DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 600

Office of the Secretary

45 CFR Parts 153, 154, 155, 156, and 158

[CMS–9883–P]

RIN 0938–AV62

Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program

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

ACTION: Proposed rule.

SUMMARY: This proposed rule contains provisions to improve implementation of the Patient Protection and Affordable Care Act, including payment parameters and provisions related to the HHS-operated risk adjustment and risk adjustment data validation (HHS–RADV) programs, as well as 2027 user fee rates for issuers offering qualified health plans (QHPs) through Federally-facilitated Exchanges (FFEs) and State-based Exchanges on the Federal platform (SBE–FPs). This proposed rule also includes provisions related to civil money penalties (CMPs) for noncompliant issuers and other responsible entities; standards governing agents, brokers, and web-brokers; the expansion and codification of hardship exemption eligibility; implementation of the State Exchange Improper Payment Measurement (SEIPM); provider access standards and essential community provider standards for QHP certification; QHP certification of non-network plans; a prohibition on issuers from including routine non-pediatric dental services as an Essential Health Benefit (EHB); cost-sharing flexibilities for catastrophic and individual market bronze plans; establishment of catastrophic plans with plan terms of up to 10 consecutive years; QHP issuer quality improvement strategies (QISs); revisions affecting which enrollees are included in Federal Basic Health Program (BHP) payment calculations to States; and seeks comment on potential adjustments to other Federal standards, including the Federal medical loss ratio (MLR) standard in the individual market. This proposed rule also includes amendments to implement certain provisions of the Working Families Tax Cut (WFTC) legislation.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by March 13, 2026.

ADDRESSES: In commenting, please refer to file code CMS–9883–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9883–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9883–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Jeff Wu, (301) 492–4305, Rogelyn McLean, (410) 786–1524, Grace Bristol, (410) 786–8437, for general information.

Ayesha Anwar, (301) 448–3625, or Joshua Paul, (301) 492–4347, for matters related to HHS-operated risk adjustment and HHS-operated risk adjustment data validation.

Aaron Franz, (410) 786–8027 for matters related to user fees.

Brian Gubin, (410) 786–1659, for matters related to agent, broker, and web-broker guidelines.

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

Ken Buerger, (410) 786–1190, for matters related to certification standards for QHPs, cost-sharing requirements, and dental coverage as EHB.

Kelly Carda, (312) 886–5210, or Cassandra Thompson, (667) 414–0870, for matters related to Provider Access standards.

Ariana Koenitzer, (410) 786–0724, or Samantha Nguyen Kella, (816) 426–6339, for matters related to Essential Community Provider Standards.

Ariana Koenitzer, (410) 786–0724, or Cassandra Thompson, (667) 414–0870, for matters related to QHP Certification of Non-Network Plans.

Nikolas Berkobien, (667) 290–9903, for matters related to standardized plan options, non-standardized plan option limits and exceptions.

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

Rebecca Braun-Harrison, (667) 290–8846, or Nia Blasingame, (470) 890–4178, for matters related to civil money penalties of issuers and non-Federal governmental group health plans.

Preeti Hans, (301) 492–5144, for matters related to the Quality Improvement Strategy.

Beth Freshcorn, (410) 786–3831, for matters related to administrative actions against agents, brokers, and web-brokers.

Jennifer McIlvaine, (410) 786–0947, for matters related to the Basic Health Program.

Christina Whitefield, (301) 492–4172, for matters related to the medical loss ratio (MLR) program.

David Mlawsky, (410) 786–6851, for matters related to catastrophic plans with multi-year plan terms.

Jessica Veffer, (301) 492–4827, for matters related to expanding hardship exemptions for individuals ineligible for APTC or CSRs due to projected household income.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments. We encourage commenters to include supporting facts, research, and evidence in their comments. When doing so, commenters are encouraged to provide citations to the published materials referenced, including active

hyperlinks. Likewise, commenters who reference materials which have not been published are encouraged to upload relevant data collection instruments, data sets, and detailed findings as a part of their comment. Providing such citations and documentation will assist us in analyzing the comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a summary of not more than 100 words in length of this proposed rule, in plain language, may be found at *https://www.regulations.gov/.*

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I. Executive Summary

We propose changes to the provisions and parameters implemented through prior rulemaking to implement the Patient Protection and Affordable Care Act and propose to implement new provisions.[1] These requirements are published under the authority granted to the Secretary of HHS (the Secretary) by the Affordable Care Act and the Public Health Service (PHS) Act.[2] In this document, we are proposing changes related to some of the Affordable Care Act provisions and parameters we previously implemented under the authority granted to the Secretary by Public Law (Pub. L.) 119–21, which CMS refers to as the Working Families Tax Cut (WFTC) legislation.[3] Our goal with these requirements is providing quality, more affordable coverage to consumers while minimizing administrative burden and ensuring program integrity. The changes proposed in this rule are also intended to enhance the role of States in these programs, provide issuers and States with additional flexibilities, reduce unnecessary regulatory burden on interested parties, and improve affordability.

II. Background

A. Legislative and Regulatory Overview

Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) added a new title XXVII to the PHS Act to establish various reforms to the group and individual health insurance markets. These provisions of the PHS Act were later augmented by other laws, including the Affordable Care Act. Subtitles A and C of title I of the Affordable Care Act reorganized, amended, and added to the provisions of part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. The term ''group health plan'' includes both insured and self-insured group health plans.

In the upcoming sections, we summarize sections of the PHS Act, Affordable Care Act, and WFTC legislation that are relevant to this proposed rule.

Section 1301(a)(1)(B) of the Affordable Care Act directs all issuers of qualified health plans (QHPs) to cover the Essential Health Benefit (EHB) package described in section 1302(a) of the Affordable Care Act, including coverage of the services described in section 1302(b) of the Affordable Care Act, adherence to the cost-sharing limits described in section 1302(c) of the Affordable Care Act, and meeting the Actuarial Value (AV) levels established in section 1302(d) of the Affordable Care Act. Section 2707(a) of the PHS Act, which is effective for plan or policy years beginning on or after January 1, 2014, extends the requirement to cover the EHB package to non-grandfathered individual and small group health insurance coverage, irrespective of whether such coverage is offered through an Exchange. In addition, section 2707(b) of the PHS Act directs non-grandfathered group health plans to ensure that cost sharing under the plan does not exceed the limitations

[1] The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Healthcare and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this rulemaking, the two statutes are referred to collectively as the ''Patient Protection and Affordable Care Act'' or ''Affordable Care Act.''

[2] *See* sections 1301, 1302, 1311, 1312, 1313, 1321, 1331, and 1343 of the Affordable Care Act and section 2792 of the PHS Act.

[3] The WFTC legislation (Pub. L. 119–21) was enacted on July 4, 2025.

described in section 1302(c)(1) of the Affordable Care Act.

Section 1302 of the Affordable Care Act provides for the establishment of an EHB package that includes coverage of EHB (as defined by the Secretary), cost-sharing limits, and AV requirements. The law directs that EHB be equal in scope to the benefits provided under a typical employer plan, and that they cover at least the following 10 general categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Section 1302(b)(4)(A) through (D) of the Affordable Care Act establish that the Secretary must define EHB in a manner that: (1) reflects appropriate balance among the 10 categories; (2) is not designed in such a way as to discriminate based on age, disability, or expected length of life; (3) takes into account the health care needs of diverse segments of the population; and (4) does not allow denials of EHB based on age, life expectancy, disability, degree of medical dependency, or quality of life.

Section 1302(e) of the Affordable Care Act establishes that catastrophic coverage may only be offered to individuals who: (1) are under the age of 30 before the beginning of the plan year; (2) have been certified as exempt from the individual responsibility requirement because coverage is unaffordable; or (3) have been certified as experiencing a hardship with respect to obtaining coverage under a qualified health plan (QHP).

Section 1311(c) of the Affordable Care Act provides the Secretary the authority to issue regulations to establish criteria for the certification of QHPs. Among the criteria for certification that the Secretary must establish by regulation is that QHPs ensure a sufficient choice of providers (section 1311(c)(1)(B) of the Affordable Care Act) and include essential community providers that serve predominately low-income, medically-underserved individuals (section 1311(c)(1)(C)). Section 1311(d)(4)(A) of the Affordable Care Act requires the Exchange to implement procedures for the certification, recertification, and decertification of health plans as QHPs, consistent with guidelines developed by the Secretary under section 1311(c) of the Affordable Care Act. Section 1311(e)(1) of the Affordable Care Act grants the Exchange the authority to certify a health plan as a QHP if the health plan meets the Secretary's requirements for certification issued under section 1311(c) of the Affordable Care Act, and the Exchange determines that making the plan available through the Exchange is in the interests of qualified individuals and qualified employers in the State. Section 1311(c)(6)(C) of the Affordable Care Act directs the Secretary to require an Exchange to provide for special enrollment periods (SEPs) and section 1311(c)(6)(D) of the Affordable Care Act directs the Secretary to require an Exchange to provide for American Indians and Alaska Natives (AI/AN), as defined by section 4 of the Indian Health Care Improvement Act.

Section 1311(d)(3)(B) of the Affordable Care Act permits a State, at its option, to require QHPs to cover benefits in addition to EHB. This section also requires a State to make payments, either to the individual enrollee or to the issuer on behalf of the enrollee, to defray the cost of these additional State-required benefits.

Section 1312(c) of the Affordable Care Act generally requires a health insurance issuer to consider all enrollees in all health plans (except grandfathered health plans) offered by such issuer to be members of a single risk pool for each of its individual and small group markets. States have the option to merge the individual and small group market risk pools under section 1312(c)(3) of the Affordable Care Act.

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

Sections 1313 and 1321 of the Affordable Care Act provide the Secretary with the authority to oversee the financial integrity of State Exchanges, their compliance with HHS standards, and the efficient and non-discriminatory administration of State Exchange activities. Section 1313(a)(5)(A) of the Affordable Care Act provides the Secretary with the authority to implement any measure or procedure that the Secretary determines is appropriate to reduce fraud and abuse in the administration of the Exchanges. Section 1321 of the Affordable Care Act provides for State flexibility in the operation and enforcement of Exchanges and related requirements.

Section 1321(a) of the Affordable Care Act provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs and other components of title I of the Affordable Care Act, including such other requirements as the Secretary determines appropriate. When operating an FFE under section 1321(c)(1) of the Affordable Care Act, HHS has the authority under sections 1321(c)(1) and 1311(d)(5)(A) of the Affordable Care Act to collect and spend user fees. Office of Management and Budget (OMB) Circular No. A–25 Revised establishes Federal policy regarding user fees and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the public.[4]

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

Section 1331 of the Affordable Care Act provides States with an option to establish a BHP. In the States that elect to operate a BHP, the BHP makes affordable health benefits coverage available for individuals under age 65 with household incomes between 133 percent and 200 percent of the FPL who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), or affordable employer-sponsored coverage, or for noncitizens whose income is equal to or below 200 percent of FPL but are ineligible for Medicaid benefits that at a minimum consist of the EHB described in section 1302(b) of the Affordable Care Act. For those States that have expanded Medicaid coverage under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act), the lower income threshold for BHP eligibility is effectively 138 percent of the FPL due to the application of a required 5 percent income disregard in determining the upper limits of Medicaid income eligibility (section 1902(e)(14)(I) of the Act).

Section 1343 of the Affordable Care Act establishes a permanent risk

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

adjustment program to provide payments to health insurance issuers that attract higher-than-average risk enrollees, such as those with chronic conditions, funded by charges collected from those issuers that attract lower-than-average risk enrollees, thereby reducing incentives for issuers to avoid higher-risk enrollees. Section 1343(b) of the Affordable Care Act provides that the Secretary, in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. Consistent with section 1321(c) of the Affordable Care Act, the Secretary is responsible for operating the HHS risk adjustment program in any State that fails to do so.[5]

Section 1401(a) of the Affordable Care Act added section 36B to the Internal Revenue Code (the Code), which, among other things, requires that a taxpayer reconcile APTC for a year of coverage with the amount of the premium tax credit (PTC) the taxpayer is allowed for the year.

Section 1402 of the Affordable Care Act provides for, among other things, reductions in cost sharing for EHB for qualified low- and moderate-income enrollees in silver level QHPs offered through the individual market Exchanges. This section also provides for reductions in cost sharing for American Indians and Alaska Natives (AI/AN) enrolled in QHPs at any metal level.

Section 1411(f) of the Affordable Care Act requires the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Homeland Security, and the Commissioner of Social Security, to establish procedures for hearing and making decisions governing appeals of Exchange eligibility determinations. Section 1411(f)(1)(B) of the Affordable Care Act requires the Secretary to establish procedures to redetermine eligibility on a periodic basis, in appropriate circumstances, including eligibility to purchase a QHP through the Exchange and for APTC and CSRs.

Section 1411(g) of the Affordable Care Act allows the use of applicant information only for the limited purpose of, and to the extent necessary for, ensuring the efficient operation of the Exchange, including by verifying eligibility to enroll through the Exchange and for APTC and CSRs, and limits the disclosure of such information.

Section 1413 of the Affordable Care Act directs the Secretary to establish, subject to minimum requirements, a streamlined enrollment process for enrollment in QHPs and all insurance affordability programs.

Section 2718 of the PHS Act, as added by the Affordable Care Act, generally requires health insurance issuers to submit an annual medical loss ratio (MLR) report to HHS and provide rebates to enrollees if the issuers do not achieve specified MLR thresholds.

Section 5000A of the Code, as added by section 1501(b) of the Affordable Care Act, requires individuals to have minimum essential coverage (MEC) for each month, qualify for an exemption, or make an individual shared responsibility payment. Under the Tax Cuts and Jobs Act, which was enacted on December 22, 2017, the individual shared responsibility payment is reduced to $0, effective for months beginning after December 31, 2018. Notwithstanding that reduction, certain exemptions are still relevant to determine whether individuals aged 30 and above qualify to enroll in catastrophic coverage under §§ 155.305(h) and 156.155(a)(5).

Section 5000A(e) of the Internal Revenue Code defines exemptions from the individual shared responsibility penalty. Section 5000A(e)(5) of the Internal Revenue Code defines a hardship exemption as a situation in which an individual experiences difficulty obtaining QHP coverage and provides the HHS Secretary the authority to determine whether an individual has experienced a hardship.

Section 71301 of WFTC legislation amends 26 U.S.C. 36B(e), effective with respect to plan years beginning on or after January 1, 2027, to provide that a PTC is allowed for the coverage of a lawfully present individual only if the individual is an ''eligible alien.''

Section 71302 of WFTC legislation removes subparagraph (B) of 26 U.S.C. 36B(c)(1), eliminating PTC eligibility for lawfully present individuals with income below 100 percent of the FPL who are ineligible for Medicaid due to their immigration status. Section 71302 is effective for taxable years beginning after December 31, 2025.

Section 71303 of WFTC legislation, effective to taxable years beginning after December 31, 2027, amends the definition of coverage month such that it would be imprudent to maintain a 2-year failure to file and reconcile (FTR) policy for 2028 and beyond, but it would not be legally prohibited to do so.

Section 71304 of WFTC legislation amends section 36B of the Code, effective with respect to plan years beginning after December 31, 2025, such that a plan is not considered a QHP, and therefore no PTC is allowed for coverage under the plan, if the plan is enrolled in through a special enrollment period (SEP) that is based solely on the basis of an individual's expected income to the FPL and not on a change in circumstance (an ''income-based SEP''). This provision is effective January 1, 2026.

Section 71305 of WFTC legislation eliminates, effective for taxable years beginning after December 31, 2025, APTC repayment limits and requires individuals whose APTC exceeds their PTC to increase their tax liability by the amount of the excess.

Section 71307 of WFTC legislation amends the definition of ''high deductible health plan'' to include bronze and catastrophic plans, effective to months beginning after December 31, 2025.

1. Premium Stabilization Programs

The premium stabilization programs refer to the risk adjustment, risk corridors, and reinsurance programs established by the Affordable Care Act.[6] For past rulemaking, we refer readers to the following rules:

- In the March 23, 2012 **Federal Register** (77 FR 17219) (Premium Stabilization Rule), we implemented the premium stabilization programs.
- In the March 11, 2013 **Federal Register** (78 FR 15409) (2014 Payment Notice), we finalized the benefit and payment parameters for the 2014 benefit year to expand the provisions related to the premium stabilization programs and set forth payment parameters in those programs.
- In the October 30, 2013 **Federal Register** (78 FR 65046), we finalized the modification to the HHS risk adjustment methodology related to community rating States.
- In the November 6, 2013 **Federal Register** (78 FR 66653), we issued a correcting amendment to the 2014 Payment Notice to address how an enrollee's age for the risk score calculation would be determined under the HHS risk adjustment methodology.
- In the March 11, 2014 **Federal Register** (79 FR 13743) (2015 Payment Notice), we finalized the benefit and payment parameters for the 2015 benefit year to expand the provisions related to the premium stabilization programs, set forth certain oversight provisions, and

[5] *See* Affordable Care Act section 1341 (transitional reinsurance program), Affordable Care Act section 1342 (risk corridors program), and Affordable Care Act section 1343 (HHS risk adjustment program).

[6] *See* Affordable Care Act section 1341 (transitional reinsurance program), Affordable Care Act section 1342 (risk corridors program), and Affordable Care Act section 1343 (HHS risk adjustment program).

establish payment parameters in those programs.

• In the May 27, 2014 **Federal Register** (79 FR 30240), we announced the fiscal year 2015 sequestration rate for the HHS-operated risk adjustment program.

• In the February 27, 2015 **Federal Register** (80 FR 10749) (2016 Payment Notice), we finalized the benefit and payment parameters for the 2016 benefit year to expand the provisions related to the premium stabilization programs, set forth certain oversight provisions, and establish the payment parameters in those programs.

• In the March 8, 2016 **Federal Register** (81 FR 12203) (2017 Payment Notice), we finalized the benefit and payment parameters for the 2017 benefit year to expand the provisions related to the premium stabilization programs, set forth certain oversight provisions, and establish the payment parameters in those programs.

• In the December 22, 2016 **Federal Register** (81 FR 94058) (2018 Payment Notice), we finalized the benefit and payment parameters for the 2018 benefit year, added the high-cost risk pool parameters to the HHS risk adjustment methodology, incorporated prescription drug factors in the adult models, established enrollment duration factors for the adult models, and finalized policies related to the collection and use of enrollee-level External Data Gathering Environment (EDGE) data.

• In the April 17, 2018 **Federal Register** (83 FR 16930) (2019 Payment Notice), we finalized the benefit and payment parameters for the 2019 benefit year, created the State flexibility framework permitting States to request a reduction in risk adjustment State transfers calculated by HHS, and adopted a new error rate methodology for HHS–RADV adjustments to transfers.

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

• On July 27, 2018, consistent with 45 CFR 153.320(b)(1)(i), we updated the 2019 benefit year final HHS risk adjustment model coefficients to reflect an additional recalibration related to an update to the 2016 enrollee-level EDGE data set.[7]

• In the July 30, 2018 **Federal Register** (83 FR 36456), we adopted the 2017 benefit year HHS risk adjustment methodology as established in the final rules issued in the March 23, 2012 (77 FR 17220 through 17252) and March 8, 2016 (81 FR 12204 through 12352) editions of the **Federal Register**. The final rule set forth an additional explanation of the rationale supporting the use of Statewide average premium in the State payment transfer formula for the 2017 benefit year, including the reasons why the program is operated by HHS in a budget-neutral manner. The final rule also permitted HHS to resume 2017 benefit year HHS risk adjustment payments and charges. HHS also provided guidance as to the operation of the HHS-operated risk adjustment program for the 2017 benefit year in light of the publication of the final rule.

• In the December 10, 2018 **Federal Register** (83 FR 63419), we adopted the 2018 benefit year HHS risk adjustment methodology as established in the final rules issued in the March 23, 2012 (77 FR 17219) and the December 22, 2016 (81 FR 94058) editions of the **Federal Register**. In the rule, we set forth an additional explanation of the rationale supporting the use of Statewide average premium in the State payment transfer formula for the 2018 benefit year, including the reasons why the program is operated by HHS in a budget-neutral manner.

• In the April 25, 2019 **Federal Register** (84 FR 17454) (2020 Payment Notice), we finalized the benefit and payment parameters for the 2020 benefit year, as well as the policies related to making the enrollee-level EDGE data available as a limited data set for research purposes and expanding the HHS uses of the enrollee-level EDGE data, approval of the request from Alabama to reduce HHS risk adjustment transfers by 50 percent in the small group market for the 2020 benefit year, and updates to HHS–RADV program requirements.

• On May 12, 2020, consistent with § 153.320(b)(1)(i), we issued the 2021 Benefit Year Final HHS Risk Adjustment Model Coefficients on the CCIIO website.[8]

• In the May 14, 2020 **Federal Register** (85 FR 29164) (2021 Payment Notice), we finalized the benefit and payment parameters for the 2021 benefit year, as well as adopted updates to the HHS risk adjustment models' hierarchical condition categories (HCCs) to transition to the 10th revision of the International Classification of Diseases (ICD–10) codes, approved the request from Alabama to reduce HHS risk adjustment transfers by 50 percent in the small group market for the 2021 benefit year, and modified the outlier identification process under the HHS–RADV program.

• In the December 1, 2020 **Federal Register** (85 FR 76979) (Amendments to the HHS-Operated Risk Adjustment Data Validation Under the Patient Protection and Affordable Care Act's HHS-Operated Risk Adjustment Program (2020 HHS–RADV Amendments Rule)), we adopted the creation and application of Super HCCs in the sorting step that assigns HCCs to failure rate groups, finalized a sliding scale adjustment in HHS–RADV error rate calculation, and added a constraint for negative error rate outliers with a negative error rate. We also established a transition from the prospective application of HHS–RADV adjustments to apply HHS–RADV results to risk scores from the same benefit year as that being audited.

• In the May 5, 2021 **Federal Register** (86 FR 24140) (part 2 of the 2022 Payment Notice), we finalized a subset of proposals from the December 4, 2020 **Federal Register** (85 FR 78572) (the 2022 Payment Notice proposed rule), including policy and regulatory revisions related to the HHS-operated risk adjustment program, finalization of the benefit and payment parameters for the 2022 benefit year, and approval of the request from Alabama to reduce HHS risk adjustment transfers by 50 percent in the individual and small group markets for the 2022 benefit year. In addition, this final rule established a revised schedule of collections for HHS–RADV and updated the provisions regulating second validation audit (SVA) and initial validation audit (IVA) entities.

• On July 19, 2021, consistent with § 153.320(b)(1)(i), we released Updated 2022 Benefit Year Final HHS Risk Adjustment Model Coefficients on the CCIIO website, announcing some minor revisions to the 2022 benefit year final HHS risk adjustment adult model coefficients.[9]

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

[7] CMS. (2018 July, 27). *Updated 2019 Benefit Year Final HHS Risk Adjustment Model Coefficients. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Updtd-Final-HHS-RA-Model-Coefficients.pdf.*

[8] CMS. (2020, May 12). Final 2021 Benefit Year Final HHS Risk Adjustment Model Coefficients. *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2021-Benefit-Year-Final-HHS-Risk-Adjustment-Model-Coefficients.pdf.*

[9] CMS. (2021, July 19). 2022 Benefit Year Final HHS Risk Adjustment Model Coefficients. *https://www.cms.gov/files/document/updated-2022-benefit-year-final-hhs-risk-adjustment-model-coefficients-clean-version-508.pdf.*

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

- In the April 27, 2023 **Federal Register** (88 FR 25740) (2024 Payment Notice), we finalized the benefit and payment parameters for the 2024 benefit year, amended the EDGE discrepancy materiality threshold and data collection requirements, and reduced the risk adjustment user fee. For the 2024 benefit year, we approved 50 percent reductions to HHS risk adjustment transfers for Alabama's individual and small group markets and repealed prior participant States' ability to request reductions of their risk adjustment transfers for the 2025 benefit year and beyond. We finalized refinements to HHS–RADV program requirements, such as shortening the window to confirm SVA findings or file a discrepancy report, changing the HHS–RADV materiality threshold for random and targeted sampling, and no longer exempting exiting issuers from adjustments to risk scores and HHS risk adjustment transfers when they are negative error rate outliers. We announced the discontinuance of the Lifelong Permanent Condition List and Non-EDGE Claims in HHS–RADV beginning with the 2022 benefit year.
- In the April 15, 2024 **Federal Register** (89 FR 26218) (2025 Payment Notice), we finalized the benefit and payment parameters for the 2025 benefit year, including the 2025 risk adjustment models and updated the adjustment factors for the receipt of CSRs for the AI/AN subpopulation who are enrolled in zero and limited cost-sharing plans to improve prediction in the HHS risk adjustment models. In addition, we finalized that in certain cases, we may require a corrective action plan (CAP) to address an observation identified in an HHS risk adjustment program audit.
- In the January 15, 2025 **Federal Register** (90 FR 4424) (2026 Payment Notice), we finalized the benefit and payment parameters for the 2026 benefit year, including the 2026 risk adjustment models and updated the adjustment factors, phased out the market pricing adjustment to the plan liability associated with Hepatitis C drugs, and incorporated of pre-exposure prophylaxis (PrEP) as an Affiliated Cost Factor (ACF) starting with the 2026 benefit year. Beginning with the 2025 benefit year, we excluded enrollees without HCCs from the IVA sample, removed the Finite Population Correction (FPC) from the IVA sampling methodology, and replaced the source of the Neyman allocation data used for HHS–RADV sampling with the most recent 3 consecutive years of HHS–RADV data. Beginning with the 2024 benefit year, we modified the SVA pairwise means test and increased the initial SVA subsample size. At § 156.1220(a), we established a new materiality threshold for HHS–RADV appeals.

2. Program Integrity

We have finalized program integrity standards related to the Exchanges and premium stabilization programs in two rules: the ''first Program Integrity Rule'' issued in the August 30, 2013 **Federal Register** (78 FR 54069), and the ''second Program Integrity Rule'' issued in the October 30, 2013 **Federal Register** (78 FR 65045). We also refer readers to the 2019 Patient Protection and Affordable Care Act; Exchange Program Integrity final rule (2019 Program Integrity Rule) issued in the December 27, 2019 **Federal Register** (84 FR 71674), as well as the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability final rule (2025 Marketplace Integrity and Affordability final rule) issued in the June 25, 2025 **Federal Register** (90 FR 27074).

In the May 6, 2022 **Federal Register** (87 FR 27208) (2023 Payment Notice), we finalized policies to address certain agent, broker, and web-broker practices and conduct. In the April 27, 2023 **Federal Register** (88 FR 25740) (2024 Payment Notice), we implemented the improper payment pre-testing and assessment (IPPTA) requirements for State Exchanges to ensure adherence to the Payment Integrity Information Act of 2019. In addition, we finalized allowing additional time for HHS to review evidence submitted by agents and brokers to rebut allegations pertaining to Exchange Agreement suspensions or terminations. We also introduced consent and eligibility application documentation requirements for agents, brokers, and web-brokers that assist Exchange consumers in FFE and SBE–FP States.

In the 2025 Payment Notice, issued in the April 15, 2024 **Federal Register** (89 FR 26218), we finalized that the CMS Administrator is the entity responsible for handling requests by agents, brokers, and web-brokers for reconsideration of HHS' decision to terminate their Exchange agreement(s) for cause. We also finalized changes to §§ 155.220 and 155.221 to apply certain standards to web-brokers and Direct Enrollment (DE) entities assisting consumers and applicants across all Exchanges. In the January 15, 2025 **Federal Register** (90 FR 4424) (2026 Payment Notice), we addressed our authority to investigate and undertake compliance reviews and enforcement actions occurring at the insurance agency level to hold lead agents of insurance agencies accountable. We also finalized changes to § 155.220(k)(3) to reflect our authority to suspend an agent's or broker's ability to transact information with the Exchange in certain circumstances until the incident, breach, or noncompliance are remedied or sufficiently mitigated to HHS' satisfaction.

3. Market Rules

In the February 27, 2013 **Federal Register** (78 FR 13406), we issued the health insurance market rules, including provisions related to the single risk pool. We clarified that issuers may make a plan-specific adjustment to the market-wide index rate that accounts for differences between catastrophic and non-catastrophic plans in expected average enrollee gross spending and expected average risk adjustment payment transfers. This plan-specific adjustment would be uniform across all of an issuer's catastrophic plans (that is, risk across all catastrophic plans must be pooled).

In that rule we also codified that a health plan is a catastrophic plan if it: (1) meets all applicable requirements for health insurance coverage in the individual market; (2) does not offer coverage at the bronze, silver, gold, or platinum levels of coverage (3) does not provide coverage of essential health benefits until the enrolled individual reaches the annual limitation in cost sharing; and (4) covers at least three primary care visits per year before reaching the deductible. A catastrophic plan may not impose any cost-sharing requirements for preventive services identified in section 2713 of the PHS Act. We also codified the statutory

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

eligibility criteria identified in section 1302(e)(2) of the Affordable Care Act.

