchanges will have the flexibility to continue offering the current coverage effective dates as described at § 155.420(b)(2)(iv) or the new finalized 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 earlier coverage effective dates for consumers attesting to a future loss of MEC will be applicable market-wide at the option of the applicable State authority.

Additionally, we believe this final rule does have federalism implications due to the finalized policy 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 new special rule providing consumers with 60 days before or 90 days after their loss of Medicaid or CHIP to enroll in QHP coverage. State Exchanges will also have

additional flexibility to implement this special rule earlier than January 1, 2024, if they so choose, and are permitted to offer a longer attestation window up to the number of days provided for the applicable Medicaid or CHIP reconsideration period, if the State Medicaid agency allows or provides for a Medicaid or CHIP reconsideration period greater than 90 days.

H. Congressional Review Act

This final rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801, *et seq.*), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information. The Office of Information and Regulatory Affairs in OMB has determined that this final rule is a ''major rule'' as that term is defined in 5 U.S.C. 804(2), because it is likely to result in an annual effect on the economy of $100 million or more.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on April 12, 2023.

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, 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, Youth.

For the reasons set forth in the preamble, under the authority at 5 U.S.C. 301, the Department of Health and Human Services amends 45 CFR subtitle A, subchapter B, as set forth below.

PART 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. Section 153.320 is amended 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, 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) * * *

(i) * * *

(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 medical loss ratio (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 a State-based Exchanges on the Federal platform (SBE–FP), in accordance with HHS rules in this chapter, as a State Exchange utilizing the Federal platform;

* * * * *

§ 155.210 [Amended]

■ 7. Section 155.210 is amended by:

■ a. Removing the period at the end of paragraph (c)(6) and adding a semicolon in its place;

■ b. Adding the word ''or'' following the semicolon at the end of paragraph (d)(7); and

■ c. 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, or other similar means or methods specified by HHS in guidance.

(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:

■ a. Adding the word ''or'' following the semicolon in paragraph (g)(4); and

■ b. Removing and reserving paragraph (g)(5).

■ 10. Section 155.305 is amended by revising paragraphs (f)(1)(ii)(B) and (f)(4) to read as follows.

§ 155.305 Eligibility standards.

* * * * *

(f) * * *

(1) * * *

(ii) * * *

(B) Is not eligible for minimum essential coverage for the full calendar month for which advance payments of the premium tax credit would be paid, with the exception of coverage in the individual market, in accordance with 26 CFR 1.36B–2(a)(2) and (c).

* * * * *

(4) *Compliance with filing requirement.* The Exchange may not determine a tax filer eligible for advance payments of the premium tax credit (APTC) if HHS notifies the Exchange as part of the process described in § 155.320(c)(3) that APTC payments were made on behalf of either the tax filer or spouse, if the tax filer is a married couple, for 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 the tax filer's spouse did not comply with the requirement to file an income tax return for that year and for the previous year as required by 26 U.S.C. 6011, 6012, and in 26 CFR chapter I, and reconcile APTC for that period.

* * * * *

■ 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) *Acceptance of attestation.* Notwithstanding any other requirement described in this paragraph (c) to the contrary, when the Exchange requests tax return data and family size from the Secretary of Treasury as described in paragraph (c)(1)(i)(A) of this section but no such data is returned for an applicant, the Exchange will accept that applicant's attestation of income and family size without further verification.

* * * * *

■ 13. Section 155.335 is amended by—

■ a. Revising paragraphs (j)(1) introductory text, (j)(1)(i) and (ii), (j)(1)(iii)(A) and (B), (j)(1)(iv), (j)(2), and (j)(3) introductory text; and

■ b. Adding paragraph (j)(4).

The revisions and addition read as follows:

§ 155.335 Annual eligibility redetermination.