We amended requirements related to index rates under the single risk pool provision in a final rule issued in the July 2, 2013 **Federal Register** (78 FR 39870). In the October 30, 2013 **Federal Register** (78 FR 65046), we clarified when issuers may establish and update premium rates. In the March 8, 2016 **Federal Register** (81 FR 12203), we clarified single risk pool provisions related to student health insurance coverage. We finalized minor adjustments to the single risk pool regulations in the 2018 Payment Notice, issued in the December 22, 2016 **Federal Register** (81 FR 94058).

4. Rate Review

In the May 23, 2011 **Federal Register** (76 FR 29963) (Rate Review Rule), we implemented a rate review program. We amended the provisions of the Rate Review Rule in final rules published in the September 6, 2011 **Federal Register** (76 FR 54969), the February 27, 2013 **Federal Register** (78 FR 13405), the May 27, 2014 **Federal Register** (79 FR 30239), the February 27, 2015 **Federal Register** (80 FR 10749), the March 8, 2016 **Federal Register** (81 FR 12203) and the December 22, 2016 **Federal Register** (81 FR 94058).

5. Exchanges

We requested comment relating to Exchanges in the August 3, 2010 **Federal Register** (75 FR 45584). We issued initial guidance to States on Exchanges on November 18, 2010. In the March 27, 2012 **Federal Register** (77 FR 18310) (Exchange Establishment Rule), we implemented the Affordable Insurance Exchanges (Exchanges), consistent with title I of the Affordable Care Act, to provide competitive marketplaces for individuals and small employers to directly compare available private health insurance coverage options based on price, quality, and other factors. This included implementation of components of the Exchanges and standards for eligibility for Exchanges, as well as network adequacy and essential community provider (ECP) certification standards.

In the 2014 Payment Notice and the Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 interim final rule, issued in the March 11, 2013 **Federal Register** (78 FR 15541), we set forth standards related to Exchange user fees. We established an adjustment to the FFE user fee in the Coverage of Certain Preventive Services under the Affordable Care Act final rule, issued in the July 2, 2013 **Federal Register** (78 FR 39869) (Preventive Services Rule).

In the 2016 Payment Notice, we also set forth the ECP certification standard at § 156.235, with revisions in the 2017 Payment Notice in the March 8, 2016 **Federal Register** (81 FR 12203) and the 2018 Payment Notice in the December 22, 2016 **Federal Register** (81 FR 94058).

In the 2018 Payment Notice, issued in the December 22, 2016 **Federal Register** (81 FR 94058), we set forth the standards for the request for reconsideration of denial of QHP certification specific to the FFEs at § 155.1090.

In an interim final rule, issued in the May 11, 2016 **Federal Register** (81 FR 29146), we made amendments to the parameters of certain SEPs (2016 Interim Final Rule).

We finalized these in the 2018 Payment Notice, issued in the December 22, 2016 **Federal Register** (81 FR 94058).

In the Market Stabilization final rule, issued in the April 18, 2017 **Federal Register** (82 FR 18346), we amended standards relating to SEPs and QHP certification. In the 2019 Payment Notice, issued in the April 17, 2018 **Federal Register** (83 FR 16930), we modified parameters around certain SEPs. In the April 25, 2019 **Federal Register** (84 FR 17454), the 2020 Payment Notice established a new SEP for certain individuals who become newly eligible for APTC.

In the May 14, 2020 **Federal Register** (85 FR 29164) (2021 Payment Notice), we finalized revisions to the parameters of SEPs and the quality rating information display standards for State Exchanges and amended the periodic data matching requirements.

In the January 19, 2021 **Federal Register** (86 FR 6138) (part 1 of the 2022 Payment Notice), we finalized only a subset of the proposals in the 2022 Payment Notice proposed rule. In the May 5, 2021 **Federal Register** (86 FR 24140), we issued part 2 of the 2022 Payment Notice. In the September 27, 2021 **Federal Register** (86 FR 53412) (part 3 of the 2022 Payment Notice), in conjunction with the Department of the Treasury, we finalized amendments to certain policies in part 1 of the 2022 Payment Notice.

In the May 6, 2022 **Federal Register** (87 FR 27208), we finalized changes to maintain the user fee rate for issuers offering plans through the FFEs and maintain the user fee rate for issuers offering plans through the SBE–FPs for the 2023 benefit year. We also finalized various policies to address certain agent, broker, and web-broker practices and conduct. We also finalized updates to the requirement that all Exchanges conduct SEP verifications.

In the 2024 Payment Notice, issued in the April 27, 2023 **Federal Register** (88 FR 25740), we revised Exchange Blueprint approval timelines, lowered the user fee rate for QHPs in the FFEs and SBE–FPs, and amended re-enrollment hierarchies for enrollees. We finalized a requirement that all plans seeking certification on the Exchanges utilize a provider network. We also finalized policies to update FFE and SBE–FP standardized plan options; reduce the risk of plan choice overload on the FFEs and SBE–FPs by limiting the number of non-standardized plan options that issuers may offer through Exchanges on the Federal platform; and ensure correct QHP information. In addition, we amended coverage effective date rules, lengthened the SEP from 60 to 90 days for those who lose Medicaid coverage, and prohibited QHPs on FFEs and SBE–FPs from terminating coverage mid-year for dependent children who reach the applicable maximum age. We also finalized policies on verifying consumer income and permitting door-to-door assisters to solicit consumers. We finalized provider network and ECP policies for QHPs.

In the 2025 Payment Notice, issued in the April 15, 2024 **Federal Register** (89 FR 26218), we required a State seeking to operate a State Exchange to first operate an SBE–FP for at least one plan year, revised Exchange Blueprint requirements for States transitioning to a State Exchange, established additional minimum standards for Exchange call center operations, and required an Exchange to operate a centralized eligibility and enrollment platform on its website. We required State Exchanges and State Medicaid agencies to remit payment to HHS for their use of certain income data, amended re-enrollment hierarchies for enrollees enrolled in catastrophic coverage, revised the parameters around a State Exchange adopting an alternative open enrollment period, and extended the availability of a SEP for APTC-eligible qualified individuals with a projected annual household income no greater than 150 percent of the FPL. We finalized provider network adequacy policies applicable to such Exchanges for Plan Year (PY) 2026 and subsequent plan years. We finalized the policy to maintain FFE and SBE–FP standardized plan option metal levels from the 2024 Payment Notice and finalized an exceptions process to the limitation on non-standardized plan options in FFEs and SBE–FPs. We also finalized the

requirement for Exchanges to provide notification to enrollees or their tax filers who have failed to file their Federal income taxes and reconcile APTC for 1 tax year.

In the 2026 Payment Notice, published in the January 15, 2025 **Federal Register** (90 FR 4424), we codified a timeliness standard for State Exchanges to review and resolve enrollment data inaccuracies at § 155.400(d)(1), finalized at § 155.1000 that an Exchange may deny certification to any plan that does not meet the criteria at § 155.1000(c), and revised the standards at § 155.1090 for an issuer to request a reconsideration of a denial of certification specific to the FFEs. We also finalized publicly releasing certain data and information that State Exchanges submit to HHS, affirmed that CSR loading practices permitted by State regulators are permissible under Federal law to the extent that they are actuarially justified and the issuer does not receive reimbursement for such CSR, and finalized that we will only release a single, final version of the AV Calculator. We also updated the standardized plan option designs for PY 2026 to ensure these plans continue to have AVs within the permissible *de minimis range* for each metal level, amended § 156.201 to require issuers to meaningfully differentiate standardized plan options from one another, and finalized that HHS would conduct ECP certification reviews in States performing plan management functions beginning PY 2026. We also finalized updates affecting the exchanges in the 2025 Marketplace Integrity and Affordability final rule issued in the June 25, 2025 **Federal Register** (90 FR 27074).

6. Essential Health Benefits

We established requirements relating to EHB in the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule, which was issued in the February 25, 2013 **Federal Register** (78 FR 12834) (EHB Rule). We established at § 156.135(a) that AV is generally to be calculated using the AV Calculator developed and made available by HHS for a given benefit year. In the 2015 Payment Notice (79 FR 13743), we established at § 156.135(g) provisions for updating the AV Calculator in future plan years. In the 2017 Payment Notice (81 FR 12349), we amended the provisions at § 156.135(g) to allow for additional flexibility in our approach and options for updating of the AV Calculator.

In the 2025 Payment Notice, issued in the April 15, 2024 **Federal Register** (89 FR 26218), we revised § 155.170(a) to codify that benefits covered in a State's EHB-benchmark plan are not considered in addition to EHB, even if they had been required by State action taking place after December 31, 2011, other than for purposes of compliance with Federal requirements. We finalized three revisions to the standards for State selection of EHB-benchmark plans for benefit years beginning on or after January 1, 2026: revising the typicality standard at § 156.111 for States to demonstrate that their new EHB-benchmark plan provides a scope of benefits that is equal to that of a typical employer plan in the State; revising requirements such that States do not need to submit a formulary drug list as part of their application unless they are changing their prescription drug EHB; and consolidating options for States to change their EHB-benchmark plans. At § 156.115(d), we removed the prohibition on issuers from including routine non-pediatric dental services as an EHB beginning with PY 2027.

In the 2026 Payment Notice, published in the January 15, 2025 **Federal Register** (90 FR 4424), we revised § 156.80(d)(2)(i) to require the actuarially justified plan-specific factors by which an issuer may vary premium rates for a particular plan from its market-wide index rate include the AV and cost-sharing design of the plan.

7. Quality Improvement Strategy

We issued regulations in § 155.200(d) to direct Exchanges to evaluate quality improvement strategies, and § 156.200(b) to direct QHP issuers to implement and report on a quality improvement strategy or strategies consistent with section 1311(g) standards as QHP certification criteria for participation in an Exchange. In the 2016 Payment Notice, issued in the February 27, 2015 **Federal Register** (80 FR 10749), we finalized regulations at § 156.1130 to establish standards and the associated timeframe for QHP issuers to submit the necessary information to implement quality improvement strategy standards for QHPs offered through an Exchange. In the 2026 Payment Notice, published in the January 15, 2025 **Federal Register** (90 FR 4424), we finalized sharing summary-level QIS information publicly on an annual basis beginning on January 1, 2026, with information QHP issuers submit during the PY 2025 QHP Application Period.

8. Medical Loss Ratio (MLR)

We published a request for comment on section 2718 of the PHS Act in the April 14, 2010 **Federal Register** (75 FR 19297), and published an interim final rule with a 60-day comment period relating to the MLR program on December 1, 2010 (75 FR 74863). A final rule with a 30-day comment period was published in the December 7, 2011 **Federal Register** (76 FR 76573). An interim final rule with a 60-day comment period was published in the December 7, 2011 **Federal Register** (76 FR 76595). A final rule was published in the May 16, 2012 **Federal Register** (77 FR 28790). The MLR program requirements were amended in final rules published in the March 11, 2014 **Federal Register** (79 FR 13743), the May 27, 2014 **Federal Register** (79 FR 30339), the February 27, 2015 **Federal Register** (80 FR 10749), the March 8, 2016 **Federal Register** (81 FR 12203), the December 22, 2016 **Federal Register** (81 FR 94183), the April 17, 2018 **Federal Register** (83 FR 16930), the May 14, 2020 **Federal Register** (85 FR 29164), the May 5, 2021 **Federal Register** (86 FR 24140), and the May 6, 2022 **Federal Register** (87 FR 27208), and an interim final rule that was published in the September 2, 2020 **Federal Register** (85 FR 54820).

B. Summary of Major Provisions

The regulations outlined in this proposed rule would be codified in 42 CFR part 600, and 45 CFR parts 150, 153, 155, 156 and 158.

1. 42 CFR Part 600

We propose to make updates in 42 CFR 600.5 to align BHP regulations with section 71301 of the WFTC legislation. Section 71301 of the WFTC legislation amended section 36B of the Code to provide that a PTC is allowed for the QHP coverage of a noncitizen lawfully present only if he or she is an ''eligible alien'', effective for plan years beginning on or after January 1, 2027. Because Federal BHP payments to States are based in part on the amount of PTC an individual enrolled in the BHP is eligible for and would have qualified for had he or she been enrolled in a QHP through an Exchange, only lawfully present noncitizens who are considered to be ''eligible aliens'' will generate Federal BHP payments to the State. We propose to add a new definition of ''eligible noncitizen at 42 CFR 600.5, cross-referencing 45 CFR 155.20.

2. 45 CFR Part 153

In accordance with the OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2026, the HHS-operated risk adjustment program is subject to the fiscal year 2026

sequestration.[11] Therefore, the HHS-operated risk adjustment program will sequester payments made from fiscal year 2026 resources (that is, funds collected during the 2026 fiscal year) at a rate of 5.7 percent.

We propose to recalibrate the 2027 benefit year HHS risk adjustment models using the 2021, 2022, and 2023 benefit year enrollee-level EDGE data and solicit comment on whether we should retain separate risk adjustment transfer calculations under the State payment transfer formula for individual catastrophic plans and individual non-catastrophic plans. We also propose a risk adjustment user fee rate for the 2027 benefit year of $0.20 per member per month (PMPM).

We propose to modify one intermediate step of the HHS–RADV error estimation methodology starting with 2025 benefit year HHS–RADV to add an additional scaling factor to appropriately estimate the proportion of the issuer's total plan liability risk score (PLRS) that is HCC-related after the removal of no HCC enrollees from the IVA sample beginning with 2025 benefit year HHS–RADV, as finalized in the 2026 Payment Notice (90 FR 4424).

3. 45 CFR Part 154

We propose to require issuers that intend to load rates to account for unpaid CSRs for the applicable rating year to submit certain information related to CSR loading in their Unified Rate Review Templates (URRTs) and the Actuarial Memoranda for each filing year in which CSRs are not funded beginning with PY 2027 rate filings.[12]

4. 45 CFR Part 155

We propose to remove the requirement at § 155.105(b)(4) that a State seeking to operate a State Exchange must first operate an SBE–FP for at least one plan year.

We propose to amend § 155.106(a)(2) to rescind the requirement that as part of a State's activities for its establishment of a State Exchange, the State must provide supporting documentation demonstrating progress toward meeting or implementing State Exchange Blueprint requirements, given preexisting processes per the State Blueprint Application [13] for CMS to collect supporting documentation from a State as part of a State Exchange implementation efforts.

We propose to amend § 155.170(a) to provide that beginning with PY 2027, a State-required benefit would be considered ''in addition to EHB'' (and thus not EHB) if it is: required by a State action taking place after December 31, 2011; applicable to the small group and/or individual markets; specific to required care, treatment, or services; and not required by State action for purposes of compliance with Federal requirements. Under this proposal, such State-required benefits would be considered in addition to EHB regardless of whether the required benefits are embedded in the State's EHB-benchmark plan. We also propose revisions to the regulatory text at §§ 155.170(a)(2) and 156.115(a) to align with this proposal.

We propose amendments to § 155.205(b) to amend the requirement that a State Exchange operate a centralized eligibility and enrollment consumer interface on the Exchange's website for an individual to submit a single streamlined eligibility application and subsequently select a QHP following a determination of eligibility. Under this proposal, a State Exchange could choose to operate a centralized eligibility and enrollment consumer interface on the Exchange's website through which individuals may submit an application and enroll in a QHP, or a State Exchange could provide such functionality exclusively through one or more State Exchange-approved consumer websites operated by a web-broker . . .

We propose at § 155.221(k) that State Exchanges may elect a new EDE option (SBE–EDE option), in which a State Exchange could seek HHS approval to allow web-brokers to operate enrollment websites as the exclusive pathway through which consumers can apply, receive an eligibility determination from the Exchange, and purchase an individual market QHP offered through the Exchange with APTC and CSRs, if otherwise eligible.

We propose changes to the existing regulatory authority under § 155.220(j)(2)(ii) and (iii) to require agents, brokers, and web-brokers to use an HHS-approved and created consumer consent form to meet the eligibility application review requirements and consumer consent documentation requirements.[14] Our proposal would eliminate the current flexibility, which allows agents, brokers, and web-brokers to use their own standards and templates for documentation requirements, and instead sets a universal standard that requires agents, brokers, and web-brokers to use the HHS-approved and created consumer consent form.[15] We also propose to revise § 155.220(j)(2)(ii) and (j)(2)(iii) to clarify what constitutes a consumer ''taking an action'' for eligibility application review and confirmation and providing consumer consent.

We propose several new provisions at § 155.220(j)(3) to establish more robust standards of conduct related to the marketing practices of agents, brokers, and web-brokers which would include examples of prohibited marketing practices. Furthermore, we propose to require agents, brokers, and web-brokers to provide HHS marketing documentation in response to monitoring, audit, and enforcement activities. We also propose to notify agents, brokers, and web-brokers that they may be held responsible for marketing content created, written, released, or otherwise produced by an entity on their behalf.

We propose to discontinue the vendor program, which allows for certain training and information verification functions to be provided by HHS-approved vendors. To accomplish this, we propose removing § 155.222.

We propose to make updates in § 155.20, § 155.305(f)(1), and § 155.320 to align Exchange regulations with section 71301 of the WFTC legislation. Section 71301 of the WFTC legislation amended section 36B of the Code to provide that PTC is allowed for the QHP coverage of a lawfully present noncitizen only if such noncitizen is an ''eligible alien.'' It also makes conforming amendments to section 1411 of the Affordable Care Act requiring Exchanges to verify applicants' ''eligible alien'' status effective for taxable years beginning after December 31, 2026. We propose to add a new definition in § 155.20, to update our APTC eligibility regulations at § 155.305(f)(1), and to add to our verification regulations in § 155.320 to align Exchange eligibility and verification rules with section 71301 of the WFTC legislation. This proposal would also impact Federal payments to States effective January 1, 2027 for individuals enrolled in the BHP who are lawfully present noncitizens but are not ''eligible aliens,'' as Federal payments to States for these individuals are also no longer allowed.

[11] OMB. (2025). *OMB Report to the Congress on the BBEDCA 251A Sequestration for Fiscal Year 2026. https://www.whitehouse.gov/wp-content/uploads/2025/04/OMB-Report-to-the-Congress-on-the-BBEDCA-251A-Sequestration-for-Fiscal-Year-2026.pdf.*

[12] CMS 10379/OMB Control Number: 0938–1141.

[13] CMS–10416/OMB control number: 0938–1172.

[14] CMS–10840/OMB Control Number: 0938–1438.

[15] For the current HHS-approved and created form, see CMS Model Consent Form for Marketplace Agents, Brokers, Web-brokers, and Agencies. Available at *https://www.cms.gov/files/document/cms-model-consent-form-marketplace-agents-and-brokers.pdf.*

To align Exchange regulations with section 71302 of the WFTC legislation, we propose to remove § 155.305(f)(2) and make conforming updates to § 155.320(c)(3)(iii)(A) and 155.420(d)(13). Section 71302 of the WFTC legislation amended section 36B(c) of the Code to provide that PTC is no longer allowed for noncitizens lawfully present in the United States who were ineligible for Medicaid due to their immigration status and have household income below 100 percent of the FPL. Removing § 155.305(f)(2) and updating § 155.320(c)(3)(iii)(A) would align Exchange APTC eligibility and verification rules with section 71302 of the WFTC legislation. This proposal would also impact Federal payments to States for individuals enrolled in the BHP who are ineligible for Medicaid due to their immigration status and with household income below 100 percent of the FPL, for whom Federal payments to States are also no longer allowed.

We propose to revise the failure to file and reconcile process at § 155.305(f)(4) such that Exchanges on the Federal platform would conduct the 1-year policy beginning in PY 2027. State Exchanges would have the option to conduct either the 1-year or 2-year policy in PY 2027, but would be required to conduct the 1-year policy beginning in PY 2028). Under the 1-year policy, if finalized, an Exchange must determine a tax filer ineligible for APTC if: (1) HHS notifies the Exchange that the tax filer (or their spouse if the tax filer is a married couple) received APTC for a prior year for which tax data will be utilized for verification of income, and (2) the tax filer or tax filer's spouse did not comply with the requirement to file a Federal income tax return and reconcile APTC for that year. This proposal would align with the statutory requirement in section 71303 of the WFTC legislation that effectively requires Exchanges to follow the 1-year policy as a requirement for a month to be a coverage month under section 36B of the Code as of PY 2028. We are also proposing to remove the notice requirement at § 155.305(f)(4)(ii) for PY 2027 to conform with the notice policy under the PY 2026 policy.

We seek comment on considerations for future policy development and implementation under section 71303 of the WFTC legislation, which imposes new requirements on Exchanges related to eligibility verification. Specifically, we seek comment on: operational considerations for interested parties; effective rollout and communications; required timelines for interested parties to comply with the law; anticipated complexity, costs, burden, enrollment impacts; and any State-specific considerations.

We propose to revise § 155.320(c) such that all Exchanges are required to continue conducting the income verifications changes introduced in the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability final rule (90 FR 27074) (the 2025 Marketplace Integrity and Affordability final rule) in PY 2027 and beyond. Specifically, we propose updating § 155.320(c)(3)(iii) and § 155.320 (c)(3)(vi)(C)(2) to extend the requirement indefinitely to create income data matching issues (DMIs) when trusted data sources indicate that projected consumer household income is under 100 percent of the FPL. Additionally, we propose removing § 155.320(c)(5), which outlines the requirement to accept the annual household income attestation when no tax data is returned for a household.

We seek comment on whether we should regulate the option for issuers to implement the fixed-dollar and/or gross percentage-based premium payment thresholds in § 155.400(g) for PY 2027 and beyond. Currently, issuers are only able to implement a net premium percentage-based premium threshold for PY 2026, and effective January 1, 2027, issuers will be able to implement the fixed-dollar and/or either net or gross premium percentage-based thresholds, which was finalized in the 2025 Marketplace Integrity and Affordability final rule.

We propose to remove § 155.420(d)(16) such that Exchanges would continue to be prohibited from offering the 150 percent FPL SEP in PY 2027 and beyond, in alignment with section 71304 of the WFTC legislation. We propose to make conforming amendments at §§ 155.420(a)(4)(ii)(D), 155.420(b)(2)(vii), and 155.420(a)(4)(iii).

We propose to revise § 155.420(g) to remove the restriction for Exchanges on the Federal platform to only conduct Special Enrollment Period Verification (SEPV) for Loss of Minimum Essential Coverage (MEC). We also propose to require Exchanges on the Federal platform to conduct SEPV for at least 75 percent of new enrollments. These proposals were finalized in the 2025 Marketplace Affordability and Integrity rule but were stayed in *City of Columbus et. al.* v. *Kennedy et. al.*[16] We are therefore reproposing these provisions.

We propose to amend § 155.605 to codify and expand hardship exemption eligibility. Specifically, this proposal would allow individuals who are ineligible for APTC or CSRs due to projected household income below 100 percent or above 250 percent of the FPL to qualify for a hardship exemption under § 155.605(d)(1)(iii). This change would allow individuals aged 30 and older who receive this hardship exemption to enroll in catastrophic coverage, if otherwise eligible.

We propose, for plan years beginning on or after January 1, 2027, to amend § 155.1050(a)(2) to remove the requirements at § 155.1050(a)(2)(i) and (ii) that State Exchanges and SBE–FPs establish and impose quantitative time and distance network adequacy standards that are at least as stringent as standards for QHPs participating on the FFEs and to no longer require State Exchanges and SBE–FPs to conduct quantitative network adequacy reviews to evaluate a plan's compliance with certain network adequacy standards under § 156.230 prior to certifying any plan as a QHP. Instead, we propose to restore the requirement at § 155.1050(a)(2) that State Exchanges and SBE–FPs ensure that each QHP provides sufficient access to providers in a manner that meets applicable standards consistent with § 156.230(a)(1)(ii) and (a)(1)(iii) for network plans, or proposed § 156.236(a) for non-network plans, as applicable. We also propose at new § 155.1050(d) to defer provider access reviews of QHP issuers, with or without a provider network, applying for certification as a QHP to be offered through the FFE to FFE States that elect to conduct such reviews, should the FFE State demonstrate sufficient authority and the technical capacity to conduct such reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program under proposed § 155.1050(d)(2) through (d)(4).

We propose to implement new requirements for an Effective Essential Community Provider Review Program by adding § 155.1051. Under this proposal, FFE States may elect to conduct their own ECP certification reviews of issuers with or without a provider network that are applying for certification to be offered as a QHP through an FFE, including in States performing plan management. In order to conduct their own reviews, we propose that FFE States would be required to demonstrate that they have sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective Essential Community Provider Review Program under proposed § 155.1051.

[16] *City of Columbus* v. *Kennedy,* 796 F. Supp. 3d 123, 159–60 (D. Md. 2025).

We propose to amend § 155.1200(d) and add new paragraph (e) to permit State Exchanges to satisfy certain requirements of the independent external programmatic audit, as outlined in paragraph (d), by completing the SEIPM process that would be established at 45 CFR 155, subpart Q.

We propose to add new subpart Q (§§ 155.1600 through 1650) to establish the SEIPM program. The Payment Integrity Information Act of 2019 (PIIA) requires Federal agencies to annually review, measure, and report on the programs they administer that have been determined to be susceptible to significant improper payments. To satisfy the requirements of PIIA, we are proposing to measure improper payments of APTC that are administered by State Exchanges and to annually report statistically valid improper payment estimates in the HHS Agency Financial Report.

5. 45 CFR part 156

We propose the 2027 benefit year FFE and SBE–FP user fee rates of 2.5 percent and 2.0 percent of total monthly premiums, respectively.

We are pausing review of State applications to select EHB-benchmark plans in accordance with § 156.111. We are reviewing section 1302 of the Affordable Care Act and are considering future rulemaking to revise § 156.111 and EHB standards more broadly.

We propose to revise § 156.115(d) to prohibit issuers from including routine non-pediatric dental services as an EHB.

We propose to modify the requirements for catastrophic plans in § 156.155 to specify that a catastrophic plan has a plan term of either 1 year, or of multiple consecutive years not to exceed 10 years. We propose that catastrophic plans with terms of at least 2 years may utilize value-based insurance designs to offer benefits for preventive services pursuant to section 2713(c) of the PHS Act, without the beneficiary having to first satisfy their deductible or annual cost-sharing limitation. We also propose to amend § 156.130 to specify that, in the case of a catastrophic plan with a consecutive multi-year term, the annual limitation on cost sharing for the initial plan year of the contract may apply on an annual basis, or over the life of the contract. In the latter case, the limitation applicable to the specific plan year under each plan year of the coverage would be divided by 12 to determine the monthly limit on cost sharing under the plan. Further, we propose to amend § 156.80 to permit issuers of multi-year catastrophic plans to make a plan-level adjustment to the index rate that reflects the length of the entire term.

To address an issue that has arisen in the implementation of section 1302(c) through (e) of the Affordable Care Act, we propose changes to the permissible cost-sharing parameters for individual market bronze plans through new proposed § 156.136 and to the required cost-sharing parameters for catastrophic plans through revisions to § 156.155(a)(3).

We propose to remove the following from our regulations effective beginning in PY 2027: the definition of ''standardized options'' at § 155.20; all requirements pertaining to standardized plan options at § 156.201; the differential display of standardized plan options on *HealthCare.gov* at § 155.205(b)(1); the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv); the annual design and publication of these standardized plan options in the applicable Payment Notice for each plan year; and non-standardized plan option limits and exceptions at § 156.202.

We propose to revise the network adequacy and ECP standards at §§ 156.230 and 156.235 to make clear that these sections contain the provider access standards for all individual market QHPs and stand-alone dental plans (SADPs) and all Small Business Health Options Program (SHOP) QHPs across all QHP issuers that use a network of providers. We also propose to revise these sections to remove the requirement that all QHPs must use a network of providers.

Additionally, we propose to revise § 156.230 to provide that HHS would continue to conduct network adequacy reviews using standards described at § 156.230 for QHP issuers that use a provider network in FFE States that do not elect to conduct such reviews, or in FFE States that HHS has determined do not satisfy the criteria to be considered to have an Effective Provider Access Review Program, as described at proposed § 155.1050(d). We also propose to add new § 156.236 to allow plans that do not use a network (non-network plans) to receive QHP certification by demonstrating that they ensure a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full, and reasonable and timely access to ECPs that accept the plan's benefit amount as payment in full. Proposed § 156.236 would set forth provider access and ECP standards for assessing whether non-network plans provide sufficient choice of providers.

For PY 2027 and subsequent plan years, we propose changes to the QHP certification requirements with respect to essential community providers (ECPs) included within a network plan issuer's provider network. First, we propose to reduce the minimum percentage requirement from 35 to 20 percent for both medical QHP and SADP issuers, such that issuers would be required to contract with at least 20 percent of available ECPs in each plan's service area to participate in the plan's network, and separately, at least 20 percent of available Federally Qualified Health Centers (FQHCs) and 20 percent of available family planning providers that qualify as ECPs in the plan's service area. Additionally, we propose to modify the narrative justification requirements at §§ 156.235(a)(3) and 156.235(b)(3) to be consistent with systems changes and existing QHP issuer ECP data submission requirements as part of ECP certification reviews.

We propose to modify § 156.480(c) to clarify HHS' authority to audit or conduct a compliance review of an issuer that offers a QHP through an Exchange for the purposes of administering and providing oversight of the APTC, CSR, and user fee programs. We also propose that HHS may conduct a compliance review to assess issuers' compliance with requirements related to these programs as needed or on an annual basis rather than only on an ad hoc basis.

We propose to amend § 156.805(b) to reiterate in § 156.805(b) that in determining the amount of CMPs, in addition to the factors HHS takes into account when determining a CMP amount listed in § 156.805(b)(1) through (3), HHS would identify the lawful purpose or purposes of the CMP. We also propose to amend the introductory text of § 150.317 to make corresponding edits with respect to the factors HHS considers when determining the amount of CMPs as enforcement remedies against issuers more broadly or other responsible entities, such as a non-Federal governmental plan sponsor that is subject to applicable PHS Act requirements. In addition, we propose to amend § 156.805(f) to reiterate that HHS has the authority to impose CMPs against issuers in a State Exchange or SBE–FP for an identified violation of any Exchange requirements applicable to issuers offering a QHP in an Exchange, when a State notifies HHS that it is not enforcing these requirements or HHS determines that a

State is failing to substantially enforce these requirements.

We propose to amend § 156.903 to provide the option for an administrative law judge (ALJ) to issue subpoenas, upon his or her own motion or at the request of a party, if reasonably necessary for the full presentation of a case and to add procedures governing the process for issuing subpoenas. We also propose to amend § 156.935 to ensure that the discovery provisions set forth therein do not apply to administrative appeals of proposed CMPs for violations identified through audits of the APTC, cost sharing reduction, or user fee programs conducted in accordance with § 156.480(c).

We propose to require QHP issuers to submit QISs addressing any two of the five topic areas listed in section 1311(g)(1) of the Affordable Care Act, without mandating which specific topics areas a QHP issuer would be required to address to meet the QIS statutory certification requirement, beginning with PY 2027.

We propose to amend § 156.1215(b) to provide that CMPs assessed against health coverage issuers and their affiliates under the same taxpayer identification (TIN) number would be subject to netting as part of HHS' integrated monthly payment and collection cycle. We also propose to amend § 156.1215(c) to provide that any amount owed to the Federal Government by an issuer and its affiliates for unpaid CMP amounts, after HHS nets amounts owed by the Federal Government, would be the basis for calculating the debt.

6. 45 CFR part 158

We solicit comment on the impact of the Federal MLR standard on individual market stability and whether HHS should use its authority under section 2718(b)(1)(A)(ii) of the PHS Act and § 158.301 to adjust the MLR standard in a State to promote individual market stability. We also solicit comment on whether and how to amend regulations allowing States to request an adjustment to the MLR standard in their individual market to reduce burden and encourage States to request adjustments as appropriate in their State markets.

III. Provisions of the Proposed Regulations

A. Part 150—CMS Enforcement in Group and Individual Insurance Markets

1. Factors CMS Uses To Determine the Amount of a Civil Money Penalty (CMP) (§ 150.317)

To align with the proposal discussed in section III.F.14 of this proposed rule, which would reiterate in § 156.805(b) what factors HHS considers when determining the amount of CMPs as enforcement remedies against QHP issuers in Exchanges, we propose a conforming amendment to § 150.317 introductory text to clarify that HHS, through CMS, will identify the lawful purpose or purposes of the penalty, and take into account the enumerated factors as appropriate for the circumstances. In proposing the conforming edits to § 150.317, we do not propose other changes to the legal bases and procedural processes for imposing CMPs.

We request comment on this proposal.

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

In subparts A, B, D, G, and H of part 153, we established standards for the administration of the risk adjustment program. The risk adjustment program is a permanent program created by section 1343 of the Affordable Care Act that transfers funds from issuers of risk adjustment covered plans that have lower-than-average risk enrollees to issuers of risk adjustment covered plans that have higher-than-average risk enrollees, which includes issuers with plans in the individual, small group, or merged markets, inside and outside the Exchanges. In accordance with § 153.310(a), a State that is approved or conditionally approved by the Secretary to operate an Exchange may establish a risk adjustment program or have HHS do so on the State's behalf.[17] HHS did not receive any requests from States to operate risk adjustment for the 2027 benefit year. Therefore, HHS will operate risk adjustment in every State and the District of Columbia for the 2027 benefit year.

1. Sequestration

In accordance with the OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2026, the HHS-operated risk adjustment program is subject to the fiscal year 2026 sequestration.[18] The Federal Government's 2026 fiscal year began on October 1, 2025. Therefore, the HHS-operated risk adjustment program is sequestered at a rate of 5.7 percent for payments made from fiscal year 2026 resources (that is, funds collected during the 2026 fiscal year).

HHS, in coordination with OMB, has determined that, under section 256(k)(6) of the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA),[19] as amended, and the underlying authority for the HHS-operated risk adjustment program, the funds that are sequestered in fiscal year 2026 from the HHS-operated risk adjustment program will become available for payment to issuers in fiscal year 2027 without further congressional action. If Congress does not enact deficit reduction provisions that replace the Joint Committee reductions, the program would be sequestered in future fiscal years, and any sequestered funding would become available in the fiscal year following that year in which the funds were sequestered.

Additionally, we note that the Infrastructure Investment and Jobs Act[20] amended section 251A(6) of the BBEDCA to extend the sequestration first mandated under the Budget Control Act of 2011 for all non-exempt direct spending programs, including the HHS-operated risk adjustment program, through fiscal year 2031 at a rate of 5.7 percent per fiscal year.[21]

2. HHS Risk Adjustment (§ 153.320)

The HHS risk adjustment models predict plan liability for an average enrollee based on that person's age, sex, and diagnoses (also referred to as hierarchical condition categories (HCCs)), producing a risk score. The State payment transfer formula[22] that is

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

[18] OMB. (2025). *OMB Report to the Congress on the BBEDCA 251A Sequestration for Fiscal Year 2026. https://www.whitehouse.gov/wp-content/uploads/2025/04/OMB-Report-to-the-Congress-on-the-BBEDCA-251A-Sequestration-for-Fiscal-Year-2026.pdf.*

[19] Public Law 99–177, 99 Stat. 1037 (1985).

[20] Public Law 117–58, section 90001(1), 135 Stat. 429, 1341 (2021), codified at 2 U.S.C. 901a(6)(B).

[21] Section 251A(6)(B) of the Balanced Budget and Emergency Deficit Control Act, 2 U.S.C. 901a(6)(B), as amended, requires sequestration of non-exempt direct spending programs, excluding Medicare, through fiscal year 2031 at a uniform percentage calculated by OMB to be necessary to meet certain deficit reduction targets in fiscal year 2021. That uniform percentage was calculated to be 5.7 percent in the OMB Report to the Congress on the Joint Committee Reductions for Fiscal Year 2021.

[22] The State payment transfer formula refers to part of the Federally certified risk adjustment methodology that applies in States where HHS is responsible for operating the program. The formula calculates payments and charges at the State market

Continued

part of the HHS Federally certified risk adjustment methodology utilizes separate models for adults, children, and infants to account for clinical and cost differences in each age group.

In the adult and child models, the relative risk assigned to an individual's age, sex, and diagnoses are added together to produce an individual risk score. Additionally, to calculate enrollee risk scores in the adult models, we added enrollment duration factors beginning with the 2017 benefit year,[23] and prescription drug categories (RXCs) beginning with the 2018 benefit year.[24] Starting with the 2023 benefit year, we removed the severity illness factors in the adult models and added interacted HCC count factors (that is, additional factors that express the presence of a severity or transplant HCC in combination with a specified number of total payment HCCs or HCC groups on the enrollee's record) to the adult and child models [25] applicable to certain severity and transplant HCCs (87 FR 27224 through 27228).[26] Starting with the 2026 benefit year (90 FR 4424 at 4438), we added a new type of model factor in the adult and child models to account for risk associated with non-demographic enrollee characteristics that do not indicate the presence of a specific active medical condition. We referred to the new type of factor as an ''affiliated cost factor'' (ACF), thereby distinguishing this new type of factor from RXCs and HCCs, which do indicate the presence of a specific active medical condition.

Infant risk scores are determined by inclusion in one of 25 mutually exclusive groups, based on the infant's maturity and the severity of diagnoses. If applicable, the risk score for adults, children, or infants is multiplied by a cost-sharing reduction (CSR) adjustment factor.[27] The enrollment-weighted average risk score of all enrollees in a particular risk adjustment covered plan (also referred to as the plan liability risk score (PLRS)) within a geographic rating area is one of the inputs into the State payment transfer formula, which determines the State transfer payment or charge that an issuer will receive or be required to pay for that plan for the applicable State market risk pool for a given benefit year. Thus, the HHS risk adjustment models predict average group costs to account for risk across plans, in keeping with the Actuarial Standards Board's Actuarial Standards of Practice for risk classification.

a. Data for HHS Risk Adjustment Model Recalibration for the 2027 Benefit Year

We propose to recalibrate the 2027 benefit year HHS risk adjustment models with the 2021, 2022, and 2023 benefit years' enrollee-level EDGE data. Consistent with the approach outlined in the 2020 Payment Notice (84 FR 17454, 17464), we propose to recalibrate the HHS risk adjustment models for the 2027 benefit year using only enrollee-level EDGE data, and to continue to use blended, or averaged, coefficients from 3 years of separately solved models for the 2027 benefit year model recalibration. Additionally, as outlined in the 2022 Payment Notice (86 FR 24140, 24152), we propose to use the 3 most recent consecutive years of enrollee-level EDGE data that are available at the time we estimate the draft recalibrated coefficients published in the proposed rule for the applicable benefit year.[28] We believe this promotes stability, meets the goal of the HHS-operated risk adjustment program, and allows issuers more time to incorporate this information when pricing their plans for the upcoming benefit year.

Consistent with our prior approach when a new benefit year of enrollee-level EDGE data becomes available,[29] we performed reviews of the 2023 benefit year enrollee-level EDGE data to identify potential anomalies prior to incorporating the 2023 benefit year enrollee-level EDGE data as part of the proposed recalibration of the HHS risk adjustment models. Our review did not identify systematic anomalies in the 2023 benefit year enrollee-level EDGE data. Therefore, after considering these analyses, we propose to determine coefficients for the 2027 benefit year HHS risk adjustment models based on a blend of separately solved coefficients from the 2021, 2022, and 2023 benefit years' enrollee-level EDGE data, with the costs of services identified from the data trended between the relevant year of data and the 2027 benefit year.[30] [31] The draft coefficients tables reflect the use of trended 2021, 2022, and 2023 benefit year enrollee-level EDGE data, as well as other HHS risk adjustment model updates (including, for example, the multi-year approach finalized in the 2026 Payment Notice (90 FR 4438 through 4440) to phase out the market

risk pool level (prior to the calculation of the high-cost risk pool payments and charges that apply beginning with the 2018 benefit year). See, for example, 81 FR 94080.

[23] For the 2017 through 2022 benefit years, there is a set of 11 binary enrollment duration factors in the adult models that decrease monotonically from 1 to 11 months, reflecting the increased annualized costs associated with fewer months of enrollments. See, for example, 81 FR 94071 through 94074. These enrollment duration factors were replaced beginning with the 2023 benefit year with HCC-contingent enrollment duration factors for up to 6 months in the adult models. See, for example, 87 FR 27228 through 27230.

[24] For the 2018 benefit year, there were 12 RXCs, but starting with the 2019 benefit year, the two severity-only RXCs were removed from the adult models. See, for example, 83 FR 16941.

[25] See Table 1 for a list of factors in the adult models and Table 2 for a list of factors in the child models.

[26] Also see Table 3.

[27] For unique State-specific plans, we apply the CSR adjustment factors that correspond to each plan's AV. See, *e.g.,* the 2025 Payment Notice, 89 FR at 26252–26253. However, a different approach is taken for States whose State-specific plans take the form of Medicaid expansion plans offered on the Exchange (for example, Arkansas), because these Medicaid-expansion plans are identical in all their parameters, including AV and degree of plan liability, to other plans offered on the Exchange in those States and are differentiated from their comparable plans only in eligibility criteria, plan enrollment selection, and sources of funding. *Ibid.* Footnote 79 of the 2025 Payment Notice (89 FR 26253), erroneously stated that, ''we would use the proposed CSR adjustment factor of 1.12 for Arkansas 94 percent AV Medicaid-expansion plans and the proposed CSR adjustment factor that corresponds to the silver metal level zero cost sharing variants (that is, the proposed 1.46 CSR adjustment factor for zero cost sharing variants) for Arkansas 100 percent AV Medicaid-expansion plans in the plan liability risk score calculation.'' See *https://regtap.cms.gov/reg_librarye.php?i=4690.* Arkansas 100 percent AV Medicaid-expansion plan features remain more similar to the 94 percent silver plan variant than to the silver metal level zero cost sharing variant for AI/AN enrollees. Therefore, for both the 94 and 100 percent Medicaid-expansion plans in Arkansas, we use the same CSR adjustment factor of 1.12 used for the 94 percent silver plan variant CSR adjustment factor in the plan liability risk score calculation. We will continue to align the CSR adjustment factor for both the 94 and 100 percent Medicaid-expansion plans in Arkansas with the 94 percent silver plan variant CSR adjustment factor for the 2027 benefit year and beyond unless the AVs for these unique Arkansas-specific plans change. More information on the CSR factors used for CSR plan variants, including state program CSR variants, can be found in the applicable Risk Adjustment HHS-Developed Risk Adjustment Model Algorithm ''Do It Yourself (DIY)'' Software instructions, available at: *https://www.cms.gov/marketplace/resources/regulations-guidance#Premium-Stabilization-Programs.*

[28] Although we do receive the next year of enrollee-level EDGE data prior to the proposed rule, that data must go through several quality and analysis checks before it is useable for HHS risk adjustment model calibration.

[29] See, for example, the 2024 Payment Notice proposed rule (87 FR 78215 through 78216) and final rule (88 FR 25749 through 25753).

[30] Because EDGE data do not generally account for drug rebates per the EDGE Server Business Rules (ESBR) (available at *https://regtap.cms.gov/reg_librarye.php?i=3765*), for the purposes of risk adjustment recalibration, we also incorporate assumptions about drug rebates in our trending of prescription drug data.

[31] We note that we apply some standard data exclusions to all years of enrollee-level EDGE data for the purposes of risk adjustment recalibration. For example, enrollees with at least one capitated claim in EDGE are excluded from recalibration because we have some concerns that the methods for computing and reporting derived amounts from capitated claims could be inconsistent across issuers and would not provide reliable or comparable data. See, *e.g.,* the 2025 Payment Notice (89 FR 26252).

pricing adjustment to the plan liability associated with Hepatitis C drugs in the HHS risk adjustment models and align Hepatitis C drugs' trending with the trending approach for specialty drugs [32]). However, we note that the draft coefficients could change between the proposed and final rule if we identify an error after publication of this proposed rule or if any proposed models are modified or not finalized in response to comments.[33] In addition, consistent with § 153.320(b)(1)(i), if we are unable to finalize the final coefficients in time for publication in the final rule, we would publish the final coefficients for the 2027 benefit year in guidance soon after the publication of the final rule.

We seek comment on the proposal to determine 2027 benefit year coefficients for the HHS risk adjustment models based on a blend of separately solved coefficients from the 2021, 2022, and 2023 benefit year enrollee-level EDGE data.

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

The proposed 2027 benefit year HHS risk adjustment model factors resulting from the equally weighted (averaged) blended factors from separately solved models using the 2021, 2022, and 2023 benefit year enrollee-level EDGE data are shown in Tables 1 through 6. The HHS risk adjustment adult, child, and infant models have been truncated to account for the high-cost risk pool payment parameters by removing 60 percent of costs above the $1 million threshold.[34] Table 1 contains proposed factors for each adult model, including the age-sex, HCC, RXC,[35] RXC–HCC interaction, interacted HCC count, ACF, and enrollment duration coefficients. Table 2 contains the proposed factors for each child model, including the age-sex, HCC, interacted HCC count, and ACF coefficients. Table 3 lists the proposed HCCs selected for the interacted HCC count factors that would apply to the HHS risk adjustment adult and child models. Table 4 contains the proposed factors for each HHS risk adjustment infant model. Tables 5 and 6 contain the HCCs included in the HHS risk adjustment infant models' maturity and severity categories, respectively.

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[32] To begin this transition for the 2026 benefit year HHS risk adjustment models, we applied the specialty drug trend to 1 year of trending Hepatitis C treatment costs (that is, the trend from 2025 to 2026) for all 3 years of enrollee-level EDGE data used (that is, 2020, 2021, and 2022 benefit year enrollee-level EDGE data) in 2026 benefit year HHS risk adjustment model recalibration. To continue this transition for the 2027 benefit year HHS risk adjustment models, we would apply the specialty drug trend to 2 years of trending Hepatitis C treatment costs (that is, the trend from 2025 to 2026 and from 2026 to 2027) for all 3 years of enrollee-level EDGE data (that is, 2021, 2022, and 2023 benefit year enrollee-level EDGE data) proposed to be used in 2027 benefit year HHS risk adjustment model recalibration.

[33] If an error were identified after publication of a proposed rule or any proposed changes to the HHS risk adjustment models are modified or not finalized, updated coefficients would be published in the final rule or in guidance after the publication of the final rule consistent with § 153.320(b)(1)(i).

[34] As finalized in the 2020 Payment Notice (84 FR 17466 through 17468), we will maintain the high-cost risk pool parameters for the 2020 benefit year and beyond, unless amended through notice-and-comment rulemaking. We do not propose changes to the high-cost risk pool parameters for the 2027 benefit year. Therefore, we will maintain the $1 million threshold and 60 percent coinsurance rate for the 2027 benefit year.

[35] In the 2026 Payment Notice, we incorrectly stated that for RXC eligibility (including medically administered injectable claims), a professional or outpatient medical claim does not need to have a risk adjustment eligible service code or bill type code. We subsequently updated the January 2025 version of the 2024 Benefit Year Risk Adjustment DIY software instructions (*https://www.cms.gov/files/document/cy2024-diy-instructions-01072025.pdf*) to reflect this erroneous statement. In the Final 2024 Risk Adjustment DIY software instructions updated April 9, 2025 (*https://www.cms.gov/files/document/cy2024-diy-instructions-04092025.pdf*), we corrected this error and clarified that the HCPCS-level file for RXC assignment can only be sourced from institutional inpatient and outpatient claims with RA-eligible bill types. We expect ACFs related to prescription drugs will be sourced using the same criteria as RXCs. We will announce changes to ESBR concerning RXC or ACF eligibility in future guidance documents or notice and comment rulemakings, as appropriate.

TABLE 1: Proposed Adult Risk Adjustment Model Factors for the 2027 Benefit Year

	Demographic Factors					
	Age 21-24, Male	0.189	0.135	0.097	0.068	0.060
	Age 25-29, Male	0.201	0.142	0.100	0.067	0.059
	Age 30-34, Male	0.231	0.166	0.118	0.080	0.070
	Age 35-39, Male	0.252	0.183	0.130	0.088	0.076
	Age 40-44, Male	0.280	0.206	0.149	0.101	0.088
	Age 45-49, Male	0.322	0.244	0.183	0.132	0.118
	Age 50-54, Male	0.371	0.286	0.219	0.163	0.147
	Age 55-59, Male	0.413	0.322	0.250	0.188	0.171
	Age 60-64, Male	0.467	0.366	0.286	0.216	0.198
	Age 21-24, Female	0.278	0.196	0.132	0.082	0.067
	Age 25-29, Female	0.311	0.221	0.149	0.091	0.074
	Age 30-34, Female	0.384	0.288	0.209	0.144	0.126
	Age 35-39, Female	0.435	0.335	0.253	0.184	0.166
	Age 40-44, Female	0.484	0.379	0.292	0.216	0.195
	Age 45-49, Female	0.491	0.385	0.293	0.214	0.192
	Age 50-54, Female	0.506	0.397	0.302	0.219	0.197
	Age 55-59, Female	0.467	0.358	0.265	0.184	0.162
	Age 60-64, Female	0.467	0.355	0.260	0.177	0.154
	Diagnosis Factors					
HCC001	HIV/AIDS	0.000	0.000	0.000	0.000	0.000
HCC002	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	8.520	8.314	8.233	8.129	8.123
HCC003	Central Nervous System Infections, Except Viral Meningitis	7.760	7.653	7.601	7.527	7.511
HCC004	Viral or Unspecified Meningitis	6.855	6.746	6.678	6.590	6.569
HCC006	Opportunistic Infections	8.110	8.053	7.995	7.916	7.892
HCC008	Metastatic Cancer	22.129	21.703	21.654	21.525	21.533
HCC009	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	12.286	11.994	11.925	11.798	11.789
HCC010	Non-Hodgkin Lymphomas and Other Cancers and Tumors	5.400	5.216	5.126	5.002	4.980
HCC011	Colorectal, Breast (Age < 50), Kidney, and Other Cancers	3.851	3.657	3.554	3.419	3.396
HCC012	Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	2.465	2.326	2.237	2.127	2.105
HCC013	Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.025	0.930	0.825	0.710	0.681
HCC018	Pancreas Transplant Status	5.506	5.552	5.642	5.734	5.757
HCC019	Diabetes with Acute Complications	0.189	0.145	0.102	0.060	0.050
HCC020	Diabetes with Chronic Complications	0.189	0.145	0.102	0.060	0.050
HCC021	Diabetes without Complication	0.189	0.145	0.102	0.060	0.050
HCC022	Type 1 Diabetes Mellitus, add-on to Diabetes HCCs 19-21	0.179	0.155	0.111	0.045	0.023
HCC023	Protein-Calorie Malnutrition	10.099	9.974	9.925	9.854	9.843
HCC026	Mucopolysaccharidosis	18.785	18.604	18.567	18.498	18.495
HCC027	Lipidoses and Glycogenosis	18.785	18.604	18.567	18.498	18.495
HCC029	Amyloidosis, Porphyria, and Other Metabolic Disorders	5.455	5.353	5.299	5.229	5.216

HCC030	Adrenal, Pituitary, and Other Significant Endocrine Disorders	1.291	1.216	1.150	1.071	1.053
HCC034	Liver Transplant Status/Complications	5.506	5.552	5.642	5.734	5.757
HCC035_1[a]	Acute Liver Failure/Disease, Including Neonatal Hepatitis	6.880	6.693	6.630	6.548	6.543
HCC035_2	Chronic Liver Failure/End-Stage Liver Disorders	2.234	2.070	2.000	1.906	1.896
HCC036	Cirrhosis of Liver	0.616	0.537	0.476	0.401	0.387
HCC037_1	Chronic Viral Hepatitis C	0.516	0.455	0.396	0.336	0.325
HCC037_2	Chronic Hepatitis, Except Chronic Viral Hepatitis C	0.516	0.455	0.396	0.336	0.325
HCC041	Intestine Transplant Status/Complications	5.506	5.552	5.642	5.734	5.757
HCC042	Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	10.409	10.234	10.209	10.146	10.144
HCC045	Intestinal Obstruction	4.795	4.594	4.499	4.369	4.350
HCC046	Chronic Pancreatitis	2.131	1.971	1.875	1.755	1.738
HCC047	Acute Pancreatitis	2.131	1.971	1.875	1.755	1.738
HCC048	Inflammatory Bowel Disease	3.007	2.889	2.788	2.652	2.614
HCC054	Necrotizing Fasciitis	6.731	6.567	6.536	6.475	6.470
HCC055	Bone/Joint/Muscle Infections/Necrosis	4.138	3.961	3.912	3.843	3.843
HCC056	Rheumatoid Arthritis and Specified Autoimmune Disorders	1.363	1.259	1.188	1.104	1.086
HCC057	Systemic Lupus Erythematosus and Other Autoimmune Disorders	0.355	0.286	0.198	0.098	0.069
HCC061	Osteogenesis Imperfecta and Other Osteodystrophies	1.753	1.635	1.546	1.437	1.415
HCC062	Congenital/Developmental Skeletal and Connective Tissue Disorders	1.753	1.635	1.546	1.437	1.415
HCC063	Cleft Lip/Cleft Palate	0.823	0.732	0.640	0.542	0.520
HCC066	Hemophilia	70.952	70.627	70.590	70.491	70.495
HCC067	Myelodysplastic Syndromes and Myelofibrosis	9.888	9.761	9.718	9.648	9.639
HCC068	Aplastic Anemia	9.888	9.761	9.718	9.648	9.639
HCC069	Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	9.888	9.761	9.718	9.648	9.639
HCC070	Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero	1.833	1.725	1.635	1.537	1.518
HCC071	Sickle-Cell Disorders, Except Sickle-Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia Major	1.457	1.397	1.348	1.292	1.279
HCC073	Combined and Other Severe Immunodeficiencies	4.364	4.272	4.239	4.184	4.176
HCC074	Disorders of the Immune Mechanism	4.364	4.272	4.239	4.184	4.176
HCC075	Coagulation Defects and Other Specified Hematological Disorders	2.167	2.085	2.024	1.948	1.930
HCC081	Drug Use with Psychotic Complications	1.479	1.349	1.232	1.092	1.059
HCC082	Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	1.479	1.349	1.232	1.092	1.059
HCC083	Alcohol Use with Psychotic Complications	0.857	0.746	0.647	0.533	0.507

HCC084	Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications	0.857	0.746	0.647	0.533	0.507
HCC087_1	Schizophrenia	2.215	2.050	1.928	1.784	1.757
HCC087_2	Delusional and Other Specified Psychotic Disorders, Unspecified Psychosis	2.087	1.932	1.803	1.645	1.611
HCC088	Major Depressive Disorder, Severe, and Bipolar Disorders	0.927	0.831	0.728	0.609	0.578
HCC090	Personality Disorders	0.666	0.587	0.487	0.377	0.343
HCC094	Anorexia/Bulimia Nervosa	1.855	1.749	1.663	1.555	1.529
HCC096	Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	9.243	9.207	9.184	9.155	9.144
HCC097	Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	0.779	0.715	0.659	0.596	0.581
HCC102	Autistic Disorder	0.670	0.590	0.496	0.397	0.367
HCC103	Pervasive Developmental Disorders, Except Autistic Disorder	0.666	0.587	0.487	0.377	0.343
HCC106	Traumatic Complete Lesion Cervical Spinal Cord	9.567	9.405	9.331	9.227	9.211
HCC107	Quadriplegia	9.567	9.405	9.331	9.227	9.211
HCC108	Traumatic Complete Lesion Dorsal Spinal Cord	6.337	6.186	6.106	5.994	5.975
HCC109	Paraplegia	6.337	6.186	6.106	5.994	5.975
HCC110	Spinal Cord Disorders/Injuries	4.665	4.482	4.406	4.296	4.280
HCC111	Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	6.067	5.909	5.822	5.707	5.686
HCC112	Quadriplegic Cerebral Palsy	0.975	0.868	0.773	0.658	0.631
HCC113	Cerebral Palsy, Except Quadriplegic	0.426	0.363	0.300	0.229	0.210
HCC114	Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	1.116	1.035	0.959	0.864	0.841
HCC115	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	4.927	4.844	4.822	4.783	4.779
HCC117	Muscular Dystrophy	1.362	1.272	1.191	1.094	1.070
HCC118	Multiple Sclerosis	2.461	2.331	2.253	2.151	2.131
HCC119	Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	1.362	1.272	1.191	1.094	1.070
HCC120	Seizure Disorders and Convulsions	0.929	0.840	0.758	0.660	0.637
HCC121	Hydrocephalus	8.919	8.823	8.773	8.704	8.689
HCC122	Nontraumatic Coma, Except Diabetic, Hepatic, or Hypoglycemic; Nontraumatic Brain Compression/Anoxic Damage	9.620	9.477	9.417	9.325	9.307
HCC123	Narcolepsy and Cataplexy	4.303	4.171	4.101	4.006	3.987
HCC125	Respirator Dependence/Tracheostomy Status	20.117	19.902	19.845	19.752	19.744
HCC126	Respiratory Arrest	7.858	7.659	7.579	7.478	7.472
HCC127	Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	7.858	7.659	7.579	7.478	7.472
HCC128	Heart Assistive Device/Artificial Heart	14.408	14.322	14.312	14.307	14.304