* * * * *

(j) * * *

(1) The product under which the QHP in which the enrollee is enrolled remains available through the Exchange for renewal, consistent with § 147.106 of this subchapter, the Exchange will renew the enrollee in a QHP under that product, unless the enrollee terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430, or unless otherwise provided in paragraph (j)(1)(iii)(A) or (j)(4) of this section, as follows:

(i) The Exchange will re-enroll the enrollee in the same plan as the enrollee's current QHP, unless the current QHP is not available through the Exchange;

(ii) If the enrollee's current QHP is not available through the Exchange, the Exchange will re-enroll the enrollee in a QHP within the same product at the same metal level as the enrollee's current QHP 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 the enrollee's current product and that has the most similar network compared to the enrollee's current QHP. 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; or

(B) 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; 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 and that has the most similar network compared to the enrollee's current QHP.

(2) No plans under the product under which the QHP in which the enrollee is enrolled are available through the Exchange for renewal, consistent with § 147.106 of this subchapter, the Exchange will enroll the enrollee in a QHP under a different product offered by the same QHP issuer, to the extent permitted by applicable State law, unless the enrollee terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430, as follows, except as provided in paragraph (j)(4) of this section.

(i) The Exchange will re-enroll the enrollee in a QHP 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 and that has the most

similar network compared to the enrollee's current QHP;

(ii) 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

(iii) 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 and that has the most similar network compared to the enrollee's current QHP in the product that is most similar to the enrollee's current product.

(3) No QHPs from the same issuer are available through the Exchange, the Exchange may enroll the enrollee in a QHP issued by a different issuer, to the extent permitted by applicable State law, unless the enrollee terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430, as follows:

* * * * *

(4) The enrollee is determined upon annual redetermination eligible for cost-sharing reductions, in accordance with § 155.305(g), is currently enrolled in a bronze level QHP, and would be re-enrolled in a bronze level QHP under paragraph (j)(1) or (2) of this section, then to the extent permitted by applicable State law, unless the enrollee terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430, at the option of the Exchange, the Exchange may re-enroll such enrollee in a silver level QHP within the same product, with the same provider network, and with a lower or equivalent premium after the application of advance payments of the premium tax credit as the bronze level QHP into which the Exchange would otherwise re-enroll the enrollee under paragraph (j)(1) or (2) of this section.

* * * * *

■ 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);

■ c. Removing the heading from paragraph (d)(6); and

■ d. Revising paragraph (d)(12).

The revisions and addition read as follows:

§ 155.420 Special enrollment periods.

(a) * * *

(4) * * *

(ii) * * *

(A) If an enrollee or their dependents become newly eligible for cost-sharing reductions in accordance with paragraph (d)(6)(i) or (ii) of this section and the enrollee or their dependents are not enrolled in a silver-level QHP, the Exchange must allow the enrollee and their 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 their 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 their 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 paragraph (d)(1) or (d)(6)(iii) of this section, or is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer contributions or government subsidies completely cease as described in paragraph (d)(15) of this section, gains access to a new QHP as described in paragraph (d)(7) of this section, becomes newly eligible for enrollment in a QHP through the Exchange in accordance with § 155.305(a)(2) as described in paragraph (d)(3) of this section, becomes newly eligible for advance payments of the premium tax credit in conjunction with a permanent move as described in paragraph (d)(6)(iv) of this section, and if the plan selection is made on or before the day of the triggering event, the Exchange must ensure that the coverage effective date is the first day of the month following the date of the triggering event. If the plan selection is made after the date of the triggering event, the Exchange must ensure that coverage is effective in accordance with paragraph (b)(1) of this section or on the first day of the following month, at the option of the Exchange. Notwithstanding the requirements of this paragraph (b)(2)(iv) with respect to losses of coverage as described at paragraphs (d)(1), (d)(6)(iii), and (d)(15) of this section, at the option of the Exchange, if the plan selection is made on or before the last day of the month preceding the triggering event, the Exchange must ensure that the coverage effective date is the first day of the month in which the triggering event occurs.