HCC129	Heart Transplant Status/Complications	14.408	14.322	14.312	14.307	14.304
HCC130	Heart Failure	1.628	1.543	1.490	1.421	1.407
HCC131	Acute Myocardial Infarction	4.410	4.188	4.129	4.044	4.047
HCC132	Unstable Angina and Other Acute Ischemic Heart Disease	3.261	3.073	2.986	2.868	2.856
HCC135	Heart Infection/Inflammation, Except Rheumatic	7.943	7.850	7.792	7.709	7.689
HCC137	Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders	2.004	1.911	1.843	1.763	1.745
HCC138	Major Congenital Heart/Circulatory Disorders	2.004	1.911	1.843	1.763	1.745
HCC139	Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders	2.004	1.911	1.843	1.763	1.745
HCC142	Specified Heart Arrhythmias	1.831	1.725	1.640	1.531	1.501
HCC145	Intracranial Hemorrhage	9.782	9.608	9.545	9.452	9.441
HCC146	Ischemic or Unspecified Stroke	1.438	1.326	1.258	1.173	1.161
HCC149	Cerebral Aneurysm and Arteriovenous Malformation	1.977	1.859	1.772	1.659	1.634
HCC150	Hemiplegia/Hemiparesis	2.618	2.497	2.459	2.405	2.403
HCC151	Monoplegia, Other Paralytic Syndromes	2.198	2.088	2.019	1.931	1.916
HCC153	Atherosclerosis of the Extremities with Ulceration or Gangrene	7.585	7.409	7.407	7.376	7.389
HCC154	Vascular Disease with Complications	4.906	4.756	4.694	4.605	4.591
HCC156	Pulmonary Embolism and Deep Vein Thrombosis	7.104	7.018	6.942	6.837	6.805
HCC158	Lung Transplant Status/Complications	11.333	11.261	11.238	11.227	11.221
HCC159	Cystic Fibrosis	2.992	2.873	2.799	2.714	2.700
HCC160	Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	0.615	0.539	0.454	0.360	0.334
HCC161_1	Severe Asthma	0.615	0.539	0.454	0.360	0.334
HCC161_2	Asthma, Except Severe	0.615	0.539	0.454	0.360	0.334
HCC162	Fibrosis of Lung and Other Lung Disorders	1.305	1.231	1.161	1.075	1.052
HCC163	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	6.880	6.765	6.706	6.629	6.616
HCC174	Exudative Macular Degeneration	1.231	1.115	0.988	0.838	0.804
HCC183	Kidney Transplant Status/Complications	5.506	5.552	5.642	5.734	5.757
HCC184	End Stage Renal Disease	17.965	17.541	17.668	17.485	17.544
HCC187	Chronic Kidney Disease, Stage 5	0.749	0.679	0.661	0.621	0.622
HCC188	Chronic Kidney Disease, Severe (Stage 4)	0.749	0.679	0.661	0.621	0.622
HCC203	Ectopic and Molar Pregnancy	1.438	1.302	1.131	0.927	0.875
HCC204	Miscarriage with Complications	0.638	0.554	0.420	0.253	0.193
HCC205	Miscarriage with No or Minor Complications	0.638	0.554	0.420	0.253	0.193
HCC207	Pregnancy with Delivery with Major Complications	3.610	3.349	3.031	2.654	2.581
HCC208	Pregnancy with Delivery with Complications	3.610	3.349	3.031	2.654	2.581
HCC209	Pregnancy with Delivery with No or Minor Complications	2.645	2.446	2.126	1.713	1.597

HCC210	(Ongoing) Pregnancy without Delivery with Major Complications	0.668	0.572	0.416	0.240	0.186
HCC211	(Ongoing) Pregnancy without Delivery with Complications	0.494	0.412	0.283	0.148	0.106
HCC212	(Ongoing) Pregnancy without Delivery with No or Minor Complications	0.023	0.000	0.000	0.000	0.000
HCC217	Chronic Ulcer of Skin, Except Pressure	1.351	1.259	1.205	1.140	1.131
HCC218	Extensive Third Degree Burns	28.529	28.296	28.253	28.168	28.162
HCC219	Major Skin Burn or Condition	2.661	2.532	2.452	2.356	2.337
HCC223	Severe Head Injury	16.085	15.926	15.853	15.744	15.724
HCC226	Hip and Pelvic Fractures	7.742	7.485	7.431	7.338	7.340
HCC228	Vertebral Fractures without Spinal Cord Injury	4.007	3.844	3.742	3.608	3.582
HCC234	Traumatic Amputations and Amputation Complications	4.272	4.112	4.068	3.998	3.995
HCC251	Stem Cell, Including Bone Marrow, Transplant Status/Complications	17.990	18.025	18.043	18.074	18.067
HCC253	Artificial Openings for Feeding or Elimination	5.400	5.276	5.237	5.177	5.172
HCC254	Amputation Status, Upper Limb or Lower Limb	0.923	0.828	0.775	0.708	0.699
	Interacted HCC Counts Factors					
	Severe illness, 1 payment HCC	-5.506	-5.552	-5.642	-5.734	-5.757
	Severe illness, 2 payment HCCs	-5.381	-5.451	-5.529	-5.615	-5.630
	Severe illness, 3 payment HCCs	-4.624	-4.683	-4.671	-4.664	-4.645
	Severe illness, 4 payment HCCs	-4.046	-4.060	-3.933	-3.798	-3.740
	Severe illness, 5 payment HCCs	-3.634	-3.590	-3.359	-3.113	-3.027
	Severe illness, 6 payment HCCs	-3.188	-3.063	-2.734	-2.385	-2.275
	Severe illness, 7 payment HCCs	-2.710	-2.475	-2.060	-1.614	-1.485
	Severe illness, 8 payment HCCs	-2.359	-2.047	-1.553	-1.014	-0.870
	Severe illness, 9 payment HCCs	-0.965	-0.515	0.053	0.682	0.839
	Severe illness, 10 or more payment HCCs	4.976	5.806	6.546	7.415	7.608
	Transplant severe illness, 4 payment HCCs	3.531	3.394	3.262	3.071	3.034
	Transplant severe illness, 5 payment HCCs	6.812	6.664	6.540	6.354	6.326
	Transplant severe illness, 6 payment HCCs	10.112	9.960	9.839	9.656	9.631
	Transplant severe illness, 7 payment HCCs	15.321	15.165	15.051	14.879	14.859
	Transplant severe illness, 8 or more payment HCCs	29.664	29.601	29.511	29.375	29.357
	Enrollment Duration Factors					
	Enrolled for 1 month, at least one payment HCC	11.074	9.697	8.663	7.661	7.414
	Enrolled for 2 months, at least one payment HCC	4.976	4.271	3.729	3.226	3.102
	Enrolled for 3 months, at least one payment HCC	3.206	2.743	2.369	2.026	1.944
	Enrolled for 4 months, at least one payment HCC	1.883	1.566	1.297	1.054	0.995
	Enrolled for 5 months, at least one payment HCC	1.400	1.164	0.955	0.763	0.714

	Enrolled for 6 months, at least one payment HCC	0.936	0.762	0.599	0.448	0.407
	Affiliated Cost Factors					
ACF01	HIV Pre-Exposure Prophylaxis (PrEP)	3.620	3.551	3.472	3.304	3.258
	Prescription Drug Factors					
RXC01	Anti-HIV Agents	4.595	4.125	3.714	3.356	3.280
RXC02	Anti-Hepatitis C (HCV) Agents, Direct Acting Agents	9.107	8.614	8.476	8.335	8.361
RXC03[b]	Antiarrhythmics	0.058	0.052	0.046	0.039	0.046
RXC04	Phosphate Binders	0.868	0.993	0.785	0.988	0.917
RXC05	Inflammatory Bowel Disease Agents	1.133	1.100	1.040	0.981	0.962
RXC06	Insulin	1.313	1.147	0.991	0.843	0.805
RXC07	Anti-Diabetic Agents, Except Insulin and Metformin Only	0.973	0.862	0.698	0.485	0.419
RXC08	Multiple Sclerosis Agents	12.472	11.759	11.490	11.110	11.042
RXC09	Immune Suppressants and Immunomodulators	11.545	10.994	10.921	10.759	10.777
RXC10	Cystic Fibrosis Agents	22.801	22.295	22.221	22.083	22.098
RXC01 x HCC001	Additional effect for enrollees with RXC 01 and HCC 001	2.629	2.556	2.848	3.009	3.091
RXC02 x HCC037_1, 036, 035_2, 035_1, 034	Additional effect for enrollees with RXC 02 and (HCC 037_1 or 036 or 035_2 or 035_1 or 034)	-0.516	-0.455	-0.396	-0.336	-0.325
RXC03 x HCC142	Additional effect for enrollees with RXC 03 and HCC 142	0.000	0.000	0.000	0.000	0.000
RXC04 x HCC184, 183, 187, 188	Additional effect for enrollees with RXC 04 and (HCC 184 or 183 or 187 or 188)	0.000	0.000	0.000	0.000	0.000
RXC05 x HCC048, 041	Additional effect for enrollees with RXC 05 and (HCC 048 or 041)	-1.106	-1.087	-1.040	-0.981	-0.962
RXC06 x HCC018, 019, 020, 021	Additional effect for enrollees with RXC 06 and (HCC 018 or 019 or 020 or 021)	0.466	0.511	0.522	0.482	0.474
RXC07 x HCC018, 019, 020, 021	Additional effect for enrollees with RXC 07 and (HCC 018 or 019 or 020 or 021)	-0.187	-0.143	-0.102	-0.060	-0.050
RXC08 x HCC118	Additional effect for enrollees with RXC 08 and HCC 118	-0.156	0.110	0.411	0.745	0.854
RXC09 x HCC056 or 057 and 048 or 041	Additional effect for enrollees with RXC 09 and (HCC 048 or 041) and (HCC 056 or 057)	0.492	0.557	0.646	0.751	0.780
RXC09 x HCC056	Additional effect for enrollees with RXC 09 and HCC 056	-1.363	-1.259	-1.188	-1.104	-1.086
RXC09 x HCC057	Additional effect for enrollees with RXC 09 and HCC 057	-0.355	-0.286	-0.198	-0.098	-0.069
RXC09 x HCC048, 041	Additional effect for enrollees with RXC 09 and (HCC 048 or 041)	-1.901	-1.802	-1.748	-1.670	-1.651

RXC10 x HCC159, 158	Additional effect for enrollees with RXC 10 and (HCC 159 or 158)	36.448	36.460	36.625	36.751	36.785

[a] HCC numbers that appear with an underscore in this document will appear without the underscore in the "Do It Yourself (DIY)" software. For example, HCC 35_1 in this table will appear as HCC 351 in the DIY software.

[b] We constrain RXC 03 to be equal to average plan liability for RXC 03 drugs, RXC 04 to be equal to the average plan liability for RXC 04 drugs, and we constrain RXC 03 x HCC142 and RXC 04 x HCC184, 183, 187, 188 to be equal to zero. *See March 2016 Risk Adjustment Methodology Discussion Paper* (2016 March, 16), available at: *https://www.cms.gov/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 HHS risk adjustment models).

TABLE 2: Proposed Child Risk Adjustment Model Factors for the 2027 Benefit Year

Demographic Factors					
Age 2-4, Male	0.297	0.217	0.162	0.118	0.106
Age 5-9, Male	0.222	0.154	0.113	0.085	0.077
Age 10-14, Male	0.210	0.146	0.108	0.082	0.076
Age 15-20, Male	0.246	0.179	0.132	0.097	0.088
Age 2-4, Female	0.237	0.166	0.124	0.092	0.084
Age 5-9, Female	0.162	0.102	0.067	0.044	0.039
Age 10-14, Female	0.216	0.153	0.115	0.089	0.082
Age 15-20, Female	0.267	0.187	0.124	0.077	0.063
Diagnosis Factors					
HIV/AIDS	4.494	4.068	3.903	3.679	3.658
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	14.480	14.282	14.169	14.032	14.013
Central Nervous System Infections, Except Viral Meningitis	14.430	14.273	14.207	14.113	14.097
Viral or Unspecified Meningitis	12.991	12.869	12.785	12.679	12.655
Opportunistic Infections	20.233	20.191	20.119	20.039	20.013
Metastatic Cancer	31.479	31.228	31.163	31.056	31.045
Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	9.613	9.381	9.254	9.091	9.059
Non-Hodgkin Lymphomas and Other Cancers and Tumors	8.609	8.408	8.278	8.118	8.083
Colorectal, Breast (Age < 50), Kidney, and Other Cancers	3.753	3.604	3.500	3.366	3.332
Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	3.753	3.604	3.500	3.366	3.332
Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.204	1.092	0.978	0.855	0.818
Pancreas Transplant Status	11.308	11.349	11.403	11.462	11.475
Diabetes with Acute Complications	2.107	1.904	1.613	1.264	1.175
Diabetes with Chronic Complications	2.107	1.904	1.613	1.264	1.175
Diabetes without Complication	2.107	1.904	1.613	1.264	1.175
Protein-Calorie Malnutrition	17.913	17.788	17.745	17.685	17.674
Mucopolysaccharidosis	27.455	27.228	27.158	27.051	27.042
Lipidoses and Glycogenosis	27.455	27.228	27.158	27.051	27.042
Congenital Metabolic Disorders, Not Elsewhere Classified	4.860	4.741	4.671	4.584	4.566
Amyloidosis, Porphyria, and Other Metabolic Disorders	4.860	4.741	4.671	4.584	4.566
Adrenal, Pituitary, and Other Significant Endocrine Disorders	4.585	4.353	4.263	4.148	4.135
Liver Transplant Status/Complications	11.308	11.349	11.403	11.462	11.475
Acute Liver Failure/Disease, Including Neonatal Hepatitis	12.753	12.612	12.564	12.499	12.492
Chronic Liver Failure/End-Stage Liver Disorders	8.744	8.588	8.509	8.401	8.379
Cirrhosis of Liver	2.077	1.972	1.888	1.798	1.778
Chronic Viral Hepatitis C	2.077	1.972	1.888	1.798	1.778
Chronic Hepatitis, Except Chronic Viral Hepatitis C	1.367	1.287	1.195	1.098	1.073
Intestine Transplant Status/Complications	15.155	15.082	15.015	14.930	14.907

Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	17.893	17.607	17.538	17.427	17.422
Intestinal Obstruction	3.920	3.746	3.616	3.458	3.423
Chronic Pancreatitis	9.814	9.635	9.554	9.449	9.434
Acute Pancreatitis	6.643	6.415	6.272	6.089	6.054
Inflammatory Bowel Disease	10.636	10.225	10.089	9.880	9.859
Necrotizing Fasciitis	4.686	4.490	4.367	4.224	4.197
Bone/Joint/Muscle Infections/Necrosis	4.686	4.490	4.367	4.224	4.197
Rheumatoid Arthritis and Specified Autoimmune Disorders	4.802	4.534	4.429	4.288	4.270
Systemic Lupus Erythematosus and Other Autoimmune Disorders	1.211	1.106	1.002	0.884	0.852
Osteogenesis Imperfecta and Other Osteodystrophies	1.112	1.008	0.919	0.822	0.799
Congenital/Developmental Skeletal and Connective Tissue Disorders	1.112	1.008	0.919	0.822	0.799
Cleft Lip/Cleft Palate	0.852	0.729	0.606	0.470	0.433
Hemophilia	59.554	59.072	58.973	58.779	58.763
Myelodysplastic Syndromes and Myelofibrosis	11.606	11.431	11.349	11.244	11.231
Aplastic Anemia	11.606	11.431	11.349	11.244	11.231
Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	11.606	11.431	11.349	11.244	11.231
Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero	3.359	3.193	3.083	2.958	2.929
Sickle-Cell Disorders, Except Sickle-Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia Major	3.359	3.193	3.083	2.958	2.929
Combined and Other Severe Immunodeficiencies	5.693	5.547	5.470	5.368	5.350
Disorders of the Immune Mechanism	5.693	5.547	5.470	5.368	5.350
Coagulation Defects and Other Specified Hematological Disorders	4.135	4.022	3.937	3.839	3.817
Drug Use with Psychotic Complications	2.239	2.101	1.978	1.833	1.799
Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	2.239	2.101	1.978	1.833	1.799
Alcohol Use with Psychotic Complications	0.811	0.683	0.540	0.377	0.338
Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications	0.811	0.683	0.540	0.377	0.338
Schizophrenia	3.875	3.617	3.437	3.224	3.185
Delusional and Other Specified Psychotic Disorders, Unspecified Psychosis	3.273	3.038	2.852	2.625	2.575
Major Depressive Disorder, Severe, and Bipolar Disorders	2.710	2.509	2.352	2.169	2.126
Personality Disorders	0.597	0.513	0.416	0.311	0.277
Anorexia/Bulimia Nervosa	2.132	1.994	1.886	1.751	1.717
Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	12.106	12.042	12.004	11.952	11.938
Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	0.799	0.693	0.601	0.491	0.463
Autistic Disorder	2.710	2.509	2.352	2.169	2.126
Pervasive Developmental Disorders, Except Autistic Disorder	0.597	0.513	0.416	0.321	0.297
Traumatic Complete Lesion Cervical Spinal Cord	10.342	10.139	10.066	9.954	9.944
Quadriplegia	10.342	10.139	10.066	9.954	9.944

Traumatic Complete Lesion Dorsal Spinal Cord	7.706	7.483	7.370	7.223	7.201
Paraplegia	7.706	7.483	7.370	7.223	7.201
Spinal Cord Disorders/Injuries	4.354	4.171	4.045	3.880	3.841
Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	44.922	44.615	44.563	44.454	44.447
Quadriplegic Cerebral Palsy	1.301	1.125	1.017	0.881	0.861
Cerebral Palsy, Except Quadriplegic	0.394	0.278	0.202	0.113	0.091
Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	1.403	1.295	1.208	1.102	1.078
Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	11.196	11.067	11.035	10.986	10.988
Muscular Dystrophy	6.335	6.182	6.087	5.966	5.942
Multiple Sclerosis	7.535	7.183	7.067	6.898	6.885
Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	6.335	6.182	6.087	5.966	5.942
Seizure Disorders and Convulsions	1.519	1.389	1.256	1.104	1.063
Hydrocephalus	11.643	11.592	11.599	11.603	11.602
Nontraumatic Coma, Except Diabetic, Hepatic, or Hypoglycemic; Nontraumatic Brain Compression/Anoxic Damage	11.490	11.480	11.484	11.487	11.485
Narcolepsy and Cataplexy	3.550	3.402	3.296	3.156	3.115
Respirator Dependence/Tracheostomy Status	26.852	26.609	26.531	26.418	26.408
Respiratory Arrest	15.129	14.889	14.754	14.581	14.559
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	15.129	14.889	14.754	14.581	14.559
Heart Assistive Device/Artificial Heart	15.155	15.082	15.015	14.930	14.907
Heart Transplant Status/Complications	15.155	15.082	15.015	14.930	14.907
Heart Failure	3.656	3.549	3.481	3.391	3.370
Acute Myocardial Infarction	0.225	0.196	0.157	0.107	0.088
Unstable Angina and Other Acute Ischemic Heart Disease	0.225	0.196	0.157	0.107	0.088
Heart Infection/Inflammation, Except Rheumatic	15.433	15.322	15.236	15.136	15.111
Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders	3.711	3.564	3.444	3.307	3.273
Major Congenital Heart/Circulatory Disorders	0.962	0.862	0.757	0.652	0.624
Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders	0.525	0.439	0.352	0.268	0.248
Specified Heart Arrhythmias	3.136	2.983	2.882	2.759	2.732
Intracranial Hemorrhage	12.158	12.048	12.010	11.963	11.955
Ischemic or Unspecified Stroke	0.531	0.420	0.353	0.272	0.255
Cerebral Aneurysm and Arteriovenous Malformation	0.813	0.690	0.607	0.502	0.480
Hemiplegia/Hemiparesis	4.230	4.089	3.989	3.861	3.834
Monoplegia, Other Paralytic Syndromes	2.776	2.633	2.537	2.417	2.392
Atherosclerosis of the Extremities with Ulceration or Gangrene	10.094	9.865	9.741	9.588	9.568
Vascular Disease with Complications	12.595	12.449	12.389	12.300	12.286
Pulmonary Embolism and Deep Vein Thrombosis	19.285	19.147	19.070	18.968	18.947
Lung Transplant Status/Complications	15.155	15.082	15.015	14.930	14.907
Cystic Fibrosis	49.902	49.319	49.258	49.095	49.105
Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	1.825	1.669	1.534	1.379	1.342

Severe Asthma	1.253	1.093	0.929	0.748	0.704
Asthma, Except Severe	0.323	0.248	0.165	0.092	0.072
Fibrosis of Lung and Other Lung Disorders	1.444	1.329	1.211	1.083	1.051
Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	11.365	11.349	11.403	11.462	11.475
Kidney Transplant Status/Complications	11.308	11.349	11.403	11.462	11.475
End Stage Renal Disease	23.942	23.682	23.657	23.578	23.576
Chronic Kidney Disease, Stage 5	2.630	2.522	2.430	2.344	2.325
Chronic Kidney Disease, Severe (Stage 4)	2.630	2.522	2.430	2.344	2.325
Ectopic and Molar Pregnancy	0.988	0.833	0.642	0.431	0.386
Miscarriage with Complications	0.526	0.409	0.233	0.036	0.005
Miscarriage with No or Minor Complications	0.526	0.409	0.233	0.036	0.005
Pregnancy with Delivery with Major Complications	3.019	2.757	2.391	1.934	1.805
Pregnancy with Delivery with Complications	3.019	2.757	2.391	1.934	1.805
Pregnancy with Delivery with No or Minor Complications	2.183	1.972	1.629	1.180	1.023
(Ongoing) Pregnancy without Delivery with Major Complications	0.513	0.378	0.189	0.011	0.000
(Ongoing) Pregnancy without Delivery with Complications	0.513	0.378	0.189	0.011	0.000
(Ongoing) Pregnancy without Delivery with No or Minor Complications	0.284	0.182	0.068	0.000	0.000
Chronic Ulcer of Skin, Except Pressure	2.113	2.020	1.939	1.855	1.833
Extensive Third Degree Burns	22.256	22.021	21.922	21.792	21.772
Major Skin Burn or Condition	2.590	2.420	2.281	2.120	2.083
Severe Head Injury	22.256	22.021	21.922	21.792	21.772
Hip and Pelvic Fractures	4.114	3.906	3.772	3.623	3.596
Vertebral Fractures without Spinal Cord Injury	4.144	3.952	3.811	3.639	3.600
Traumatic Amputations and Amputation Complications	3.694	3.520	3.372	3.192	3.147
Stem Cell, Including Bone Marrow, Transplant Status/Complications	15.155	15.082	15.015	14.930	14.907
Artificial Openings for Feeding or Elimination	4.495	4.323	4.257	4.161	4.151
Amputation Status, Upper Limb or Lower Limb	3.694	3.520	3.372	3.192	3.147
Interacted HCC Counts Factors					
Severe illness, 1 payment HCC	-11.308	-11.349	-11.403	-11.462	-11.475
Severe illness, 2 payment HCCs	-11.308	-11.349	-11.403	-11.462	-11.475
Severe illness, 3 payment HCCs	-10.149	-10.211	-10.174	-10.162	-10.141
Severe illness, 4 payment HCCs	-9.055	-9.082	-8.919	-8.762	-8.697
Severe illness, 5 payment HCCs	-8.454	-8.416	-8.172	-7.938	-7.853
Severe illness, 6 or 7 payment HCCs	-4.190	-3.978	-3.561	-3.133	-3.003
Severe illness, 8 or more payment HCCs	18.133	18.860	19.604	20.422	20.625
Transplant severe illness, 4 or more payment HCCs	15.299	15.306	15.287	15.271	15.267
Affiliated Cost Factors					
HIV Pre-Exposure Prophylaxis (PrEP)	2.089	2.042	1.984	1.923	1.905

TABLE 3: HHS HCCs Selected for the HCC Interacted Counts Variables for the Adult and Child Models for the 2027 Benefit Year

HCC 2 Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	X	
HCC 3 Central Nervous System Infections, Except Viral Meningitis	X	
HCC 4 Viral or Unspecified Meningitis	X	
HCC 6 Opportunistic Infections	X	
HCC 23 Protein-Calorie Malnutrition	X	
HCC 34 Liver Transplant Status/Complications	X	X
HCC 41 Intestine Transplant Status/Complications	X	X
HCC 42 Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	X	
HCC 96 Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	X	
HCC 121 Hydrocephalus	X	
HCC 122 Nontraumatic Coma, Except Diabetic, Hepatic, or Hypoglycemic; Nontraumatic Brain Compression/Anoxic Damage	X	
HCC 125 Respirator Dependence/Tracheostomy Status	X	
HCC 135 Heart Infection/Inflammation, Except Rheumatic	X	
HCC 145 Intracranial Hemorrhage	X	
HCC 156 Pulmonary Embolism and Deep Vein Thrombosis	X	
HCC 158 Lung Transplant Status/Complications	X	X
HCC 163 Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	X	
HCC 218 Extensive Third Degree Burns	X	
HCC 223 Severe Head Injury	X	
HCC 251 Stem Cell, Including Bone Marrow, Transplant Status/Complications	X	X
G13 (Includes HCC 126 Respiratory Arrest and HCC 127 Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes)	X	
G14 (Includes HCC 128 Heart Assistive Device/Artificial Heart and HCC 129 Heart Transplant Status/Complications)	X	X
G24 (Includes HCC 18 Pancreas Transplant Status and HCC 183 Kidney Transplant Status/Complications)	X	X

TABLE 4: Proposed Infant Risk Adjustment Model Factors for the 2027 Benefit Year

Extremely Immature * Severity Level 5 (Highest)	197.671	196.159	195.801	195.221	195.198
Extremely Immature * Severity Level 4	129.748	128.048	127.479	126.693	126.619
Extremely Immature * Severity Level 3	29.087	27.703	27.191	26.528	26.453
Extremely Immature * Severity Level 2	29.087	27.703	27.191	26.528	26.453
Extremely Immature * Severity Level 1 (Lowest)	29.087	27.703	27.191	26.528	26.453
Immature * Severity Level 5 (Highest)	123.452	121.973	121.649	121.124	121.107
Immature * Severity Level 4	67.497	65.845	65.420	64.760	64.712
Immature * Severity Level 3	29.087	27.703	27.191	26.528	26.453
Immature * Severity Level 2	22.383	21.155	20.619	19.967	19.876
Immature * Severity Level 1 (Lowest)	21.881	20.636	20.094	19.436	19.346
Premature/Multiples * Severity Level 5 (Highest)	107.440	105.978	105.584	105.002	104.960
Premature/Multiples * Severity Level 4	27.962	26.600	26.069	25.389	25.317
Premature/Multiples * Severity Level 3	12.192	11.287	10.647	9.906	9.741
Premature/Multiples * Severity Level 2	7.667	6.967	6.351	5.654	5.480
Premature/Multiples * Severity Level 1 (Lowest)	5.481	4.884	4.306	3.679	3.503
Term * Severity Level 5 (Highest)	80.094	78.884	78.453	77.860	77.791
Term * Severity Level 4	16.487	15.512	14.880	14.150	14.017
Term * Severity Level 3	5.490	4.920	4.339	3.704	3.528
Term * Severity Level 2	3.764	3.279	2.717	2.108	1.931
Term * Severity Level 1 (Lowest)	2.081	1.689	1.247	0.869	0.778
Age1 * Severity Level 5 (Highest)	69.546	68.851	68.623	68.313	68.286
Age1 * Severity Level 4	12.005	11.504	11.187	10.827	10.759
Age1 * Severity Level 3	2.842	2.580	2.365	2.151	2.097
Age1 * Severity Level 2	1.802	1.576	1.352	1.132	1.070
Age1 * Severity Level 1 (Lowest)	0.569	0.478	0.421	0.380	0.368
Age 0 Male	0.498	0.460	0.421	0.360	0.340
Age 1 Male	0.067	0.052	0.032	0.011	0.007

TABLE 5: HHS HCCs Included in Infant Model Maturity Categories

Extremely Immature	Extremely Immature Newborns, Birth weight < 500 Grams
Extremely Immature	Extremely Immature Newborns, Including Birth weight 500-749 Grams
Extremely Immature	Extremely Immature Newborns, Including Birth weight 750-999 Grams
Immature	Premature Newborns, Including Birth weight 1000-1499 Grams
Immature	Premature Newborns, Including Birth weight 1500-1999 Grams
Premature/Multiples	Premature Newborns, Including Birth weight 2000-2499 Grams
Premature/Multiples	Other Premature, Low Birth weight, Malnourished, or Multiple Birth Newborns
Term	Term or Post-Term Singleton Newborn, Normal or High Birth weight
Age 1	All age 1 infants

TABLE 6: HHS HCCs Included in Infant Model Severity Categories

Severity Level 5 (Highest)	Metastatic Cancer
Severity Level 5	Pancreas Transplant Status
Severity Level 5	Liver Transplant Status/Complications
Severity Level 5	Intestine Transplant Status/Complications
Severity Level 5	Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis
Severity Level 5	Respirator Dependence/Tracheostomy Status
Severity Level 5	Heart Assistive Device/Artificial Heart
Severity Level 5	Heart Transplant Status/Complications
Severity Level 5	Heart Failure
Severity Level 5	Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders
Severity Level 5	Lung Transplant Status/Complications
Severity Level 5	Kidney Transplant Status/Complications
Severity Level 5	End Stage Renal Disease
Severity Level 5	Stem Cell, Including Bone Marrow, Transplant Status/Complications
Severity Level 4	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
Severity Level 4	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
Severity Level 4	Mucopolysaccharidosis
Severity Level 4	Adrenal, Pituitary, and Other Significant Endocrine Disorders
Severity Level 4	Acute Liver Failure/Disease, Including Neonatal Hepatitis
Severity Level 4	Chronic Liver Failure/End-Stage Liver Disorders
Severity Level 4	Major Congenital Anomalies of Diaphragm, Abdominal Wall, and Esophagus, Age < 2
Severity Level 4	Myelodysplastic Syndromes and Myelofibrosis
Severity Level 4	Aplastic Anemia
Severity Level 4	Combined and Other Severe Immunodeficiencies
Severity Level 4	Traumatic Complete Lesion Cervical Spinal Cord
Severity Level 4	Quadriplegia
Severity Level 4	Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease
Severity Level 4	Quadriplegic Cerebral Palsy
Severity Level 4	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
Severity Level 4	Nontraumatic Coma, Except Diabetic, Hepatic, or Hypoglycemic; Nontraumatic Brain Compression/Anoxic Damage
Severity Level 4	Respiratory Arrest
Severity Level 4	Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes
Severity Level 4	Acute Myocardial Infarction
Severity Level 4	Heart Infection/Inflammation, Except Rheumatic
Severity Level 4	Major Congenital Heart/Circulatory Disorders
Severity Level 4	Intracranial Hemorrhage
Severity Level 4	Ischemic or Unspecified Stroke
Severity Level 4	Vascular Disease with Complications
Severity Level 4	Pulmonary Embolism and Deep Vein Thrombosis
Severity Level 4	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections
Severity Level 4	Chronic Kidney Disease, Stage 5
Severity Level 4	Artificial Openings for Feeding or Elimination
Severity Level 3	HIV/AIDS
Severity Level 3	Central Nervous System Infections, Except Viral Meningitis
Severity Level 3	Opportunistic Infections
Severity Level 3	Non-Hodgkin Lymphomas and Other Cancers and Tumors
Severity Level 3	Colorectal, Breast (Age < 50), Kidney, and Other Cancers
Severity Level 3	Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors
Severity Level 3	Lipidoses and Glycogenosis
Severity Level 3	Intestinal Obstruction

Severity Level 3	Necrotizing Fasciitis
Severity Level 3	Bone/Joint/Muscle Infections/Necrosis
Severity Level 3	Osteogenesis Imperfecta and Other Osteodystrophies
Severity Level 3	Cleft Lip/Cleft Palate
Severity Level 3	Hemophilia
Severity Level 3	Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero
Severity Level 3	Disorders of the Immune Mechanism
Severity Level 3	Coagulation Defects and Other Specified Hematological Disorders
Severity Level 3	Drug Use with Psychotic Complications
Severity Level 3	Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications
Severity Level 3	Alcohol Use with Psychotic Complications
Severity Level 3	Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications
Severity Level 3	Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes
Severity Level 3	Traumatic Complete Lesion Dorsal Spinal Cord
Severity Level 3	Paraplegia
Severity Level 3	Spinal Cord Disorders/Injuries
Severity Level 3	Cerebral Palsy, Except Quadriplegic
Severity Level 3	Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies
Severity Level 3	Muscular Dystrophy
Severity Level 3	Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders
Severity Level 3	Hydrocephalus
Severity Level 3	Unstable Angina and Other Acute Ischemic Heart Disease
Severity Level 3	Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders
Severity Level 3	Specified Heart Arrhythmias
Severity Level 3	Cerebral Aneurysm and Arteriovenous Malformation
Severity Level 3	Hemiplegia/Hemiparesis
Severity Level 3	Cystic Fibrosis
Severity Level 3	Extensive Third Degree Burns
Severity Level 3	Severe Head Injury
Severity Level 3	Hip and Pelvic Fractures
Severity Level 3	Vertebral Fractures without Spinal Cord Injury
Severity Level 2	Viral or Unspecified Meningitis
Severity Level 2	Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors
Severity Level 2	Diabetes with Acute Complications
Severity Level 2	Diabetes with Chronic Complications
Severity Level 2	Diabetes without Complication
Severity Level 2	Protein-Calorie Malnutrition
Severity Level 2	Congenital Metabolic Disorders, Not Elsewhere Classified
Severity Level 2	Amyloidosis, Porphyria, and Other Metabolic Disorders
Severity Level 2	Cirrhosis of Liver
Severity Level 2	Chronic Pancreatitis
Severity Level 2	Acute Pancreatitis
Severity Level 2	Inflammatory Bowel Disease
Severity Level 2	Rheumatoid Arthritis and Specified Autoimmune Disorders
Severity Level 2	Systemic Lupus Erythematosus and Other Autoimmune Disorders
Severity Level 2	Congenital/Developmental Skeletal and Connective Tissue Disorders
Severity Level 2	Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn
Severity Level 2	Sickle-Cell Disorders, Except Sickle-Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia Major
Severity Level 2	Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes
Severity Level 2	Seizure Disorders and Convulsions
Severity Level 2	Monoplegia, Other Paralytic Syndromes
Severity Level 2	Atherosclerosis of the Extremities with Ulceration or Gangrene

Severity Level 2	Chronic Obstructive Pulmonary Disease, Including Bronchiectasis
Severity Level 2	Severe Asthma
Severity Level 2	Fibrosis of Lung and Other Lung Disorders
Severity Level 2	Chronic Kidney Disease, Severe (Stage 4)
Severity Level 2	Chronic Ulcer of Skin, Except Pressure
Severity Level 2	Major Skin Burn or Condition
Severity Level 1 (Lowest)	Chronic Viral Hepatitis C
Severity Level 1	Chronic Hepatitis, Except Chronic Viral Hepatitis C
Severity Level 1	Autistic Disorder
Severity Level 1	Pervasive Developmental Disorders, Except Autistic Disorder
Severity Level 1	Multiple Sclerosis
Severity Level 1	Asthma, Except Severe
Severity Level 1	Traumatic Amputations and Amputation Complications
Severity Level 1	Amputation Status, Upper Limb or Lower Limb

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c. Model Performance Statistics

Each benefit year, to evaluate the HHS risk adjustment model performance, we examine each model's R-squared statistic and predictive ratios (PRs). The R-squared statistic, which calculates the percentage of individual variation explained by a model, measures the predictive accuracy of the model overall. The PR for each of the HHS risk adjustment models is the ratio of the weighted mean predicted plan liability for the model sample population to the weighted mean actual plan liability for the model sample population. The PR represents how well the model does on average at predicting plan liability for that subpopulation.

A subpopulation that is predicted perfectly would have a PR of 1.0. For each of the current and proposed HHS risk adjustment models, the R-squared statistic and the PRs are in the range of published estimates for concurrent HHS risk adjustment models.[36] Because we propose to blend the coefficients from separately solved models based on the 2021, 2022, and 2023 benefit years' enrollee-level EDGE data, we are publishing the R-squared statistic for each model separately to assess model performance. The R-squared statistics for the proposed 2027 benefit HHS risk adjustment models are shown in Table 7.

TABLE 7: R-Squared Statistics for Proposed 2027 Benefit Year HHS Risk Adjustment Models

Platinum Adult	0.4213	0.4094	0.4152
Gold Adult	0.4154	0.4032	0.4089
Silver Adult	0.4122	0.3996	0.4048
Bronze Adult	0.4077	0.3948	0.3996
Catastrophic Adult	0.4068	0.3937	0.3982
Platinum Child	0.3569	0.3639	0.3412
Gold Child	0.3540	0.3612	0.3381
Silver Child	0.3516	0.3588	0.3357
Bronze Child	0.3484	0.3555	0.3324
Catastrophic Child	0.3474	0.3545	0.3314
Platinum Infant	0.3099	0.2883	0.2727
Gold Infant	0.3062	0.2847	0.2687
Silver Infant	0.3044	0.2827	0.2667
Bronze Infant	0.3019	0.2802	0.2640
Catastrophic Infant	0.3014	0.2797	0.2635

[36] Hileman, G., & Steele, S. (2016). *Accuracy of Claims-Based Risk Scoring Models*. Society of Actuaries. *https://www.soa.org/4937b5/globalassets/assets/files/research/research-2016-accuracy-claims-based-risk-scoring-models.pdf*.

3. Overview of the HHS Risk Adjustment Methodology (§ 153.320)

In part 2 of the 2022 Payment Notice (86 FR 24183 through 24186), we finalized the proposal to continue to use the State payment transfer formula finalized in the 2021 Payment Notice for the 2022 benefit year and beyond, unless changed through notice-and-comment rulemaking. We are not proposing changes to the formula in this rule. We therefore would continue to apply the formula as finalized in the 2021 Payment Notice (86 FR 24183 through 24186) in the States where HHS operates the risk adjustment program in the 2027 benefit year.

Additionally, as finalized in the 2020 Payment Notice (84 FR 17466 through 17468), we will maintain the high-cost risk pool parameters for the 2020 benefit year and beyond, unless amended through notice-and-comment rulemaking. We are not proposing changes to the high-cost risk pool parameters for the 2027 benefit year; therefore, we would maintain the $1 million threshold and 60 percent coinsurance rate.[37]

a. Comment Solicitation on Retaining Separate Risk Adjustment Transfer Calculations for Individual Catastrophic Plans and Individual Non-Catastrophic Plans Under the State Payment Transfer Formula

We are soliciting comment on whether we should retain separate risk adjustment transfer calculations under the State payment transfer formula for individual catastrophic plans and individual non-catastrophic plans or whether we should calculate State transfers for these plans together.

On September 4, 2025, CMS released guidance entitled ''*Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-sharing Reductions Due to Income, and Streamlining Exemption Pathways to Coverage,*'' [38] which expands upon prior FFE hardship exemption policy by expanding eligibility for catastrophic plans starting with PY 2026.[39] Specifically, this guidance allows consumers in applicable States to qualify for an exemption to purchase a catastrophic plan on or off an Exchange in accordance with § 155.605(d)(1)(iii) if they are determined or expect to be ineligible for APTC or CSRs based on their projected annual household income.

In light of this guidance and feedback from interested parties concerning this guidance and the potential for increased enrollment in catastrophic coverage starting with PY 2026, we seek comment on the impact of this policy on the HHS-operated risk adjustment program. Currently, risk adjustment transfers under the State payment transfer formula are calculated separately for individual catastrophic plans and individual non-catastrophic plans.[40] [41] By adding this additional hardship exemption that allows individuals ineligible for APTC or CSRs due to projected household income to enroll in a catastrophic plan, a broader population will be permitted to enroll in catastrophic plans starting with PY 2026, which has the potential to impact the individual catastrophic and individual non-catastrophic market risk pools.

Thus, although we are not proposing to make changes to the State payment transfer formula in light of this guidance for the 2026 benefit year or 2027 benefit year, HHS seeks comments on the potential impact of retaining the separate calculation of risk adjustment transfers under the State payment transfer formula for individual catastrophic plans and individual non-catastrophic plans or whether the calculation of State transfers for individual catastrophic plans should be combined with the calculation of State transfers for individual non-catastrophic plans in non-merged market States or combined with the calculation of State transfers for individual non-catastrophic and small group market plans in merged market States. We are particularly interested in comments on maintaining the separate calculation of risk adjustment transfers under the State payment transfer formula for individual catastrophic plans and individual non-catastrophic plans (or combining them) for risk adjustment purposes in non-merged market States [42] and the impact on risk adjustment and the resulting impact on the risk pool market composition, premiums, and risk adjustment State transfers under both scenarios, in light of the potential for increased catastrophic plan enrollment as a result of the aforementioned guidance on hardship exemptions.

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

HHS will conduct HHS–RADV under §§ 153.350 and 153.630 in any State where HHS is operating risk adjustment on the State's behalf.[43] The purpose of HHS–RADV is to ensure issuers are providing accurate high-quality information to HHS, which is crucial for the proper functioning of the HHS-operated risk adjustment program. HHS–RADV also ensures that risk adjustment transfers reflect verifiable actuarial risk differences among issuers, rather than risk score calculations that are based on poor quality data, thereby helping to ensure that the HHS-operated risk adjustment program assesses charges to issuers with plans with

[37] See for example, the 2018 Payment Notice (81 FR 94081) and 2020 Payment Notice (84 FR 17467).

[38] See CMS. (2025). *Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-sharing Reductions Due to Income, and Streamlining Exemption Pathways to Coverage. https://www.cms.gov/files/document/guidance-hardship-exemptions.pdf.*

[39] This guidance applies to consumers in FFE States and in SBE States that choose to have exemptions processed through the FFE, which currently include all SBEs except California, Connecticut, Maryland, and the District of Columbia. We note that there is a proposal elsewhere at III.D.17. of this proposed rule to expand § 155.605(d)(1) to codify the expansion of hardship exemption eligibility to consumers ineligible for APTC or CSRs due to projected household income below 100 percent or above 250 percent FPL in all States.

[40] Risk adjustment State transfers are calculated separately for individual catastrophic plans, individual non-catastrophic plans and small group market plans for non-merged market States. In merged market States, while individual catastrophic plans' risk adjustment State transfers are still calculated separately, individual non-catastrophic plans and small group market plans are treated as part of the same market risk pool and risk adjustment transfers under the State payment transfer formula are calculated jointly across all of these plans. *See* the 2014 Payment Notice (77 FR 73118). *See,* also, Pope et al. (2014). Risk Transfer Formula for Individual and Small Group Markets Under the Affordable Care Act. *Medicare & Medicaid Research Review, 4*(3). Available at: *https://www.cms.gov/mmrr/downloads/mmrr2014_004_03_a04.pdf.*

[41] We note that for the adjustment to the State payment transfer formula made by the high-cost risk pool (HCRP) is made for all issuers of risk adjustment covered plans in the HCRP national individual (including catastrophic and non-catastrophic plans and merged market plans), or small group market, across all States and the District of Columbia where HHS is responsible for operating the program, based on total premiums in the respective market. As such we adjust risk adjustment State transfers for two high-cost risk pools across all States: one for the individual market (including catastrophic, non-catastrophic, and merged market plans), and one for the small group market. This differs from our implementation of the risk adjustment State payment transfer formula for general risk adjustment transfers, which calculates transfers separately for the individual catastrophic, individual non-catastrophic, and merged markets. *See* the 2018 Payment Notice (81 FR 61471 through 94082).

[42] We are similarly interested in comments on maintaining the calculation of risk adjustment State transfers for individual catastrophic plans separate from the calculation of individual non-catastrophic and small group market plans (or combining them) in merged market states.

[43] Since the 2017 benefit year, HHS has operated the risk adjustment program in all 50 States and the District of Columbia.

lower-than-average actuarial risk while making payments to issuers with plans with higher-than-average actuarial risk. HHS–RADV consists of an initial validation audit (IVA) and a second validation audit (SVA). Under § 153.630, each issuer of a risk adjustment covered plan must engage an independent IVA entity. The issuer provides demographic, enrollment, and medical record documentation for a sample of enrollees selected by HHS to its IVA entity for data validation. Each issuer's IVA is followed by an SVA, which is conducted by an entity HHS retains to verify the accuracy of the findings of the IVA. Based on the findings from the IVA, or SVA (as applicable), HHS conducts error estimation to calculate an HHS–RADV error rate. The HHS–RADV error rate is then applied to adjust the plan liability risk scores (PLRSs) of outlier issuers, as well as the risk adjustment transfers calculated under the State payment transfer formula for the applicable State market risk pools, for the benefit year being audited.

a. HHS–RADV Error Estimation Modification To Incorporate IVA Sampling Changes

We propose to modify one intermediate step of the HHS–RADV error estimation methodology starting with 2025 benefit year HHS–RADV. In the 2026 Payment Notice (90 FR 4449 through 4452), we finalized excluding enrollees without HCCs from IVA sampling beginning with 2025 benefit year HHS–RADV. We noted that this policy will impact the steps in the error estimation methodology during which HCC-associated error rates are applied to adjust issuers' PLRSs, and stated our intent to seek comments on potential modifications to the intermediate steps in the error estimation methodology to ensure that HCC-associated error rates continue to apply to only the proportion of total PLRSs that are associated with HCC-components of EDGE risk scores. As such, we now propose to add an additional scaling factor, α_i, to the error estimation methodology to address this and capture the proportion of an issuer's total risk for the entire population that is associated with enrollees with HCCs. This scaling factor would be added to the final steps of error estimation in which HCC-associated error rates are applied to adjust issuers' PLRSs, and therefore, its addition would not impact the majority of the error estimation methodology, including the calculation of group failure rates, enrollee-level adjustments or HCC-associated error rates.

The formula for the existing scaling factor $HccPLRSweight_i$ is the sum of sampled enrollee's stratum-weighted adjusted HCC-associated portion of EDGE risk scores divided by the sum of sampled enrollees' stratum-weighted total EDGE risk score. Because this formula is based on the issuer's sample, it depends on having enrollees with and without HCCs in the audit sample to appropriately estimate the proportion of the issuer's total PLRS that is HCC-related. However, as explained in the 2026 Payment Notice (90 FR 4452), when enrollees without HCCs are excluded from issuers' audit samples beginning with 2025 benefit year HHS–RADV, this formula will only estimate the proportion of enrollees' total EDGE risk scores that is HCC-related for enrollees with HCCs.[44] Therefore, we are proposing to create another scaling factor beginning with benefit year 2025 HHS–RADV that estimates the proportion of the issuer's total PLRS that is associated with enrollees with HCCs using the issuer's EDGE data. Together, these two scaling factors would capture the proportion of the issuer's total PLRS that is HCC-related.

Therefore, we propose to introduce an additional scaling factor, α_i, as follows:

$$\alpha_i = \frac{\sum_{h=1}^{9} meanRiskScore_{i,h} * StrBMM_{i,h}}{\sum_{h=1}^{10} meanRiskScore_{i,h} * StrBMM_{i,h}}$$

Where:

$meanRiskScore_{i,h}$ is the average risk score for all enrollees in stratum h in issuer i's EDGE population

$strBMM_{i,h}$ is the total stratum billable member months (BMM) for all enrollees in stratum h in issuer i's EDGE population

Applying the scaling factor α_i to the intermediate steps in the error estimation methodology as follows:

$TotalER_i = HccER_i * HccPLRSWeight_i * \alpha_i$

The numerator in the formula for the scaling factor sums the product of each stratum's mean risk score and total BMM for strata 1 through 9, thereby creating an aggregate risk score for all enrollees with EDGE HCCs in an issuer's EDGE population.[45] The denominator sums the product of each stratum's mean risk score and total BMM for strata 1 through 10. This includes all enrollees in the issuer's EDGE population including enrollees without HCCs, and thereby creates an aggregate risk score for the issuer.[46] Overall, the scaling factor α_i estimates the proportion of the issuer's total PLRS that is associated with enrollees with HCCs and, by combining it with the HCC PLRS weighting factor, we could continue to estimate the proportion of the issuer's total PLRS that is HCC-related after the removal of no HCC enrollees from the IVA sample beginning with 2025 benefit year HHS–RADV. After leveraging EDGE data from the relevant benefit year to calculate the scaling factor and the total error rate , we would continue to adjust issuers' PLRSs using the following formula:

$AdjPLRS_i = (1 - TotalER_i) * PLRS_i$

Without adding this additional scaling factor to the error estimation methodology beginning with 2025 benefit year HHS–RADV, the error rate would adjust elements of issuers' total PLRSs that are associated with enrollees' without HCCs and are not intended to be adjusted during error estimation.[47] We believe these adjustments would be inappropriate, and moreover, could result in double adjustments for any identified data errors of non-HCC components, such as demographic and enrollment factors, that are adjusted through separate

[44] In other words, this will factor out the contribution of demographic factors, enrollee RXCs, HCC–RXC interaction factors, CSR adjustment factors, HCC-contingent enrollment duration factors, and interacted HCC counts factors towards the EDGE risk scores of enrollees with HCCs. As previously explained, these factors are not included in the calculation of the HCC-associated error rate during HHS–RADV error estimation. See Section 13.3.1.3.3 Calculate Error Rates of the BY24 HHS–RADV Protocols available at *https://regtap.cms.gov/uploads/library/HHS-RADV_2024_Benefit_Year_Protocols_v1_5CR_060625.pdf.*

[45] An issuer's EDGE population only consists of enrollees in their risk adjustment covered plans. See §§ 153.610(a) and 153.700(a).

[46] Although enrollees without HCCs will be excluded from IVA sampling beginning with 2025 benefit year HHS–RADV, enrollees without HCCs on EDGE will be categorized into stratum 10 for these operational purposes.

[47] Enrollees without HCCs may contribute to the PLRS through demographic factors, enrollee RXCs, and CSR risk adjustment factors. As previously explained, these enrollees are not included in the calculation of the HCC-associated error rate during HHS–RADV error estimation.

processes.[48] Therefore, starting with the 2025 benefit year of HHS–RADV, we propose to add an additional scaling factor, α_i, to the error estimation methodology to ensure that HCC-associated error rates continue to apply to only the proportion of total PLRSs that are associated with HCC-components of EDGE risk scores.

We seek comments on this proposal.

5. HHS Risk Adjustment User Fee for the 2027 Benefit Year (§ 153.610(f))

We propose an HHS risk adjustment user fee for the 2027 benefit year of $0.20 PMPM. Under § 153.310, if a State is not approved to operate, or chooses to forgo operating, its own risk adjustment program, HHS will operate risk adjustment on its behalf. For the 2027 benefit year, HHS will operate risk adjustment in every State and the District of Columbia. As described in the 2014 Payment Notice (78 FR 15416 through 15417), HHS' operation of the risk adjustment program on behalf of States is funded through a risk adjustment user fee. Section 153.610(f)(2) provides that, where HHS operates a risk adjustment program on behalf of a State, an issuer of a risk adjustment covered plan must remit a user fee to HHS equal to the product of its monthly billable member enrollment in the plan and the PMPM risk adjustment user fee specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year.

OMB Circular No. A–25 established Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public.[49] The HHS-operated risk adjustment program provides special benefits as defined in section 6(a)(1)(B) of OMB Circular No. A–25 to issuers of risk adjustment covered plans because it mitigates the financial instability associate with potential adverse risk selection.[50] The HHS-operated risk adjustment program also contributes to consumer confidence in the health insurance industry by helping to stabilize premiums across the individual, merged, and small group markets.

In the 2026 Payment Notice (89 FR 26218), we calculated the Federal administrative expenses of operating the HHS risk adjustment program for the 2026 benefit year to result in a risk adjustment user fee rate of $0.20 PMPM based on our estimated costs for HHS risk adjustment operations and estimated BMM for individuals enrolled in risk adjustment covered plans. For the 2027 benefit year, HHS proposes to use the same methodology to estimate our administrative expenses to operate the program. These costs cover development of the models and methodology, collections, payments, account management, data collection, data validation, program integrity and audit functions, operational analytics, interested parties training, operational support, and administrative and personnel costs dedicated to HHS-operated risk adjustment program activities. To calculate the risk adjustment user fee, we divided HHS' projected total costs for administering the program on behalf of States by the expected number of BMM in risk adjustment covered plans in States where the HHS-operated risk adjustment program will apply in the 2027 benefit year.

We estimate that the total cost for HHS to operate the risk adjustment program on behalf of all States and the District of Columbia for the 2027 benefit year will be slightly more than $65 million, which is similar to the 2026 benefit year budget.[51]

Similar to prior benefit years, we projected risk adjustment enrollment scenarios for the 2027 benefit year. Based on our estimates, for the 2027 benefit year, we do not expect enrollment changes to significantly impact collections under this user fee rate.

Our intention is to reconsider the enrollment estimates for the final rule. If these newer enrollment estimates are too low in comparison to our proposed user fee estimates, the final user fee may be higher. If these enrollment estimates are higher in comparison to our proposed user fee estimates, the final user fee may be lower. We also note that if any events result in a deviation from our expectations of current conditions that would significantly change our estimates around costs, enrollment projections, or the finalization of proposed risk adjustment policies between this proposed rule and the final rule, we may modify the HHS risk adjustment user fee rate proposed in this rule in the final rule. Because we project a similar budget to operate the HHS-operated risk adjustment program for the 2027 benefit year as for the 2026 benefit year, we propose an HHS risk adjustment user fee of $0.20 PMPM for the 2027 benefit year.

We seek comment on the proposed HHS risk adjustment user fee for the 2027 benefit year.

C. Part 154—Health Insurance Issuer Rate Increases: Disclosure and Review Requirements

1. Submission of Rate Filing Justification (§ 154.215)

a. CSR Reimbursement

Section 1402 of the Affordable Care Act requires issuers to provide cost-sharing reductions (CSRs) to increase the actuarial value for consumers with incomes between 100 and 250 percent of Federal poverty level (FPL) who enroll in silver level QHPs in the individual market, as well as eligible AI/AN consumers who enroll in QHPs at any metal level. Section 1402 of the Affordable Care Act also states that HHS will reimburse issuers for the cost of providing CSRs to eligible enrollees but does not include a valid appropriation to make such payments.[52]

On October 11, 2017, the Attorney General of the United States provided a legal opinion stating that HHS and the Department of the Treasury could no longer use the permanent appropriation at 31 U.S.C. 1324 to fund CSR reimbursements to issuers.[53] In accordance with that opinion, HHS directed CMS to discontinue CSR reimbursements to issuers until Congress provides an appropriation. In response to the termination of CSR reimbursement, State Departments of Insurance either allowed or instructed issuers to increase (or ''load'') premiums either primarily, or only, on silver-level QHPs to offset the issuers' cost of providing CSRs.[54]

There are several ways that issuers have determined the CSR load factor.

[48] While HHS–RADV also includes processes for validating RXCs and demographic and enrollment factors, any errors regarding these factors are treated as materially incorrect EDGE server data submissions. See 83 FR 16970 through 16971. Also see 84 FR 17501 and 85 FR 77002 through 77005.

[49] See Circular No. A–25 Revised. *https://www.whitehouse.gov/wp-content/uploads/2017/11/Circular-025.pdf.*

[50] *Id.*

[51] We estimated that the total costs for HHS to operate the risk adjustment program on behalf of States for the 2026 calendar year would be approximately $65 million. See, 2026 Payment Notice (90 FR 4424 at 4448).

[52] Until October 2017, HHS relied on the permanent appropriation at 31 U.S.C. 1324 as the source of funds for Federal CSR reimbursement to issuers.

[53] See Verma, Seema. (2017, October 12). Letter to Acting Secretary Eric Hagan Regarding Payments to Issuers for Cost-Sharing Reductions (CSRs), *https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf,* relying on *US. House of Reps.* v. *Burwell,* 185 F. Supp. 3d 165 (D.D.C. 2016). Available at *https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.*

[54] For purposes of this preamble, we use the term ''CSR loading'' to refer to any rating practices to increase premiums to offset amounts of unreimbursed CSRs whether that is ''silver loading'' or ''broad loading.''

For example, issuers have loaded silver plans offered on-Exchange to recover expected lost CSRs based on experience, they have loaded silver plans on-Exchange based on an assumed distribution of enrollment and enrollee utilization (sometimes a set amount mandated by the State), or they have loaded all plans at all metal levels by the same amount to spread lost CSRs across the entire individual market. These differing approaches may result in loads that exceed the expected amount of unreimbursed CSRs by assuming an enrollment and claims distribution that significantly diverges from what actually occurs. Based on our review of actuarial memoranda submitted by issuers for PY 2026, HHS believes these excessive loads on silver plans in particular (and in some cases as mandated by State law) lead to inflated premiums for silver plans, further distort pricing for bronze and gold plans relative to silver plans, limit consumer choice, and significantly increase the cost of the second lowest-cost silver plan available to a consumer, which in turn increases PTC amounts and Federal expenditures.

b. Rate Filing Justifications Regarding CSRs

Section 2794 of the PHS Act directs the Secretary, in conjunction with the States, to establish a process for the annual review of premium increases for health coverage prior to the implementation of the increase. HHS has historically interpreted this requirement with respect to premiums as referring to the underlying rates that are used to develop premiums. Section 154.215 requires issuers to submit rate filing justifications to CMS and the applicable State.[55]

Pursuant to § 154.215(b)(1) through (3), the rate filing justification has three parts. The Unified Rate Review Template (URRT) (Part I of the rate filing justification) is required for all single risk pool products, including new products and products with plans that experience rate increases, rate decreases, or no rate change. It is intended to capture information needed to monitor premium increases of health insurance coverage offered through and outside the Exchanges and ensure compliance with the single risk pool methodology, including allowable market level index rate adjustments to reflect risk adjustment payments and charges, and other Federal rating requirements.[56]

Part II of the rate filing justification is the Written Description Justifying the Rate Increase (Consumer Justification Narrative). Part II is required only for rate increases in single risk pool products that are subject to review (that is, a plan within the product that has a rate increase of 15 percent or greater). Part II is a consumer-friendly narrative that provides the justification for the rate increase, describes the relevant Part I data, the assumptions used to develop the rate increase, and an explanation of the most significant factors causing the rate increase.[57]

An actuarial memorandum (Part III of the rate filing justification) is required for any rate increase in a single risk pool plan. It is also required for any rate filing containing QHPs or whenever a State requires it to be submitted. Further, an actuarial memorandum is required for all plans in States that do not have an Effective Rate Review Program and for which CMS is responsible for reviewing the rate filing.[58] The Part III actuarial memorandum includes the actuarial reasoning and assumptions, justifications, and methodologies that support the entries in the URRT.[59] The actuarial memorandum must also capture appropriate actuarial certifications related to the development of the index rate in accordance with Federal regulations, and the development of plan specific premium rates using allowable modifiers to the index rate.[60] The issuer is required to provide an explanation of how these modifiers are developed and applied to the market-wide adjusted index rate to derive the plan-adjusted index rate.