* * * * *

(c) * * *

(2) *Advanced availability.* A qualified individual or their 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 their 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 they newly satisfy 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, or earlier, at the option of the Exchange, a qualified individual or their 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. If a State Medicaid or CHIP Agency allows or provides for a Medicaid or CHIP reconsideration period greater than 90 days, the Exchange in that State may elect to provide a qualified individual or their 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 additional time to select a QHP, up to the number of days provided for the applicable Medicaid or CHIP reconsideration period.

* * * * *

(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, if higher, the maximum age a QHP issuer is required to make available dependent coverage of children under applicable State law or the issuer's business rules), 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.* Review of appeal decisions issued by an impartial official as described in § 155.535(c)(4) is available 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)(*1*) 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 must:

(*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 impartial official's 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 paragraphs (g)(1)(i)(B)(*1*) and (*3*) of this section.

(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 paragraphs (g)(1)(i)(B)(*1*) and (*3*) 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)(i)(C) 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 impartial 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 (g)(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 decision.* 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.

(3) *Implementation date.* The administrative review process is available for eligibility appeal decisions issued on or after January 1, 2024.

* * * * *

■ 17. Add subpart P, consisting of §§ 155.1500 through 155.1515, to read as follows:

Subpart P—Improper Payment Pre-Testing and Assessment (IPPTA) for State-based 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-based 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-based Exchanges. These requirements are intended to:

(1) Prepare State-based Exchanges for the planned measurement of improper payments.

(2) Test processes and procedures that support HHS's review of determinations of advance payments of the premium tax credit (APTC) made by State-based Exchanges.

(3) Provide a mechanism for HHS and State-based 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-based Exchange's internal directives defining, guiding, or constraining the State-based 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-based 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-based 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-based Exchange to submit.

Pre-testing and assessment period means the two calendar year timespan during which HHS will engage in pre-testing and assessment procedures with a State-based Exchange.

Pre-testing and assessment plan means the template developed by HHS in collaboration with each State-based 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-based Exchange at the end of the State-based Exchange's pre-testing and assessment period that will include, but not be limited to, the State-based 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-based Exchange to HHS.

§ 155.1510 Data submission.

(a) *Requirements.* For purposes of the IPPTA, a State-based Exchange must submit the following information in a form and manner specified by HHS:

(1) *Data documentation.* The State-based Exchange must provide to HHS the following data documentation:

(i) The State-based 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-based 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-based 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-based Exchanges are required to participate in the IPPTA for a period of two calendar years. The State-based 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-based Exchanges with an overview of the pre-testing and assessment procedures and identify documentation that a State-based Exchange must provide to HHS for pre-testing and assessment.

(2) As a part of the planning process, HHS, in collaboration with each State-based 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-based Exchange. The pre-testing and assessment plan will be for HHS and State-based 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-based 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-based 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-based 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-based Exchanges about the form and manner for State-based 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-based Exchange to track and manage the data and data documentation submitted by a State-based Exchange as specified in § 155.1510(a)(1) and (2).

(2) HHS will coordinate with each State-based Exchange to provide assistance in aligning the data specified in § 155.1510(a)(2) from the State-based Exchange's existing data structure to the standardized set of data elements.

(3) HHS will coordinate with each State-based 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-based 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-based Exchange's submission of the data documentation as specified in § 155.1510(a)(1).

(2) A State-based Exchange's submission of the data for processing and testing as specified in § 155.1510(a)(2); and

(3) A State-based 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-based Exchange's pre-testing and assessment period, HHS will issue a pre-testing and assessment report specific to that State-based Exchange. The pre-testing and assessment report will be for HHS and State-based 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

■ 18. 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.

■ 19. Section 156.201 is revised to read as follows:

§ 156.201 Standardized plan options.

A qualified health plan (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).

■ 20. Section 156.202 is added to read as follows:

§ 156.202 Non-standardized plan option limits.

A QHP issuer in a Federally-facilitated Exchange or a State-based Exchange on the Federal platform:

(a) For plan year 2024, is limited to offering four non-standardized plan options per product network type, as the term is described in the definition of ''product'' at § 144.103 of this subchapter, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage (as defined in paragraph (c) of this section), in any service area.