In a Bulletin issued on May 2, 2025 (PY26 Rate Filing Guidance),[61] we instructed issuers that make permitted plan-level adjustments to account for CSR amounts provided to eligible enrollees for which the issuer does not otherwise receive reimbursement [62] (that is, that load premiums) to specify the amount of unreimbursed CSRs in the actuarial memorandum of their PY 2026 rate filing. Issuers report plan-level adjustments when they submit a rate filing justification to the State or CMS for review. States or CMS review those rate filing justifications to ensure compliance with the Federal rating rules, including 45 CFR 156.80.[63]

Specifically, through the PY 26 Rate Filing Guidance, and pursuant to our authority under § 154.215(a)(2) and (3), we directed issuers that loaded for unreimbursed CSRs to: (1) specify the actual CSRs the issuer paid on behalf of enrollees for PY 2024 (in dollars); (2) specify the CSR load factor for PY 2026 and explain how it was determined; and (3) explain how the additional revenue to be collected from the applied CSR load compares to the expected amount of CSRs that will be provided to enrollees in PY 2026.

Following issuance of the PY26 Rate Filing Guidance, CMS issued additional guidance entitled, ''Frequently Asked Questions on Plan Year 2026 Individual Market Rate Filing Instructions,'' on May 27, 2025.[64] We noted that if an issuer was not able to calculate the precise amount of actual CSRs paid for enrollees for PY 2024 by the applicable rate filing deadline, CMS would accept an estimate developed using a reasonable methodology that enables it to estimate the value of CSRs provided for PY 2024 as accurately as possible, detailed in the actuarial memorandum.[65]

[55] *See* 76 FR 29964, 29969 (May 23, 2011).

[56] See *Unified Rate Review Instructions at: https://www.cms.gov/files/document/unified-rate-review-instructions.pdf.*

[57] *Id.*

[58] CMS reviews rate filing justifications from issuers in States without an Effective Rate Review Program—currently Oklahoma, Tennessee, and Wyoming.

[59] See *Unified Rate Review Instructions at: https://www.cms.gov/files/document/unified-rate-review-instructions.pdf.*

[60] *Id.*

[61] CMS. (2025, May 2). Plan Year 2026 Individual Market Rate Filing Instructions. *https://www.cms.gov/files/document/py-26-individual-market-rate-filing-instructions.pdf.*

[62] See 45 CFR 156.80(d)(2)(i).

[63] If the rate filing contains a proposed increase that meets or exceeds the threshold at § 154.200(a)(1) (currently 15 percent), then the State or CMS also reviews the proposed increase to determine if it is an unreasonable rate increase. Also see 45 CFR 154.205(a). When CMS reviews a rate increase subject to review under § 154.210(a), CMS will determine that the rate increase is an unreasonable rate increase if the increase is an excessive rate increase, an unjustified rate increase, or an unfairly discriminatory rate increase.

[64] CMS. (2025, May 7). Frequently Asked Questions on Plan Year 2026 Individual Market Rate Filing Instructions. *https://regtap.cms.gov/reg_librarye.php?i=5894.*

[65] Under § 156.80(d)(2)(i), an issuer may vary premium rates for a particular plan from its market-wide index rate for a relevant State market based on the actuarial value and cost-sharing design of the plan, including accounting for, if permitted by the applicable State authority, CSR amounts provided to eligible enrollees under § 156.410, provided the issuer does not otherwise receive reimbursement for such amounts. Therefore, if there is a valid appropriation such that HHS and the Department of the Treasury resume making advance payments of CSRs, issuers may not apply any CSR load to QHPs receiving advance CSR payments. In addition, in the event that advance payments of CSRs are made to issuers to reimburse them for CSRs provided, HHS will calculate these monthly advance payments using the formula finalized in the 2015 Payment Notice and using the standard methodology as set forth in 45 CFR 156.430(c)(2) for

Continued

Starting with rate filings for the 2027 plan year, we are proposing to continue to require issuers that make a plan-level adjustment to account for unreimbursed CSRs to submit certain information specified in the PY26 Rate Filing Guidance in their URRTs and actuarial memoranda for each plan year in which CSRs are not funded. Specifically, in the URRT for the upcoming plan year, issuers would report CSR amounts paid on behalf of enrollees and the additional revenue collected from the previously applied CSR load using the most recent annual data that is available prior to the applicable filing year, using the standard methodology set forth in § 156.430(c)(2). In most cases, the most recent annual CSR data would reflect the plan year that is two years before the upcoming plan year (for example, CSRs paid for eligible enrollees and the additional revenue collected from the CSR load applied in PY 2025 would be reported during the 2026 filing year on rate filings for PY 2027).

As described by the Secretary in applicable guidance,[66] under the CMS standard methodology, issuers re-adjudicate the actual complete set of claims incurred by an enrollee in the cost-sharing reduction plan variation as if they had been enrolled in the associated standard plan to determine the difference the enrollee would have paid in deductibles, copayments, coinsurance, and other out-of-pocket expenses for EHBs (other than premiums and balance billing). The difference equals the amount of CSRs provided by the issuer.[67] As stated in the 2016 Payment Notice, we believe that the standard methodology is the most accurate method for calculating the actual value of CSRs that the issuer has provided on behalf of enrollees in a plan year.[68] Additionally, we believe that most issuers are familiar with that methodology, which was required to calculate CSRs paid on behalf of enrollees for the 2017 plan year, the most recent year in which CMS provided advance CSR payments to issuers.

We note that although CMS is proposing that issuers use the standard methodology to calculate CSR amounts paid on behalf of enrollees and to submit an aggregate amount of CSRs provided at the plan level on the URRT, this proposed data submission would not require issuers to use the CSR reconciliation process implemented by CMS, as described in § 156.430(c)(2). We believe this proposal would result in lower burden on issuers as compared to the burden that would be associated with submitting policy-level CSR data to CMS through the CSR reconciliation process. Submission of policy-level CSR data would require direct electronic submissions of data that must conform with our business rules, data element validations, and required file formats. When HHS previously collected such data, it resulted in issuers attempting submissions multiple times before the submission could be accepted by the system. The proposed process would leverage the existing URRT submission process and be much less burdensome.

We also propose that issuers would include in the URRT the applicable CSR load factor for each plan that would be applied to the market adjusted index rate to calculate the calibrated plan adjusted index rate for the upcoming plan year. We are proposing to collect the CSR load factor, if any, to fulfill our responsibility to ensure compliance with § 156.80(d), which requires all permitted plan-level adjustments to be ''actuarially justified.'' In addition, we propose that issuers would include in the actuarial memorandum an explanation of the methodology used to determine the load factor. We propose that issuers would also include in the URRT the additional revenue expected to be collected from the applied CSR load factor and the expected amount of CSRs that will be paid for enrollees for the upcoming plan year. We also propose that issuers would include in the actuarial memorandum an explanation comparing these amounts. This explanation would allow the State or CMS, as applicable, to determine whether the load factor is actuarially justified and not excessive in relation to the amount expected to be paid for unreimbursed CSRs.

In the 2026 Payment Notice, we stated our expectation that CSR loading practices, to the extent permitted by State regulators, are intended to account for unpaid CSRs. We also noted that, while there is no requirement that a State permit CSR loading, in States that have an Effective Rate Review Program, the State has the responsibility to determine whether an issuer's adjustments to the market-wide index rate for plan-specific factors (including accounting for CSR amounts) are actuarially justified.[69] We further propose that an actuarially justified CSR load factor is one that is calibrated on actual experience and that only accounts for the projected revenue loss of unreimbursed CSR payments without materially exceeding that amount. As such, we believe that this proposal to collect through the URRT and actuarial memoranda information on paid CSRs, additional revenue collected from the previously applied CSR load, CSRs expected to be paid, the CSR load factor and expected resultant additional revenue for the upcoming plan year, the underlying methodology for determining the CSR load factor that would be applied for the upcoming plan year, and an explanation of how the expected additional revenue compares to the amount of CSRs expected to be paid, will benefit State regulators (and CMS in States where CMS functions as the primary reviewer of rates) by providing regulators the data necessary to determine whether CSR load amounts are actuarially justified plan-level adjustments to the index rate under § 156.80.

While we recognize the additional burden on issuers to provide this information, given the significant impact of CSR loading on Federal expenditures through additional premium tax credit (PTC) spending, we believe collection of this information is an important program integrity measure that will help ensure that CSR loads are appropriate to recover lost CSR payments and are not inappropriately inflating Federal expenditures or undermining Federal rating rules.

Therefore, starting with rate filings for the 2027 plan year, we are proposing to collect as part of the rate filing justification information on adjustments to the index rate to account for unreimbursed CSRs. Specifically, we propose to collect data regarding the amount of CSRs previously paid on behalf of eligible enrollees using the most recent annual data that is available prior to the applicable filing year (generally data from the plan year that is two years before the upcoming plan year), the amount previously generated by any load factors from the most recent annual data available, the amount of CSRs expected to be paid on behalf of enrollees in the upcoming plan year, the

reconciliation of cost sharing reduction amounts. See 79 FR 13804–13808. Also see 90 FR 4424, 4488.

[66] See Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Year 2017 (March 29, 2018) at *https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/downloads/final-csr-reconciliation-guidance-by2017.pdf.*

[67] CMS. (2018, March 29). Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Year 2017. *https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/downloads/final-csr-reconciliation-guidance-by2017.pdf.*

[68] HHS Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 FR 10750, 10842 (February 27, 2015), available at: *https://www.govinfo.gov/content/pkg/FR-2015-02-27/pdf/2015-03751.pdf.*

[69] HHS Notice of Benefit and Payment Parameters for 2026 Final Rule, 90 FR 4424, 4489 (January 15, 2025) available at: *https://www.govinfo.gov/content/pkg/FR-2025-01-15/pdf/2025-00640.pdf.*

underlying methodology for determining the CSR load factor that would be applied for the upcoming plan year, the load factor itself (the expected amount generated by the load factor for the upcoming plan year, and an explanation of how the expected amount generated by the load factor compares to the amount of CSRs expected to be paid on behalf of enrollees for the same period. If this proposal is finalized as proposed, we intend to release guidance on the submission of this information as part of revised Unified Rate Review Instructions, as we have historically provided detailed guidance to issuers on how to complete each field of the URRT and satisfy the criteria for the actuarial memorandum in the Unified Rate Review Instructions.[70] We are not proposing changes to any regulation text as the collection of these data is already captured under § 154.215(d)(1), which states that historical and projected claims experience must be included in the URRT. Additionally, § 156.80(d)(2)(i) states that plan-level adjustments to account for unreimbursed CSR payments provided to eligible enrollees are permissible only if actuarially justified and permitted by the applicable state authority. We request comment on all aspects of our proposal to require issuers that intend to load premium rates to account for unpaid CSRs for the upcoming plan year to submit this information in their URRTs and the actuarial memoranda for each plan year in which CSRs are not funded, beginning with PY 2027 rate filings.

D. Part 155—Exchange Establishment Standards and Other Related Standards

1. Standardized Plan Options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv))

We propose to exercise our authority under sections 1311(c)(1) and 1321(a)(1)(B) of the Affordable Care Act to discontinue the full suite of standardized plan option policies effective beginning in PY 2027. As discussed in greater detail in the preamble section of this proposed rule addressing § 156.201, we propose to remove the following from our regulations: the definition of ''standardized option'' at § 155.20; all requirements pertaining to standardized plan options at § 156.201 (the requirements for FFE and SBE–FP QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one another at paragraph (c)); the differential display of standardized plan options on *HealthCare.gov* at § 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv). We also propose to redesignate paragraphs (c)(3)(i)(I) through (M) of § 155.220 as paragraphs (c)(3)(i)(H) through (L), respectively. Finally, we propose to cease the annual design and publication of these standardized plan options in the applicable Payment Notice rulemaking for each plan year.

2. Approval of a State Exchange (§ 155.105)

We propose to remove § 155.105(b)(4) to rescind a requirement made in the 2025 Payment Notice (89 FR 26259 through 26261), that a State seeking to operate a State Exchange must first operate, for at least 1 plan year, a State-based Exchange on the Federal platform (SBE–FP). The original amendment was intended to give States sufficient time to create, staff, and structure a State Exchange. However, we recognize that requiring States to first operate as an SBE–FP for at least 1 plan year could potentially create unnecessary barriers for States that are well-prepared to implement a State Exchange more immediately.

Sections 1311(b) and 1321(b) of the Affordable Care Act allow States to elect to operate their own health insurance Exchanges to provide individuals and employers with health insurance coverage. Every State that has implemented a State Exchange after 2014—the year the initial 13 State Exchanges began operation—first operated an SBE–FP for at least 1 plan year. This history shows how first operating an SBE–FP has been the preferred approach. However, we recognize that States may have existing infrastructure, relationships, and expertise that could support a State's successful operation of a State Exchange, without first operating an SBE–FP. For example, FFE States are permitted to elect to perform plan management functions similar to the plan management functionality required of all SBE–FPs.[71] The infrastructure and the associated stakeholder relationships and State expertise to support such functionality could be leveraged from a direct FFE to State Exchange implementation. Additionally, the technology infrastructure available today to States for implementation of State Exchanges has become more compatible, such that the technology used to support one State Exchange implementation could be leveraged by another State Exchange. A State must demonstrate its ability to operationalize State Exchange functional requirements through a well-established and robust review process with HHS. Whether a State first operates an SBE–FP does not change our review process for determining whether a State is ultimately prepared to implement a State Exchange. For the reasons provided above, we propose to remove § 155.105(b)(4), such that a State seeking to operate a State Exchange is not required to first operate an SBE–FP for at least 1 plan year, including its first open enrollment period.

We seek comment on this proposal.

3. Approval of a State Exchange (§ 155.106)

In an effort to support the overall goals of Executive Order 14192, ''Unleashing Prosperity through Deregulation,'' [72] we propose to amend § 155.106(a)(2) to rescind a requirement we made in the 2025 Payment Notice (89 FR 26261 through 26263) that, as part of a State's activities for its establishment of a State Exchange, the State must provide, upon request, supporting documentation demonstrating progress toward meeting or implementing State Exchange Blueprint requirements. Section 155.106(a)(2) requires that States electing to operate a State Exchange submit a State Exchange Blueprint Application to HHS for approval. The current State Exchange Blueprint application provides that we may require live demonstrations of Exchange functionality on the State Exchange's platform, as well as supporting documentation, as evidence of the State's progress toward meeting State Exchange Blueprint application requirements. For clarity, we had

[70] The information collection described in this section will be submitted as a revision to the currently approved PRA package CMS–10379 (OMB Control Number 0938–1141) for OMB review under the Paperwork Reduction Act.

[71] A state may choose to operate plan management functions within the FFE. CMS. (2012, May). Plan Management Partnership in the Federally Facilitated Exchange (FFE). Available at: *https://www.cms.gov/CCIIO/Resources/Presentations/Downloads/hie-plan-management-partnership-in-the-ffe.pdf*.

[72] E.O. 14192, January 31, 2025 (90 FR 9065), available at *https://www.federalregister.gov/documents/2025/02/06/2025-02345/unleashing-prosperity-through-deregulation*.

finalized in the 2025 Payment Notice to codify that as part of the State's submission of a State Exchange Blueprint application, CMS has the authority to request supplemental documents it determines necessary for the State to detail its implementation of the required State Exchange functionality. To support deregulation where possible, we are now proposing to remove what we codified.

The State Exchange Blueprint continues to serve as a vehicle for a State to document its progress toward implementing its intended Exchange operational model. HHS approves a State's Exchange Blueprint Application and subsequently provides approval for a State to operate a State Exchange, based upon a State meeting State Exchange implementation requirements noted in the Blueprint Application. The current Blueprint Application requires a State to sign and agree that HHS may require supporting documentation from a State as evidence of its progress toward meeting State Exchange Blueprint Application requirements, which is part of the overall process for providing a State with approval to operate a State Exchange. Notably, in our experience, States recognize the need for HHS to request supplemental documentation in order for HHS to assess a State's readiness to operate a State Exchange, which supports a State's successful State Exchange operation. States have provided such supplemental documentation upon HHS request both before and after this requirement was originally codified. Given this preexisting process, we do not believe deregulation in this instance is harmful, nor would it lead to burden on States. Therefore, we propose to rescind the requirement that a State provide, upon request, supporting documentation demonstrating progress toward meeting or implementing State Exchange Blueprint requirements from § 155.106(a)(2).

We seek comment on this proposal.

4. Amending Requirements for State Exchanges To Operate a Centralized Eligibility and Enrollment Infrastructure (§§ 155.205(b) and 155.221(k))

a. Amending Requirements for State Exchanges To Operate a Centralized Eligibility and Enrollment Platform on the State Exchange's Website (§ 155.205(b))

We are proposing to revise § 155.205(b)(4) and (5) to remove the requirement that all State Exchanges operate a consumer-facing centralized eligibility and enrollment platform on the State Exchange's website such that a State Exchange could choose to rely entirely on web-brokers (a type of non-Exchange entity) for implementing and operating consumer-facing websites that facilitate the eligibility and enrollment process in a State Exchange, pursuant to the proposal in section III.D.4.b. of this preamble. These consumer-facing websites operated by web-brokers would facilitate the online submission of eligibility applications by individuals seeking coverage through a State Exchange and facilitate the selection and enrollment into QHPs on a State Exchange for qualified individuals. These consumer-facing websites operated by web-brokers would also interface with the State Exchange website, which the State would still be required to operate broadly under § 155.205(b), in such a manner as to transmit information from the non-Exchange website to the State Exchange website. This would facilitate the State Exchange meeting the requirements at §§ 155.205(b)(4) and (5) which requires an Exchange to maintain a website that allows an individual to submit a single streamlined eligibility application to the State Exchange and enroll in coverage through the State Exchange. Operationally, such consumer-facing websites operated by web-brokers would be required to interface with the information technology platform that the State Exchange would still need to operate to appropriately process applicant eligibility determinations and process enrollment transactions with QHP issuers (that is, the State Exchange's 'back-end' eligibility and enrollment system). Using State Exchange-approved technical specifications and/or standards for those interfaces (for example, web services) would allow the exchange of data between the consumer-facing websites operated by web-brokers and the State Exchange in a manner that is seamless to consumers. Such an interface would allow for the transmission of consumer eligibility application information and/or QHP selection and enrollment information necessary for the State Exchange to meet key Exchange functional requirements. These requirements include collecting information from applicants through an HHS-approved single, streamlined eligibility application for insurance affordability programs per §§ 155.310 and 155.405; performing eligibility verifications required at §§ 155.315 and 155.320; performing assessments or determinations of Medicaid/CHIP eligibility required at § 155.302; and performing determinations of eligibility for QHP enrollment and APTC/CSRs at §§ 155.305 and 155.310. This also includes key enrollment functions such as collecting and maintaining records of QHP enrollment for all consumers of the State Exchange as required under § 155.400 and transmitting such enrollment information to CMS and IRS. Such consumer-facing websites operated by web-brokers would also need to allow for consumers to select and enroll into a QHP (that is, through direct enrollment) in order to submit QHP selection and enrollment to the State Exchange. This model, referred to as the State Based Exchange Enhanced Direct Enrollment (SBE–EDE) model, is proposed and discussed in further detail in section III.D.4.b of this proposed rule. State Exchanges that opt to take this approach would be required to establish standards and a process for selecting the web-brokers who they may interface with in this manner, similar to the standards and criteria that we have established for direct enrollment entities at §§ 155.221(j) and 155.220(n), including a requirement that a non-Exchange web-broker entity satisfy all requirements under § 155.110(a).

When HHS finalized the requirement at § 155.205(b) that Exchanges operate a centralized eligibility and enrollment platform on the Exchange's website in the 2025 Payment Notice (89 FR 26271), HHS' intent was to tie together regulatory requirements throughout part 155 regarding the integrated nature of online, real-time automated eligibility functions that Exchanges were intended to perform. This included the intent to clearly affirm the close integration that exists and is necessary between Exchange-operated websites, the online consumer-facing single streamlined eligibility application, and the back-end eligibility system that performs automated eligibility verifications and eligibility determination functions that return real-time, online results to the consumer.

While we continue to affirm that State Exchanges are responsible for making all eligibility determinations for QHP coverage and related insurance affordability programs through a centralized eligibility processing system and enrollment records system, we have determined that requiring State Exchanges to operate a consumer-facing, centralized eligibility and enrollment consumer website that interfaces with the State Exchange's back-end eligibility processing and enrollment records system may prohibitively restrict Exchange flexibility and innovation. While all State Exchanges that do not use the Federal platform currently operate their own eligibility and enrollment consumer interface on the

State Exchange's website, we believe that maintaining this requirement in regulation could discourage State Exchanges from pursuing innovative approaches that might better serve their specific populations and enhance the consumer experience, including private sector-focused consumer engagement and enrollment strategies. We believe that providing State Exchanges with flexibility in how they offer their online eligibility and enrollment consumer interface may allow State Exchanges to develop solutions that address the unique needs of their residents and markets. Removing the requirement for an Exchange to operate an eligibility and enrollment consumer interface on its website is a necessary step in order to codify the SBE–EDE option we are proposing at § 155.221(k), as described in section III.D.4.b. and previously in this section. Under this option, the ability for State Exchanges to exclusively utilize web-brokers to operate consumer-facing websites that facilitate eligibility and enrollment is the key component.

We note that section 1311(c)(5) and (d)(4)(C) of Affordable Care Act, do not require Exchanges to operate a centralized consumer-facing eligibility and enrollment website that supports both eligibility determinations for, and enrollments in, QHPs.[73] Rather, section 1311(d)(4)(C) of the Affordable Care Act provides that an Exchange must maintain an internet website through which enrollees and prospective enrollees of QHPs may obtain standardized comparative information on QHPs available in the State. Exchanges must also undertake certain minimum functions to facilitate the purchase of QHPs under section 1311(b)(1)(A) of Affordable Care Act and make available QHPs to qualified individuals and employers under section 1311(d)(2)(A) of Affordable Care Act. These minimum functions facilitate the purchase of QHPs by helping to make the purchase of QHPs easier and also by administering elements of the structure necessary to make QHPs available. This approach of relying on private sector EDE entities aligns with the general Affordable Care Act framework that relies on and benefits from the government working within the existing health insurance coverage infrastructure rather than taking a purely governmental or public approach to advancing coverage for the individually insured population. The Affordable Care Act does not establish new government-provided health plans but instead creates Exchanges to facilitate the purchase of government-subsidized QHPs through the individual health insurance market. Exchanges support specific statutory functions that make QHPs available to purchase. These functions include certifying that QHPs conform to certain Federal standards in addition to State and Federal standards that govern the individual health insurance market. Exchanges must also provide certain tools to help consumers shop for QHPs, as well as support eligibility determinations and enrollment in other public health care programs such as Medicaid Affordable Care Act and CHIP. Importantly, these additional standards do not dictate any specific changes to the existing enrollment pathways on the individual market.

In the context of operating an internet website, we interpret the statutory language at section 1311(c)(5) and (d)(4)(C) of Affordable Care Act to require that Exchanges minimally operate an informational website that provides consumers with the ability to view comparative information on QHP options, but that the Exchange may direct consumers to other entities or resources for purposes of facilitating the submission of applications for eligibility and enrolling enrollment in QHPs, with APTC and CSRs, if otherwise eligible. Accordingly, a State Exchange that elects the new SBE–EDE option would continue to be responsible for determining eligibility for, and granting exemption certifications under, section 1311(d)(4)(H) of Affordable Care Act, as applicable; making available an electronic calculator consistent with section 1311(d)(4)(G) of Affordable Care Act; establishing a Navigator program as required under section 1311(d)(4)(K) of Affordable Care Act; and providing for the operation of a toll-free telephone hotline under section 1311(d)(4)(B) of Affordable Care Act. As mentioned earlier and consistent with section 1311(d)(4)(F) of the Affordable Care Act, a State Exchange that elects to pursue this new SBE–EDE option would continue to be responsible for conducting assessments or determinations of eligibility for Medicaid and CHIP. They would use the information provided by consumers on the consumer-facing website operated by a web-broker State Exchange's approved single, streamlined eligibility application that is made available on the consumer websites operated by the web-brokers selected by the State Exchange as part of the SBE–EDE option, and for referring individuals who are assessed or determined eligible for Medicaid or CHIP to the appropriate State Medicaid agency for enrollment in those programs.

The State Exchanges that are currently operating have had to engage with private entities in a manner that would similarly translate to what a State Exchange would be doing under the SBE–EDE model, in terms of relying on the services of private entities to develop and operate a consumer-facing website (that is, online eligibility and enrollment portal) that facilitates consumers applying for and enrolling in QHPs through the State Exchange. Most State Exchanges currently in operation have competitively-procured services from a private entity to develop and operate an online eligibility and enrollment portal (including through which an applicant can submit a single, streamlined application for insurance subsidy programs) and consumer-facing QHP enrollment portal on their respective State Exchange website. These online, consumer-facing eligibility and enrollment portals on State Exchange websites facilitate the online submission of consumer eligibility applications and QHP selection and enrollments, and through web interfaces that are seamless to consumers, transmit that information to the State Exchange's back-end eligibility and enrollment processing information system. We believe that in the absence of a centralized consumer facing website for eligibility and enrollment operating on a State Exchange's website under the proposed SBE–EDE approach, web-brokers may provide that service to a State Exchange in a manner that is similar to that which currently exists between State Exchanges and the private entities they have contracted with to operate their centralized consumer-facing online eligibility and enrollment portal on the State Exchange's website. In both approaches, whether a web-broker provides the online eligibility and enrollment portal to consumers outside of the State Exchange's website, as would be the case under this proposal, or a private entity has developed and operates the consumer-facing online eligibility and enrollment portal on the State Exchange's website in a centralized fashion, the State Exchange maintains responsibility for meeting all other Federal requirements for their online consumer assistance functions. As such,

[73] Section 1311(c)(5) of the Affordable Care Act instead requires the Secretary to make available to all Exchanges a model Exchange website template developed by the Secretary. Section 1311(d)(4)(C) of the Affordable Care Act requires the Exchanges to maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans.

the State Exchange would still need to maintain a website that meets all other website requirements for State Exchanges under § 155.205(b), in the same manner that SBE–FPs are currently required to maintain an informational website for consumers while relying on the Federal eligibility and enrollment platform for eligibility and enrollment functions. In particular, State Exchanges that elect the SBE–EDE option would be required to meet the minimum Exchange function requirement under section 1311(d)(4)(C) of the Affordable Care Act to maintain a website providing standardized comparative information on such plans to enrollees and prospective enrollees of QHPs.

In the 2025 Payment Notice (89 FR 26271), we amended § 155.302(a) to codify the Exchange's responsibility for conducting eligibility determinations and maintaining records of all QHP enrollments on the Exchange. State Exchanges would still maintain this responsibly if it elects to pursue the new SBE–EDE option and exclusively utilize web-brokers for operating consumer websites that facilitate the eligibility and enrollment process in a State Exchange. Additionally, enrollment through such a consumer website would still be considered enrolling in a QHP through the State Exchange per § 155.220(c)(3) and proposed § 155.221(k)(2).

We note that this proposed amendment would not affect other regulatory requirements throughout 45 CFR part 155 that govern State Exchange eligibility and enrollment functions. For instance, per § 155.405, State Exchanges would still be required to obtain HHS approval for the eligibility application used on the consumer websites. HHS' review of the State Exchange's eligibility application would follow the currently established processes, including requiring that the State Exchange demonstrate appropriate functionality to make accurate determination. As such, State Exchange that does not rely on the Federal eligibility and enrollment platform can continue to meet these obligations without operating a singular, centralized consumer-facing eligibility and enrollment website.

We recognize that allowing State Exchanges to take this approach would create different consumer experiences in applying for and enrolling in coverage through State Exchanges as compared to an approach where a State Exchange implements and operates a centralized eligibility and enrollment infrastructure. We seek comment on how State Exchanges that implement such an approach can create comparable consumer experience, in addition to comments on HHS oversight and the approval requirements proposed in section III.D.4.b. of this proposed rule. We seek comment on this proposal.

b. SBE-Enhanced Direct Enrollment Option (§ 155.221(k))

To build on the success of the EDE pathways and enhance the consumer enrollment experience, we are proposing to offer additional flexibility to State Exchanges to leverage the benefits of EDE through a private sector-supported consumer engagement and enrollment strategy that is tailored to the needs of local markets. Accordingly, we propose to add a new paragraph (k) to § 155.221 to establish a process for State Exchanges that do not rely on the Federal eligibility and enrollment platform to elect a new SBE–EDE option, in which the applicable State Exchange could seek HHS approval for web brokers to serve as the exclusive enrollment pathways for operating consumer-facing websites that facilitate the eligibility and enrollment process in a State Exchange. These consumer-facing websites operated by web-brokers would facilitate the online submission of eligibility applications by individuals seeking an eligibility determination for, and enrollment in, a QHP offered through the Exchange with APTC and CSRs, if otherwise eligible. Previously, the Exchange DE option was finalized in part 1 of the 2022 Payment Notice Final Rule (86 FR 6151) and later repealed in part 3 of the 2022 Payment Notice (86 FR 53429). We propose to codify this policy again and to also allow Exchanges to offer their consumers a form of EDE in which the Exchanges rely exclusively on web-brokers to implement and operate the consumer-facing websites through which consumers select and enroll in a QHP without requiring that the Exchanges also operate a centralized consumer-facing eligibility and enrollment website. We are proposing this for State Exchanges exclusively to gather their insight into, and leverage any operational experience they gain in, implementing this model. This would help inform operational considerations were we to expand this model to the FFEs and State Exchanges that use the Federal eligibility and enrollment platform, both of which were included in the previous policy. Since the repeal of the Exchange DE option, many of the policy and operational priorities, as well as then-new Federal laws cited at that time to justify the repeal, are no longer competing for agency resources, and this has created bandwidth to codify a version of the DE option once again.[74]

A State Exchange electing to implement the SBE–EDE option would continue to be responsible for meeting, and ensuring that all approved EDE partners meet all applicable statutory and regulatory requirements governing application for and enrollment in QHPs. The State Exchange would also continue to be responsible for sharing eligibility determination and enrollment information in coordination with issuers and HHS in accordance with §§ 155.340, 155.400, and 155.430. The State Exchange would continue to provide HHS enrollment data to ensure accurate APTC payments are made to issuers on behalf of qualified individuals and in support of reconciliation of APTC on individual income tax returns.

In connection with the SBE–EDE option, the State Exchange would still be required to make available a website listing basic QHP information for comparison,[75] and a listing with links to approved partner websites for consumer shopping, plan selection, and enrollment activities. Consistent with section 1311(d)(4)(E) of Affordable Care Act, the comparative plan information presented on the State Exchange's website would need to continue to utilize a standardized format, including the use of the uniform summary of benefits and coverage established under section 2715 of the PHS Act.[76] The standardized comparative information displayed on the Exchange website would also be required to continue to include the quality ratings assigned to each QHP offered through the Exchange.[77] In addition, the State

[74] Policy and operational priorities and then-new Federal laws included implementation of E.O. 13985 and E.O.14009; Affordable Care Act-related programs under the American Rescue Plan Act of 2021 (ARP) (namely, the State Exchange Modernization Grant Program) and the No Surprises Act; and activities undertaken by HHS to implement the COVID–19 SEP. While activities undertaken pursuant to the No Surprises Act continue, E.O. 13985 and 14009 have been rescinded. Additionally, many resources needed to implement and oversee administration of the enhanced subsidies codified under the ARP, and later extended under the Inflation Reduction Act of 2022, are no longer needed since they expired at the end of 2025. The State Exchange Modernization Grant program also has concluded and States closed out their grants between January and August of 2023. Additionally, activities related to implementing the COVID–19 SEP, including coordination with and oversight of State Exchanges with respect to similar SEPs they implemented in response to the COVID–19 public health emergency (PHE), concluded before the PHE ended in 2023.

[75] 45 CFR 155.205(b)(1) outlines the QHP comparative information which must be displayed.

[76] *See* § 155.205(b).

[77] *See* section 1311(d)(4)(D) of Affordable Care Act and 45 CFR 155.205(b). *Also see* sections 1311(c)(3) and (c)(4) of Affordable Care Act and §§ 155.1400 and 155.1405.

Exchange, along with its EDE partners, would continue to be responsible for meeting Federal accessibility standards under § 155.205(c) for individuals living with disabilities and for individuals who have limited English proficiency.[78] Finally, all consumer data collected, stored, or transmitted through web-broker platforms operating under the SBE–EDE option would remain subject to the privacy and security standards established at § 155.260 and web-brokers participating in the SBE–EDE option would be subject to HHS oversight and monitoring pursuant to § 155.280 as a non-Exchange entity. State Exchanges implementing the SBE–EDE option would be required to ensure that web-brokers comply with these protections, including, but not limited to, encryption, access controls, and audit logging requirements.

HHS would maintain oversight authority over State Exchanges under § 155.1200, which would enable enforcement of Federal requirements associated with the SBE–EDE option and would allow HHS to take necessary actions to mitigate program integrity risks inherent in this model. To ensure ongoing compliance and reduce program integrity risks under the SBE–EDE option, HHS would rely on the State-based Marketplace Annual Reporting Tool (SMART), as a key oversight mechanism. Under § 155.1200(b), State Exchanges would be required to complete SMART submissions annually, attesting to their compliance with relevant Exchange operational requirements under part 155. Additionally, under § 155.1200(c), State Exchanges would need to engage independent qualified auditing entities to perform annual external financial and programmatic audits, which would be included with SMART submissions. HHS would review all SMART submissions and would issue formal letters to State Exchanges summarizing observations on areas of noncompliance and identifying any required corrective actions. This SMART-based compliance monitoring process would serve as a critical safeguard against program integrity risks by providing HHS with regular, audited documentation of State Exchange operations and would be relied on under the SBE–EDE model.

Beyond the SMART process, HHS would employ additional oversight mechanisms to mitigate program integrity risks. These include formal technical assistance opportunities tailored to SBE–EDE implementation efforts and challenges, as well as ongoing informal communications with State Exchange leadership and staff for proactive, real-time issue identification and resolution. Together, these oversight tools—anchored by the SMART compliance monitoring process—would enable HHS to exercise its enforcement authority and ensure that State Exchanges implementing the SBE–EDE option maintain program integrity and meet all Federal requirements.

In this proposed rule, we propose to modify § 155.221(k) such that, subject to HHS approval, a State Exchange that does not rely on the Federal eligibility and enrollment platform may elect to engage one or more web-brokers described in paragraph § 155.221(a) to facilitate QHP enrollments through its Exchange. Such approved entities would enroll qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange[79] and would also facilitate consumer submission of eligibility applications through the entity's consumer website to the State Exchange to receive eligibility determinations from the State Exchange for APTCs and CSRs.

At § 155.221(k), we propose requirements for a State Exchange to become an SBE–EDE. We propose that a newly-transitioning or approved State Exchange must submit an Exchange Blueprint application, or Blueprint revision, to HHS for review at least 15 months prior to the targeted open enrollment launch date as an SBE–EDE.[80] For an approved State Exchange, this would be considered a significant change to its Blueprint.[81] We also propose that the State Exchange must meet all other applicable Federal statutory and regulatory requirements for the operation of an Exchange, including for approved State Exchanges to request and obtain HHS approval for any significant changes to its single, streamlined eligibility application under § 155.405. Following submission of an approved State Exchange's submission of a revised Exchange Blueprint application, in accordance with § 155.105(e), HHS would have up to 90 days[82] to review the revision and approve or deny the change.

Additionally, in accordance with § 155.105(c)(2), we propose at § 155.221(k)(1) that a State Exchange that wants to implement the SBE–EDE option would be required to demonstrate to HHS operational readiness for the State Exchange to enroll qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange and to enable individuals to apply for APTC and cost sharing for QHPs, as well as receive assessments or determinations of Medicaid and CHIP eligibility from the Exchange as described in § 155.302, using the eligibility application described in § 155.405. We propose a new requirement at § 155.221(k)(2) that the State also would receive approval only if it provides HHS with an implementation plan and timeline that details the key activities, milestones, and its communications and outreach strategy to support the transition of enrollment operations to EDE entities. This is to ensure that HHS and the State

[78] Covered entities such as States, recipients of Federal financial assistance from HHS, programs or activities administered by HHS under title I of Affordable Care Act (such as the FFE), and programs or activities administered by any entity established under Title I (such as State Exchanges), must comply with applicable Federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, sex, age, and disability. These laws include section 1557 of Affordable Care Act (42 U.S.C. 18116) (Section 1557), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d *et seq.*) (Title VI), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) (Section 504), and the Americans with Disabilities Act of 1990 (29 U.S.C. 12101 *et seq.*) (ADA).

[79] Section 1401(a) of Affordable Care Act added new section 36B to the Code, which provides for PTCs for eligible individuals, while section 1402 of Affordable Care Act provides for CSRs for eligible individuals. For individuals to be eligible to receive PTCs, among other requirements, the Affordable Care Act requires that individuals be enrolled in a QHP through an Exchange. We have interpreted this statutory language to allow a QHP issuer to enroll an applicant who initiates enrollment directly with the QHP issuer. See § 156.1230, whereby individuals enrolling directly on the website of a QHP issuer are considered enrolled ''through an Exchange'' so long as the issuer meets applicable requirements. We adopted a similar approach to allow a web-broker to enroll an applicant who seeks to enroll through the web-broker's website. See § 155.220(a)(2) and (c), whereby individuals enrolling directly through the site of a web-broker are considered enrolled ''through an Exchange'' so long as the web-broker meets applicable requirements.

[80] This approach is consistent with the 15-month State Exchange approval timeline requirements under § 155.106(a)(2) for States seeking to newly establish and operate a State Exchange to submit its State Exchange Blueprint for review and approval. While the SBE–EDE model is distinct from the State Exchange model, we would consider a transition to the SBE–EDE model to require a significant operational effort to implement such that a consistent timeframe would have many benefits to the State and HHS, particularly while the SBE–EDE model remains a new Exchange model.

[81] This approach is consistent with the requirement that a State notify HHS and receive written approval from HHS before significant changes are made to the Exchange Blueprint. See, for example, 77 FR 18316. Significant changes could include altering a key function of Exchange operations or other changes to the Exchange Blueprint that would have an impact on the operation of the Exchange. This includes, but is not limited to, the process for enrollment in a QHP. See, for example, 76 FR 41871.

[82] As detailed in § 155.105(e), HHS generally has 60 days after receipt of a completed request to complete its review of a significant change to an Exchange Blueprint and, for good cause, may extend the review period by an additional 30 days up to a total of 90 days.

have an opportunity to coordinate these details to maximize the chances of a successful transition. State Exchanges that elect to implement the SBE–EDE option would retain the flexibility to determine their own business controls while complying with § 155.220(n) and § 155.221(j), which outline the applicability of Federal web-broker and EDE requirements to State Exchanges, including requirements related to standardized website disclaimers, web-broker operational readiness, business audit and security and privacy documentation, and display of website changes. We propose at § 155.221(k)(3) that HHS would not approve a State Exchange to implement the SBE–EDE option unless the State Exchange demonstrates to HHS that at least one EDE entity selected by the State is capable of enrolling all consumers in the State. In particular, we believe it is critical that State Exchanges that elect to implement the SBE–EDE option establish that at least one EDE entity meets the minimum Federal requirements to participate in the Federally-facilitated Exchange enhanced direct enrollment program, including requirements at §§ 155.220 and 155.221, particularly § 155.220(c)(3)(i)(A) and (D),[83] to ensure consumers have at least one option through which to view detailed QHP information for all available QHPs in the State, and meets accessibility requirements under § 155.205(c). Therefore, we propose that if no EDE partner meets these requirements, the State Exchange would be required to continue operation of its own consumer-facing State Exchange website for purposes of eligibility and enrollment. To assist State Exchanges in meeting requirements to become an SBE–EDE, State Exchanges could partner with an existing, HHS-approved web-broker EDE partner[84] as a starting point to develop their own EDE programs, as these entities have already met requirements for HHS approval to participate in the FFE's EDE program.

In summary, we propose in this rule to allow newly-transitioning or approved State Exchanges to make web-brokers the exclusive enrollment pathways to facilitate the online submission of eligibility applications by individuals seeking coverage through the State Exchange, including by adding the following new provisions: § 155.221(k), which describes the proposed SBE–EDE option and approval process; § 155.221(k)(1), which lays out the proposed requirement for a State Exchange to demonstrate operational readiness to enroll qualified individuals in a QHP through approved EDE entities to be considered a SBE–EDE; § 155.221(k)(2), which details the proposed requirement to provide an implementation plan and timeline; and § 155.221(k)(3), proposing to require that a minimum of one EDE entity selected by the State meets minimum Federal requirements to participate in the FFE's EDE program and is capable of enrolling all consumers in the State in all available plan offerings, as well as meeting certain other requirements. We solicit comment on all aspects of this proposal, including any comments related to interest in pursuing this model among State Exchanges or other interested parties, expanding the option to other Exchange models, anticipated impacts to Exchange operating costs, and any other considerations or recommendations to effectively operationalize the SBE–EDE option. We also seek comment on the appropriate timing for making this option available to State Exchanges, specifically whether HHS should make this option available to State Exchanges for the PY 2028 annual open enrollment period (consistent with the 15-month Blueprint timeline referenced in this section) or delay implementation to PY 2029 (or later) to allow additional transition time for early adopters of the model.

5. Additional Required Benefits (§ 155.170)

We propose to revise § 155.170(a) to provide that any State-required benefits would be considered ''in addition to EHB'' (and thus not an EHB) if they are: required by a State action taking place after December 31, 2011; applicable to the small group and/or individual markets; specific to required care, treatment, or services; and not required by State action for purposes of compliance with Federal requirements. Under this proposal, such State-required benefits would be considered in addition to EHB regardless of whether the mandated benefits are embedded in the State's EHB-benchmark plan. We propose that this change would be effective beginning with PY 2027. We also propose revisions to the regulatory text at §§ 155.170(a)(2) and 156.115(a) to align with this proposal and to have State and issuer responsibilities with respect to State-required benefits appear in a more logical reading order in the CFR.

Section 1311(d)(3)(B) of the Affordable Care Act permits a State to require QHPs offered in the State to offer benefits in addition to the EHB, but requires the State to make payments, either to the individual enrollee or to the QHP issuer on behalf of the enrollee, to defray the cost of these additional State-required benefits.

In the EHB final rule (78 FR 12838), we finalized a standard at § 155.170(a)(2) that specified that State-required benefits enacted on or before December 31, 2011, even if not effective until a later date, are considered EHBs and therefore the costs of these benefits are not required to be defrayed by the State. The 2017 Payment Notice (81 FR 12242 through 12244) revised § 155.170(a)(2) to make clear that benefits required by State action taking place on or before December 31, 2011 are considered EHB, regardless of whether required benefits were established through legislative action, regulation, guidance, or other State action. We also amended § 155.170(a)(2) to provide that benefits required by State action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, are considered in addition to EHB.

Most recently in the 2025 Payment Notice (81 FR 26264 through 26268), we finalized that, beginning in PY 2025, covered benefits in a State's EHB-benchmark plan are considered an EHB under § 155.170(a)(2) and thus, do not require defrayal by the State. However, we noted that if at a future date the State updates its EHB-benchmark plan under § 156.111 and removes the mandated benefit from its EHB-benchmark plan, the State may have to defray the costs of the benefit under the factors set forth at § 155.170 as it will no longer be an EHB after its removal from the EHB-benchmark plan. Additionally, we noted that beginning in PY 2025, a State that is defraying the costs of a benefit required by a mandate that is in addition to the EHB under § 155.170 will be permitted to cease defraying the

[83] In addition to ensuring there is at least one website available in the State that satisfies all accessibility requirements under § 155.205(c), we proposed that there must also be at least one website available in the State through which consumers can view and enroll in all available QHPs in the State.

[84] In coordination with third-party auditors, HHS vets prospective Classic DE and EDE partners that want to operate on the FFE's DE or EDE pathway to ensure compliance with §§ 155.220 and 155.221, and meet other operational requirements further detailed in sub-regulatory guidance (available at: *https://www.cms.gov/files/document/guidelinesforenhanceddirectenrollmentauditsforyear8final.pdf* and *https://www.cms.gov/files/document/faq-regarding-decommissioning-classic-direct-enrollment-de-pathway091125.pdf*). HHS also maintains an updated list of approved DE and EDE partners, which it posts publicly on the website for the Centers for Medicare & Medicaid Services (available at: *https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/downloads/classic-de-webbrokers.pdf* and *https://www.cms.gov/files/document/ede-approved-partners.pdf*).

costs of that benefit if the benefit was included in its EHB-benchmark plan or upon updating its EHB-benchmark plan to include such benefit coverage. We further clarified that because any covered benefits in a State's EHB-benchmark plan are considered to be an EHB, such benefits are subject to the various rules applicable to EHB, including the prohibition on discrimination in accordance with § 156.125, the annual limitation on cost sharing in accordance with § 156.130, and restrictions on annual or lifetime dollar limits in accordance with § 147.126. We supported the revision to § 155.170(a)(2) finalized in the 2025 Payment Notice in part based on our understanding of States' struggle to understand and operationalize the policy that previously required States to defray the cost of State-required benefits, even if such benefits were included in the State's EHB-benchmark plan. We stated that finalization of this policy would promote consumer protections and facilitate compliance with the defrayal requirement by making the identification of benefits in addition to the EHB more intuitive.[85]

We have since reevaluated this position and believe we should not jeopardize the affordability of premiums, particularly for unsubsidized enrollees, for an intangible improvement to States' understanding of Federal defrayal requirements. When States enact benefit mandates, plan premiums must generally increase to account for the additional coverage. In the individual market (in which QHPs are sold), if State-required benefits are EHB, the associated premium increases will be entirely offset for consumers receiving APTC by higher APTC expenditures because the amount of APTC is tied directly to the premium amount. Over time, the accumulation of new State-required benefits that are EHB could substantially increase Federal APTC costs, undermining the purpose of the statutory defrayal policy. While premium increases associated with the accumulation of State-required benefits that are EHB would be offset for subsidized consumers, they are not offset for unsubsidized enrollees because they do not receive APTC. As a result, we are concerned that the policy finalized in the 2025 Payment Notice that any covered benefits in a State's EHB-benchmark plan are considered EHB has an outsized impact on unsubsidized enrollees who do not receive APTC, which threatens to disincentivize enrollment amongst this population.

We believe that our current policy incentivizes States to enact additional State-required benefits and then to select an EHB-benchmark plan under § 156.111 that includes such State-required benefits such that these benefits are considered to be EHB. We believe this approach drives up premiums, which, in turn, increases Federal APTC expenditures, negatively impacts unsubsidized enrollees, and exacerbates low enrollment amongst this population.

Therefore, we propose to revise § 155.170(a)(2) to revert to the standard that was in place prior to the 2025 Payment Notice, which required States to defray the cost of applicable State-required benefits at § 155.170(a)(1) taken by State action after December 31, 2011, even if such benefits are included in the State's EHB-benchmark plan beginning with PY 2027. Specifically, we propose to revise § 155.170(a)(1) to provide that a State mandated benefit would be considered ''in addition to EHB'' (and thus not EHB) if it is: (i) required by a State action taking place after December 31, 2011; (ii) applicable to the small group and/or individual markets; (iii) specific to required care, treatment, or services; and (iv) not required by State action for purposes of compliance with Federal requirements.

We note that the proposed revisions at § 155.170(a)(1)(i) through (iv) would explicitly add into the regulatory text four conjunctive elements that determine when State-required benefits require defrayal. These four elements have long been included as part of a State's defrayal analysis, but have not all been included in the regulatory text at § 155.170.[86] We now propose to add them to § 155.170 in order to make explicit the specific circumstances that require State defrayal of benefits in addition to EHB. We propose to revise § 155.170(a)(2) to state: ''A State must make payments in accordance with paragraph (b) of this section to defray the cost of any State-required benefits in addition to the EHB.'' We also propose to revise and reorder the requirements for health plans to provide EHB at § 156.115(a) by adding at § 156.115(a)(2) the longstanding requirement that benefits required by State action taking place on or before December 31, 2011 are EHB that must be provided by health plans, and redesignating current paragraphs (a)(2) through (a)(6) as paragraphs (a)(3) through (a)(7). We emphasize that, other than the proposed change to remove consideration of whether the benefits are included in the State's EHB-benchmark plan from the defrayal analysis, these proposed revisions are not intended to substantively change existing State and issuer responsibility with respect to State-required benefits. These revisions are only intended to codify longstanding elements of the defrayal analysis, make conforming changes to the regulatory text, and to reorder these responsibilities so they would appear in a more logical reading order in the CFR. In particular, we propose revisions to § 156.115(a) that would ensure the regulatory text captures all the instances in which a benefit provided in a health plan is an EHB, as this regulation does not reference § 155.170(a)(2).

If finalized as proposed, a State would be required to defray the costs of any benefit that does not satisfy the proposed standard at § 155.170(a)(1) by making payments to individual enrollees or to the QHP issuer on behalf of enrollees. We expect this would better mitigate premium increases and better support unsubsidized enrollees because States would be required to defray the cost of a wider array of State-required benefits than under the existing policy, such that both subsidized and unsubsidized enrollees alike would be shielded from the increase to premiums resulting from State-required benefits.

Starting in PY 2027, a State that is not defraying the costs of a State-required benefit because of the policy finalized in the 2025 Payment Notice that designated any benefit covered in the State's EHB-benchmark plan as EHB would be required to begin defraying the costs of that benefit regardless of whether the benefit is included in its EHB-benchmark plan. If this proposal is finalized and a State begins defraying costs associated with a State-required benefit and making payments to QHP issuers because it is no longer considered EHB, QHP issuers would be required to update their plan filings

[85] On November 12, 2025, the Government Accountability Office (GAO) released a report ''*Health Insurance Marketplaces: CMS Has Limited Assurance That Premium Tax Credits Exclude Certain State Benefit Costs.* GAO–25–107220, available at *https://files.gao.gov/reports/GAO-25-107220/index.html.* We concurred with the GAO's recommendation to review CMS' current oversight approach for defrayal of State mandated benefits and determine whether additional oversight is needed, and that work is ongoing.

[86] These elements appear in the EHB Final Rule (78 FR 12838) and the 2017 Payment Notice (81 FR 12242). We acknowledge that the element that the State requirement must be ''specific to required care, treatment, or services'' has not previously been included in § 155.170. However, in the EHB Final Rule (78 FR 12838), we stated that ''[W]e interpret 'State-required benefits' to include the care, treatment and services that an issuer must provide to its enrollees. Other State laws that do not relate to specific benefits, including those relating to providers and benefit delivery method, are not addressed in § 155.170.'' *See also* the 2025 Payment Notice (81 FR 26264).

accordingly beginning in PY 2027 to reflect that the benefit is no longer covered as an EHB and should not be included in the percentage of premium attributable to coverage of EHB for the purpose of calculating APTC. We clarify, however, that we would not require States with any such benefits in their EHB-benchmark plans to update their EHB-benchmark plan under § 156.111 to remove the benefit; the proposed revision to § 155.170 would simply render the benefit's inclusion in the EHB-benchmark plan null and void for purposes of defining the EHB in the State. We also clarify that a State that wants to avoid defrayal obligations for State-required benefits that are already in the State's EHB-benchmark would be able to do so by repealing the applicable State requirement as being applicable to QHPs. If the State does not repeal or otherwise limit market applicability for the applicable State requirement, the State would be financially responsible for defraying the costs associated with the State benefit mandate. Given variation in State legislative calendars and session timing, and the need for issuers to update their plan filings and rates to account for benefits that would be defrayed by the State, we solicit comment on finalizing an effective date of PY 2028 instead of PY 2027.

We acknowledge that this proposal, a reversion to the standard that was in place prior to the 2025 Payment Notice, constitutes a change in policy with respect to the treatment of State-required benefits under the Affordable Care Act. We understand that a small number of States and issuers have taken significant action based on current § 155.170, including that some States have sought or are seeking EHB-benchmark plan changes under § 156.111 to add certain State-required benefits as EHB based on the understanding that such EHB additions would be effective indefinitely absent any further EHB-benchmark plan changes under § 156.111 and that the cost of these additions would not require defrayal by the State. If finalized, any State-required benefit that fulfills the four proposed conjunctive elements at proposed § 155.170(a)(1)(i) through (iv) would require defrayal, regardless of whether the benefit is included in the State's EHB-benchmark plan.[87]

In turn, this would mean that State-required benefits that are in addition to EHB under this proposed policy would not be subject to the rules applicable to EHB, including the prohibition on discrimination in accordance with § 156.125, limitations on cost sharing in accordance with § 156.130, and restrictions on annual or lifetime dollar limits in accordance with § 147.126. Although we do not take these impacts lightly, these changes are necessary to return to the longstanding read of section 1311(d)(3)(B) of the Affordable Care Act and better balance the cost of the EHB for unsubsidized enrollees. We established our longstanding read of section 1311(d)(3)(B) of the Affordable Care Act in the EHB Rule (78 FR 12838) when we finalized that State-required benefits enacted after December 31, 2011, are not considered EHBs and therefore the costs of these benefits are required to be defrayed by the State. We believe reverting to this foundational read is warranted to remove the incentive from States to enact more benefit mandates that could in turn increase premiums and negatively impact unsubsidized enrollees to the detriment of overall enrollment by this population. The defrayal requirement in section 1311(d)(3)(B) of the Affordable Care Act prevents States from shifting costs to the Federal government through Federal expenditures. Over time, the accumulation of new State-required benefits being treated as EHB (without corresponding defrayal by States) could increase Federal outlays and undermine the purpose of section 1311(d)(3)(B) of the Affordable Care Act. While the availability of such benefits as EHB (with the associated protections) is a consideration, so is the overall affordability of coverage and the impact on overall enrollment. If such coverage is so expensive that it is unaffordable, particularly for unsubsidized enrollees, then the entire market suffers and those that cannot afford to enroll do not enjoy any benefits of coverage whatsoever. Our proposal seeks to mitigate that risk.

We are aware that this proposed policy reversal, if finalized, could also impact health plans that are not directly impacted by EHB requirements. This includes self-insured group health plans and large-group market fully insured plans that must follow the annual and lifetime dollar-limit restrictions on EHB and annual cost-sharing limitation requirements under §§ 147.126 and 156.130.[88] This proposal, if finalized, would affect plan sponsors to the extent that a plan sponsor selects a certain State's EHB-benchmark plan for purposes of complying with sections 2707 and 2711 of the PHS Act and that State changes benefits in its EHB-benchmark plan.[89] The proposal's impact would also extend beyond these plan sponsors to include BHPs established under Affordable Care Act section 1331 and Medicaid Alternative Benefit Plans (ABPs) implemented under section 1937.

Finally, we note that we are aware of State legislation that includes clauses stating that the requirement to defray the costs associated with State-required benefits is precluded if HHS fails to respond to the State's request for confirmation of whether new mandates require defrayal within a certain time. Such provisions are inconsistent with § 155.170, as they inappropriately put the onus on HHS to decide whether the State-required benefit is in addition to EHB. Failure by HHS to respond to a State's request for a determination of whether new mandates require defrayal by the State does not relieve a State from its defrayal obligation. Under § 155.170, it is the State's responsibility to identify which State-required benefits require defrayal. While States are encouraged to reach out to us concerning State defrayal questions in advance of passing and implementing benefit mandates, HHS does not provide determinations of whether the cost of a State-required benefit requires defrayal by the States.

In summary, we propose to revise § 155.170(a) to provide that any State-required benefits would be considered ''in addition to EHB'' (and thus not EHB) if they are: required by a State action taking place after December 31, 2011; applicable to the small group and/or individual markets; specific to required care, treatment, or services; and not required by State action for purposes of compliance with Federal requirements. We also propose revisions to the regulatory text at §§ 155.170(a)(2) and 156.115(a) to align with this proposal and to have State and issuer responsibilities with respect to State-required benefits appear in a more logical reading order in the CFR.

We seek comment on these proposals.

[87] If this proposal is finalized as proposed, the policy finalized in the 2025 Payment Notice would remain applicable for PYs 2025–2026. States would not be required to defray the costs of any State-mandated benefits that are included in the State's EHB-benchmark plan as EHB during PYs 2025–2026 but would be required to defray such costs beginning in PY 2027.