(b) For plan year 2025 and subsequent plan years, 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, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage (as defined in paragraph (c) of this section), in any service area.

(c) For purposes of paragraphs (a) and (b) of this section, the inclusion of dental and/or vision benefit coverage is defined as coverage of any or all of the following:

(1) Adult dental benefit coverage as defined by the following in the ''Benefits'' column in the Plans and Benefits Template:

(i) Routine Dental Services (Adult);

(ii) Basic Dental Care—Adult; or

(iii) Major Dental Care—Adult.

(2) Pediatric dental benefit coverage as defined by the following in the ''Benefits'' column in the Plans and Benefits Template:

(i) Dental Check-Up for Children;

(ii) Basic Dental Care—Child; or

(iii) Major Dental Care—Child.

(3) Adult vision benefit coverage as defined by the following in the ''Benefits'' column in the Plans and Benefits Template: Routine Eye Exam (Adult).

■ 21. Section 156.210 is amended by adding paragraph (d) to read 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.

■ 22. Section 156.225 is amended by—

■ a. Revising the section heading;

■ b. In paragraph (a), removing ''and'' from the end of the paragraph;

■ c. In paragraph (b), removing the period and adding in its place ''; and''; and

■ d. Adding paragraph (c).

The revision and addition read 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.

■ 23. Section 156.230 is amended by—

■ a. Revising paragraphs (a)(1) introductory text and (a)(2)(i)(B);

■ b. Adding paragraph (a)(4);

■ c. Revising paragraph (e) introductory text; and

■ d. Removing and reserving paragraph (f).

The revisions and addition read as follows:

§ 156.230 Network adequacy standards.

(a) * * *

(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:

* * * * *

(2) * * *

(i) * * *

(B) For plan years beginning on or after January 1, 2025, meeting appointment wait time standards established by the Federally-facilitated Exchange. Such appointment wait time standards will be developed for consistency with industry standards and published in guidance.

* * * * *

(4) A limited exception to the requirement described under paragraph (a)(1) of this section that each QHP issuer use a provider network is available to stand-alone dental plans issuers that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers; this exception is not available to medical QHP issuers. Under this exception, an area is considered ''prohibitively difficult'' for the stand-alone dental plan issuer to establish a network of dental providers based on attestations from State departments of insurance in States with at least 80 percent of counties classified as Counties with Extreme Access Considerations (CEAC) that at least one of the following factors exists in the area of concern: a significant shortage of dental providers, a significant number of dental providers unwilling to contract with Exchange issuers, or significant geographic limitations impacting consumer access to dental providers.

* * * * *

(e) *Out-of-network cost-sharing.* Beginning for the 2018 and later benefit years, for a network to be deemed adequate, each QHP must:

* * * * *

■ 24. Section 156.235 is amended by revising paragraphs (a)(1), (a)(2)(i), (a)(2)(ii)(B), and (b)(2)(i) 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 (a)(2)(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 preferred provider organizations (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.

* * * * *

(b) * * *

(2) * * *

(i) The number of its providers that are located in Health Professional Shortage Areas or five-digit zip codes in which 30 percent or more of the population falls below 200 percent of the Federal poverty level satisfies a minimum percentage, specified by HHS, of available ECPs in each plan's service area collectively across all ECP categories defined under paragraph (a)(2)(ii)(B) of this section, and at least a minimum percentage of available ECPs in each 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 would be counted towards ECP standards; and

* * * * *

■ 25. 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. Issuers offering QHPs in Exchanges on the Federal platform must provide such notices promptly and without undue delay, within 10 business days of the date the issuer should have discovered the delinquency.

* * * * *

■ 26. 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 (c), the issuer must notify HHS, the State Exchange, or State-based Exchanges on the Federal platform (SBE–FP) (as applicable) and repay any overpayments to HHS.

* * * * *

■ 27. 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) and 153.710(d)(2) of this subchapter and § 156.430(h)(1), 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: April 17, 2023.

Xavier Becerra,

Secretary, Department of Health and Human Services.

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