[88] See parallel requirements to § 147.126 at 26 CFR 54.9815–2711 (*https://www.ecfr.gov/current/title-26/chapter-I/subchapter-D/part-54/section-54.9815-2711*), and 29 CFR 2590.715–2711 (*https://www.ecfr.gov/current/title-29/subtitle-B/chapter-XXV/subchapter-L/part-2590/subpart-C/section-2590.715-2711*). Additionally, section 2707(b) of the PHS Act, as added by the Affordable Care Act, was adopted by reference into section 9815 of the Code and section 715 of the Employee Retirement Income Security Act (ERISA).

[89] See at Q2 of Affordable Care Act Implementation FAQs—Set 18 at *https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/aca_implementation_faqs18.*

6. Ability of States To Permit Agents and Brokers and Web-Brokers To Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220(j))

Section 1312(e) of the Affordable Care Act directs the Secretary to establish procedures under which a State may permit agents and brokers to enroll individuals and employers in QHPs through an Exchange and to assist individuals in applying for financial assistance for QHPs sold through an Exchange. We are proposing new standards of conduct and additional consumer protection standards related to agents, brokers, and web-brokers who assist consumers with enrollments through FFEs and SBE–FPs. These proposals focus on requirements related to consumer consent documentation (§ 155.220(j)(2)) and requirements related to marketing activities (proposed redesignation at § 155.220(j)(3)).

In addition, section 1313(a)(5)(A) of the Affordable Care Act directs the Secretary to provide for the efficient and non-discriminatory administration of Exchange activities and to implement any measure or procedure the Secretary determines is appropriate to reduce fraud and abuse. Section 155.220 specifies procedures to support the State's ability to permit agents, brokers, and web-brokers to assist individuals, employers, or employees with enrollment in QHPs offered through an Exchange, subject to applicable Federal and State requirements. This includes processes under § 155.220(g) and (h) under which HHS may suspend or terminate an agent's, broker's, or web-broker's Exchange agreement(s) in circumstances that involve fraud or abusive conduct or where there are sufficiently severe findings of noncompliance. This also includes the FFE standards of conduct for agents, brokers, and web-brokers who assist consumers in enrolling in coverage through the FFEs that we established under § 155.220(j) to protect consumers and ensure the proper administration of the FFEs. Consistent with § 155.220(l), agents, brokers and web-brokers who assist with or facilitate enrollment in States with SBE–FPs must comply with all applicable FFE standards, including the requirements in § 155.220. Similarly, consistent with § 155.220(n), web-brokers who assist with or facilitate enrollment in States with State Exchanges must comply with all applicable FFE standards, including the requirements in § 155.220(c)(3)(i)(A), (G), (I), and (j)(2)(i).

We have observed numerous abusive, misleading, and coercive practices that harm consumers both financially and medically, necessitating these proposed amendments.[90] For example, some agents, brokers, and web-brokers have been incorrectly attesting to, or failing to ascertain, whether consumers are enrolled in other minimum essential health coverage. We have also observed manipulation of income projections and tax household composition to qualify consumers for QHPs in the FFE. Further observations include agents, brokers, and web-brokers enrolling consumers with inaccurate residence addresses to conceal unauthorized enrollments and enrolling deceased consumers. Given these observations and their potential for consumer harm, we propose the following amendments to § 155.220(j): separating conduct related to consumer enrollment from conduct related to consumer marketing at § 155.220(j)(2)(i); establishing new standards of conduct and additional consumer protection standards for agents, brokers, and web-brokers at § 155.220(j)(2); and introducing new marketing requirements in redesignated § 155.220(j)(3).

a. Proposals Related to FFE Standards of Conduct and Mandating a Standard Eligibility Application Review Form and Consumer Consent Form (§ 155.220(j)(2))

Section 155.220(j)(2) sets forth the standards of conduct for agents, brokers, and web-brokers that assist with or facilitate enrollment of qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through an FFE or SBE–FP, or that assist individuals in applying for APTC and CSRs for QHPs sold through an FFE or SBE–FP.

Section 155.220(j)(2)(i) requires agents, brokers, and web-brokers to provide consumers with correct information and refrain from marketing or conduct that is misleading. Section 155.220(j)(2)(ii) requires agents, brokers, and web-brokers to document that the consumer (or the consumer's authorized representative) has reviewed and confirmed his or her eligibility application information is accurate. Under § 155.220(j)(2)(ii), agents, brokers, or web-brokers must also provide the FFEs and SBE–FPs with correct information under section 1411(b) of the Affordable Care Act. Section 155.220(j)(2)(iii) also requires agents, brokers, web-brokers to document the consumer's consent prior to facilitating enrollments through the FFEs. As explained in the 2017 Payment Notice proposed rule (81 FR 12258 through 12264), these standards are designed to protect against agent, broker, and web-broker conduct that is harmful towards consumers or prevents the efficient operation of the FFEs and SBE–FPs.

We have been conducting documentation reviews to determine compliance with eligibility application review documentation requirements and consent documentation requirements. During these reviews, we have found numerous instances of noncompliance, such as documentation not containing the name of the assisting agent, broker, or web-broker, a missing date, and more. While we have engaged in Technical Assistance (TA) or enforcement, when appropriate, given these findings, we have determined that HHS would likely reduce consumer harm by revising the current requirements in § 155.220(j)(2)(ii) and (iii).

We propose to amend existing regulatory authority under § 155.220(j)(2)(ii)(A) and (j)(2)(iii)(A) to require agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review documentation requirements and consent documentation requirements. Our proposal would eliminate the currently broad allowances on the format for meeting these requirements by mandating that agents, brokers, and web-brokers use only the HHS-approved and -created form. The regulation would also be changed to clarify what types of actions constitute a consumer ''taking an action'' within the meaning of the regulation.

Currently, agents, brokers, and web-brokers are required to document that a consumer, or the consumer's authorized representative, reviewed their eligibility application information prior to the submission of the information. In the 2024 Payment Notice (87 FR 78206), we established documentation requirements to help ensure a consumer, or their authorized representative, has reviewed and confirmed their eligibility application information to be accurate prior to enrollment submission. This language was added to the regulations to help combat fraud and reduce consumer harm caused by application submissions containing inaccurate information. Currently, however, there are no specific requirements regarding the

[90] See for example, the GAO report published on December 3, 2025, in which the GAO developed and submitted fictitious applications via brokers and subsequently gained fully-subsidized health insurance coverage through the Federal Exchanges. GAO (2025, Dec. 3). *Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist. https://www.gao.gov/products/gao-26-108742.*

format of this documentation, so long as it meets the minimum regulatory requirements under § 155.220(j)(2)(ii)(A). As a result, we have reviewed documentation submitted in response to enforcement activity in both paper and audio recording formats. During these reviews, we have found that a substantial amount of this documentation lacked regulatorily required information.[91] These documentation reviews determine next steps, such as engaging in TA or enforcement activity.

Additionally, paper documentation often contains language and formatting that are generally unique to the specific agent, broker, or web-broker. This language can sometimes be complicated or difficult to follow for consumers, leading to potential consumer harm, as explained below. Based on our experience, the documentation submitted by a significant number of agents, brokers, and web-brokers frequently failed to meet the required eligibility application review documentation criteria. These criteria may include but are not limited to: an explanation of attestations; required dates; the name of the agent, broker, or web-broker; an affirmative response from the consumer; a review of all application information; and the name of the consumer or authorized representative. Missing or incorrect information on eligibility applications can harm consumers. Inaccurate application information may lead to incorrect eligibility determinations, affect a consumer's tax liability, or result in other negative consequences. For example, if a consumer receives an incorrect APTC determination or is unaware they are enrolled, they may owe money to the Internal Revenue Service (IRS) when reconciling their Federal income taxes. Ensuring that a consumer's income determination has been reviewed and confirmed as accurate can help prevent these issues.

Incorrect consumer information on eligibility applications may also affect Exchange operations or HHS' analysis of Exchange trends. For example, a high volume of applications containing erroneous information, such as U.S. citizens attesting to not having an SSN, could hinder the efficient and effective operation of the Exchanges on the Federal platform by requiring HHS to divert time and resources to address these discrepancies. While we have processes in place to investigate and adjudicate complaints, these types of complaints can present challenges when the only available evidence consists of conflicting accounts from the parties involved. We generally do not have access to additional contextual information that could help clarify the circumstances. To help address this, the 2024 Payment Notice (88 FR 25740) revised the standards of conduct at § 155.220(j)(2)(ii) to require agents, brokers, and web-brokers to document prior to the submission of information that the eligibility application information under section 1411(b) of the Affordable Care Act was reviewed and confirmed to be accurate by the consumer or their authorized representative, who has been designated in compliance with § 155.227.

Additionally, under § 155.220(j)(2)(iii), as finalized in the 2024 Payment Notice (88 FR 25740), agents, brokers, and web-brokers are required to document consumer consent on the FFEs and SBE–FPs prior to providing enrollment assistance. This documentation must comply with specific regulatory requirements and show that the consumer took an action that created a record that the agent, broker, or web-broker can maintain and produce to confirm that consent was provided by the consumer or their authorized representative.

Presently, there are no specific format requirements for consumer consent documentation, as long as it meets the minimum regulatory requirements under existing § 155.220(j)(2)(iii)(A) which requires a consumer, or their authorized representative, to ''take an action'' that produces a record that can be maintained and produced by an agent, broker, or web-broker to confirm that the consumer's consent was documented and confirmed to be accurate. While consent must also be documented, this regulation does not explicitly require an agent, broker, or web-broker to obtain it through the same action. During HHS' investigations, we have found that a substantial amount of the submitted consumer consent documentation either lacked the required information, or presented it unclearly, potentially resulting in consumer harm. HHS has consistently received documentation from agents, broker, and web-brokers that failed to include required information, including, but not limited to: the name of the agent, broker, web-broker, or agency receiving consent; the name of the consumer or their authorized representative; the dates of consent; the scope, duration, and purpose of the consent; and the process through which a consumer or their authorized representative may rescind the consent. There have also been instances where documentation of consumer consent was not provided upon request.

Documentation that omits these regulatory requirements does not adequately demonstrate that the consumer, or their authorized representative, provided consent prior to the agent, broker, or web-broker's facilitation of enrollment or provision of enrollment assistance. Submitting consumers' eligibility applications without compliant documented consumer consent is harmful to consumers because the consumers or their representatives may be unaware of their enrollments and the submitted enrollment application may contain incorrect information. This could lead to consumers receiving inaccurate eligibility determinations; not receiving plan correspondence; not being able to access more suitable health coverage for which they may qualify; and unexpected tax liabilities.

Given these findings, we propose amendments to § 155.220(j) to improve the accuracy of application information and better ensure compliance with consumer consent documentation requirements. First, we propose amending § 155.220(j)(2)(ii)(A) to further clarify expectations for agent, broker, and web-broker compliance and to make clear that the requirements in this provision are not intended to allow for a broad range of interpretations. Specifically, we propose to revise § 155.220(j)(2)(ii)(A) to state that documentation by agents, brokers, and web-brokers showing that eligibility application information has been reviewed and confirmed to be accurate by the consumer (or the consumer's authorized representative) must be effectuated by having the consumer or the consumer's authorized representative take an action to execute the HHS-approved and created consumer consent form.[92]

We also propose redesignating § 155.220(j)(2)(ii)(A)(2) as 155.220(j)(2)(ii)(A)(3) and amending newly revised § 155.220(j)(2)(ii)(A)*(2)* to describe acceptable and unacceptable actions that either a consumer (or consumer's authorized representative) can take that would allow the agent, broker, or web-broker to demonstrate their confirmation of the review of eligibility application information. Specifically, we propose that these actions may include: a hand-written or electronic written signature or initials,

[91] CMS–10840/OMB Control Number: 0938–1438.

[92] Please find the HHS-approved and created CMS Model Consent Form for Marketplace Agents, Brokers, Web-brokers, and Agencies here: *https://www.cms.gov/marketplace/agents-brokers/files/cms-model-consent-form-marketplace-agents-brokers.pdf.*

made directly on a document indicating a person's consent, approval, or agreement; an email from the consumer or the consumer's authorized representative; a recorded verbal conversation; or other clear and verifiable means. A signature that is simply typed on the documentation or a filled-in check-box would not clearly indicate the eligibility application information was reviewed and confirmed to be accurate by the consumer or the consumer's authorized representative, as HHS is unable to verify whether the consumer or their authorized representative personally reviewed and confirmed the accuracy of their information based on such a signature or checked box. A handwritten signature or handwritten initials made directly on the document indicates a consumer's or a consumer's representative's consent because it would more clearly illustrate that the consumer or the consumer's representative indeed gave his/her consent as it can be compared against another handwritten signature or handwritten initials. The proposed amendments aim to reduce confusion among agents, brokers, and web-brokers on what constitutes compliant documentation, reduce consumer harm from noncompliant documentation, and enhance HHS' investigative efficiency.

We propose revising § 155.220(j)(2)(iii)(A) to require agents, brokers, or web-brokers to demonstrate that the consumer or their authorized representative has obtained and reviewed consent documentation by executing an HHS-approved and created consumer consent form. This form would fulfill regulatory documentation requirements related to eligibility application review and consumer consent, ensuring all regulatory requirements are in the documentation provided to and reviewed by the consumer or their authorized representative. It would also streamline the review of potentially noncompliant agents, brokers, and web-brokers, facilitate the removal of noncompliant agents, brokers, and web-brokers from assisting consumers on the Exchange, and protect consumers from potential harm while safeguarding the integrity of the Exchange. Finally, it would enable more timely resolution of investigations, benefiting agents, brokers, and web-brokers by generally providing faster final determinations from HHS.

We further propose redesignating current § 155.220(j)(2)(iii)(C) as § 155.220(j)(2)(iii)(D) and revising § 155.220(j)(2)(iii)(C). Newly proposed § 155.220(j)(2)(iii)(C) would require that the action taken by the consumer or their authorized representative to provide consent to definitively prove to HHS that consent was indeed given by the consumer or the consumer's representative. Section 155.220(j)(2)(iii)(C) would provide examples of acceptable actions, which mirror those proposed at § 155.220(j)(2)(ii)(A)(*2*). We also propose that a signature that is simply typed on the documentation or a filled-in check-box would not clearly indicate consent was provided, as, based on this information, HHS is unable to verify whether the consumer or their authorized representative personally typed the name and completed the checkboxes, or if the agent, broker, or web-broker did so without obtaining actual consent from the consumer or their authorized representative. As mentioned previously in this section, a handwritten signature or handwritten initials made directly on the document indicates a consumer's or a consumer's representative's consent because it would more clearly illustrate that the consumer or the consumer's representative indeed gave his/her consent as it can be compare against another handwritten signature or handwritten initials. Although we released an FAQ [93] in 2024 clarifying the ''take an action'' requirement, we are formalizing these expectations in regulation to provide greater transparency.

In summary, we are proposing to revise § 155.220(j)(2)(ii)(A) to state that the consumer or their authorized representative must take an action to execute the HHS-approved and created form, indicating that the eligibility application information has been reviewed and confirmed to be accurate by the consumer (or the consumer's authorized representative). We are also proposing redesignating § 155.220(j)(2)(ii)(A)(*2*) as § 155.220(j)(2)(ii)(A)(*3*) and amending newly revised § 155.220(j)(2)(ii)(A)(*2*) to describe the acceptable and unacceptable actions that a consumer (or their authorized representative) can take that would allow the agent, broker, or web-broker to demonstrate the consumer's or the consumer's authorized representative's confirmation of the review of eligibility application information. We are also proposing to revise § 155.220(j)(2)(iii)(A) to require agents, brokers, or web-brokers to demonstrate that the consumer or their authorized representative has obtained and reviewed consent documentation by executing an HHS-approved and created form. Finally, we are proposing redesignating current § 155.220(j)(2)(iii)(C) and revising § 155.220(j)(2)(iii)(D). Newly proposed § 155.220(j)(2)(iii)(C) would require that the action taken by the consumer or their authorized representative to provide consent must be clear to HHS on the face of the documentation and would describe acceptable actions.

We seek comment on these proposals.

b. Proposals Related To Creating Standards of Conduct Related To Marketing (§ 155.220(j)(3))

We propose to redesignate current § 155.220(j)(3) to § 155.220(j)(4) and add language at § 155.220(j)(3) to create standards of conduct by which agents, brokers, and web-brokers must adhere when engaging in marketing practices related to assisting or facilitating enrollment of qualified individuals, qualified employers, or qualified employees in FFE coverage, or applying for APTC or CSRs for QHPs sold through an FFE or SBE–FP. This proposal would establish marketing requirements and list certain prohibited marketing practices. The marketing practices we would prohibit are the most common misleading advertisement types we have discovered on social media websites to date.

In the Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals final rule (78 FR 54076 through 54081), we established a framework for terminating an agent's, broker's, or web-broker's Exchange agreement(s) for cause in situations in which, in HHS' determination, a specific finding of noncompliance or pattern of noncompliance is sufficiently severe.[94] Section 155.220(g)(2)(i) states that agents, brokers, or web-brokers may be determined noncompliant for violations of ''[a]ny standard specified under this section,'' which would include marketing violations under § 155.220(j)(2)(i). Under this existing framework, HHS can terminate an agent's, broker's, or web-broker's Exchange agreement(s) for cause to protect consumers and the efficient and effective operation of Exchanges in cases of sufficiently severe violations or patterns of violations. In such situations, under § 155.220(g)(3), HHS provides the agent, broker, or web-broker with 30 calendar days' notice

[93] CMS. (2024, June 12). *Frequently Asked Questions: Consumer Consent & Application Review Requirements. https://www.cms.gov/files/document/frequently-asked-questions-consumer-consent-application-review-requirements.pdf.*

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

and an opportunity to resolve and address the finding(s) of noncompliance during that 30 day notice period.[95] If after 30 calendar days the noncompliance is not addressed to HHS' satisfaction, HHS may terminate the Exchange agreement(s) for cause. Once their Exchange agreement(s) are terminated for cause under § 155.220(g)(1), the agent, broker, or web-broker is no longer registered with the FFE, is not permitted to assist with or facilitate enrollment of a qualified individual, qualified employer, or qualified employee in coverage in a manner that constitutes enrollment through the Exchange, and is not permitted to assist individuals in applying for APTC and CSRs for QHPs.[96] [97] Consistent with § 155.220(h)(1), an agent, broker, or web-broker whose Exchange agreement(s) are terminated can request reconsideration of such action. Reconsideration requests submitted to HHS are handled by a division separate and independent from the one that imposed termination. Section 155.220(h)(2) provides the agent, broker, or web-broker with 30 calendar days to submit their request (including any rebuttal evidence or information) and § 155.220(h)(3) requires HHS to provide agents, brokers, or web-brokers with written notice of HHS' reconsideration decision within 60 calendar days of receipt of the request for reconsideration.

In the 2017 Payment Notice (81 FR 12204), we added section § 155.220(j)(2) to require agents, brokers, and web-brokers to provide consumers with correct information, without omission of material fact, regarding FFEs, QHPs offered through the FFEs, and insurance affordability programs, as well as refrain from marketing or conduct that is misleading, coercive, or discriminatory.

We have found many instances of advertisements that mislead consumers during our reviews of existing advertisements. We intend to prioritize taking enforcement actions against agents, brokers, and web-brokers who engage in misleading marketing. Complaints regarding misleading marketing can be sent to the Agent Broker (AB) Helpdesk [98] and we also intend to increase our monitoring of social media sites and other sources to root out misleading marketing. If we discover what we believe is misleading marketing, we may begin enforcement by engaging in TA or directly move to following the termination process established in § 155.220(g)(1). We currently use a misleading marketing-specific evaluation method we created to help us determine whether it is appropriate to engage in TA or take an enforcement action in response to an agent's broker's, or web-broker's marketing practices. This evaluation method utilizes a scoring system, based on the number of ads used in public marketing and number of violations within each ad, to determine which response path to take, with higher scores generally indicating more egregiously noncompliant behavior that would lead to enforcement action. More egregious noncompliant behavior could be related to a large volume of ads being posted or ads containing multiple regulatory violations. Applying such a universal standard would help ensure all agents, brokers, and web-brokers are treated equitably.

Furthermore, there are instances when it can be difficult or impossible for HHS to determine who is responsible for posting the misleading marketing, hindering HHS' ability to take enforcement actions in those instances. In order to take an enforcement action, our investigation would need to find a definitive connection between the misleading marketing and an individual agent, broker, or web-broker. We could make this connection by receiving contractual information regarding the posting of the marketing, finding agent, broker, or web-broker contact information in the metadata of the posted marketing, or by finding other reliable means that provide a connection between the misleading marketing and an individual agent, broker, or web-broker. We plan to engage in TA to explain our approach when determining misleading marketing, and we would provide guidance to agents, brokers, and web-brokers to bring their materials into compliance with HHS' marketing requirements. While we anticipate each investigation would be different depending on the facts of the case, we propose to utilize two mechanisms for agents, brokers, and web-brokers who have engaged in misleading marketing to become compliant. First, the agent, broker, or web-broker would need to remove the misleading marketing in a timely fashion. This would help ensure no additional consumers would see the advertisement and be misled. Additionally, we would ask that agents, brokers, and web-brokers review CMS-provided materials on what constitutes compliant marketing practices. This would help educate agents, brokers, and web-brokers to prevent future incidents of noncompliance.

We have found emerging patterns of misleading marketing and have been engaging in TA and enforcement actions when appropriate. We have found numerous examples of misleading marketing, with common issues ranging from guaranteeing zero-dollar enrollment to misrepresenting enrollment timelines. We believe these misleading marketing practices warrant additional HHS oversight and believe more robust marketing standards of conduct under § 155.220(j) are needed. Although our current regulations provide ample authority to begin our new TA program as described above and take enforcement action against misleading marketing, we propose to amend our regulations to add more specific language on marketing prohibitions so that agents, brokers, and web-brokers know what is and is not permitted in their marketing.

Therefore, we propose to amend § 155.220(j)(2) to remove ''marketing or'' from § 155.220(j)(2)(i); separate conduct related to enrollment from conduct related to marketing in newly redesignated paragraph § 155.220(j)(3); expand marketing requirements for agents, brokers, and web-brokers; and codify a list of prohibited practices, requirements for responding to HHS requests related to marketing, and responsibilities related to marketing conducted by third parties with whom an agent, broker, or web-broker contracts. We also propose to remove language from § 155.220(j)(2)(i) that defines the term ''sex'' to include sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes. This proposed change would recognize a person's sex as referring to an individual's immutable biological classification as either male or female, consistent with Executive Order 14168 (90 FR 8615) that reflects the current policy of the United States. HHS is of the view that because the sexes are not changeable and one's sex is grounded in fundamental and incontrovertible reality, it is not necessary to address ancillary issues of

[95] See 45 CFR 155.220(g)(3)(i). The one exception is for situations where the agent, broker, or web-broker fails to maintain the appropriate license under applicable State law(s). See 45 CFR 155.220(g)(3)(ii). In these limited situations, HHS may immediately terminate the agent, broker, or web-broker's Exchange agreement(s) for cause without any further opportunity to resolve the matter upon providing notice to the agent, broker, or web-broker. Ibid.

[96] 45 CFR 155.220(g)(4).

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

[98] The Agent Broker (AB) Helpdesk can be contacted at *FFMProducer-AssisterHelpDesk@cms.hhs.gov.*

gender ideology in a regulation governing the activities of State-licensed agents, brokers, and web-brokers. Based on our experience overseeing agents, brokers, and web-brokers as they assist consumers with enrollment through the FFE, we do not believe this change would result in or facilitate any discrimination against consumers.[99]

At § 155.220(j)(3), we propose that an individual or entity described in paragraph (j)(1) is required to comply with the standards set forth at § 155.220(j)(3).

We propose at new paragraph § 155.220(j)(3)(i) to require that all conduct involving marketing must comply with the standards of conduct described within § 155.220(j)(2).

We also propose, at § 155.220(j)(3)(ii), that all agents, brokers, and web-brokers must provide consumers with correct information about FFEs, QHPs offered through the FFE, and insurance affordability programs, that does not omit any material facts. We propose that agents, brokers, and web-brokers must refrain from marketing that is misleading, materially inaccurate, coercive, or discriminates based on race, color, national origin, disability, age, or sex. For purposes of this proposal, and consistent with the proposed revisions to § 155.220(j)(2)(i), the term ''sex'' refers to an individual's immutable biological classification as either male or female consistent with Executive Order 14168 (90 FR 8615).

At § 155.220(j)(3)(iii), we propose seven examples of prohibited marketing practices. We propose at § 155.220(j)(3)(iii)(A) that agents, brokers, and web-brokers may not provide cash, monetary rebates, gift cards, travel vouchers, or cash equivalents to induce consumers to enroll or for other purposes.

At § 155.220(j)(3)(iii)(B), we propose that agents, brokers, and web-brokers may not offer gifts to consumers unless such gifts are: of nominal value; offered to similarly-situated consumers without regard to whether the consumer enrolls; and are not in the form of cash or cash equivalents.[100] Nominal value would have the meaning provided by the HHS Office of Inspector General [101] and our review of nominal gifts would utilize the same prohibitions and allowances currently used in the Medicare Advantage (MA) Program.[102] Many of these prohibitions on gifts associated with enrollments, excluding permissible nominal gifts, are also prohibited under State law and our proposals would not attempt to supersede State laws on these topics. Any termination stemming from a violation of one of these proposals would be shared with the State(s) where the agent, broker, or web-broker is licensed, as required under § 155.220(g)(6).

We propose at § 155.220(j)(3)(iii)(C) to prohibit agents, brokers, and web-brokers from falsely asserting or suggesting that consumers will always qualify for zero-dollar insurance or zero-dollar premiums. This type of advertisement may confuse or mislead consumers into providing an agent, broker, or web-broker their PII based on a false assumption of what they would qualify for. This PII may then be used by the agent, broker, or web-broker to enroll the consumer in a plan without authorization or for other unauthorized purposes. This proposed language would therefore aim to prevent consumers from providing their PII to agents, brokers, or web-brokers based on a false assumption.

At § 155.220(j)(3)(iii)(D), we propose to prohibit agents, brokers, and web-brokers from falsely using identical or facsimiles of government or other official logos and notations. This proposal is related to providing consumers with correct information and builds off existing language in § 155.220(j)(2)(i) that prohibits having a ''. . . direct enrollment website that HHS determines could mislead a consumer into believing they are visiting *HealthCare.gov* . . .'' Our proposal would extend this requirement to advertisements and be broader in scope, extending to government websites beyond *HealthCare.gov*. We wish to prevent consumers from visiting a website they believe is an official government website or is approved by the government but that, in reality, is not. Such false assumptions may lead to consumers who otherwise would not give their PII to a private entity into believing they are providing their PII to a government entity.

At § 155.220(j)(3)(iii)(E), we propose to prohibit agents, brokers, and web-brokers from miscommunicating enrollment timelines and deadlines. This proposal would include actions such as providing false information related to SEP deadlines. Inaccurate timelines or misreporting of SEP deadlines may coerce consumers to enroll prematurely, believing they are about to miss a deadline to enroll in coverage or miss an SEP deadline. This may cause consumers to enroll in a plan they may not have chosen otherwise if they realized they had more time to consider their options.

At § 155.220(j)(3)(iii)(F), we propose to prohibit the misconstruing of legislation, regulations, or Executive Orders, including listing references or citations to fake or incorrect legislation, regulations, or Executive Orders. This proposal would encompass advertisements using fictional citations, using misleading characterizations when describing specific citations, or other deceptive practices related to legislation, regulations, or Executive Orders. This proposal would help reduce misinformation and disinformation in advertisements, helping ensure consumers are not misled before providing their PII to an agent, broker, or web-broker.

We also propose at § 155.220(j)(3)(iii)(G) to prohibit the use of an image, likeness, or quote from a notable figure, such as a celebrity or politician, in an advertisement claiming that the figure has endorsed the agent, broker, web-broker, or their agency when that endorsement is not truthful. This would include using artificial intelligence-generated videos, such as, but not limited to, deep fakes, or falsely attributing a quote to the public figure. This behavior may lure consumers into clicking on an advertisement or providing their PII based on a false assumption a public figure has endorsed the product or the person promoting the product. An endorsement would not be

[99] In the May 6, 2024 **Federal Register**, we finalized the Nondiscrimination in Health Programs and Activities final rule (89 FR 37522) (hereinafter referred to as the 2024 Section 1557 final rule), which expanded the definition of prohibited discrimination on the basis of sex to include, inter alia, discrimination on the basis of sex characteristics, including intersex traits, gender identity, and sex stereotypes. Several district courts stayed or preliminarily enjoined HHS from enforcing certain portions of the 2024 Section 1557 final rule—primarily those prohibiting discrimination on the basis of gender identity. *See Florida.* v. *Dep't of Health & Hum. Servs.,* 739 F. Supp. 3d 1091 (M.D. Fla. 2024); *Tennessee* v. *Becerra,* 739 F. Supp. 3d 467 (S.D. Miss. 2024); *Texas* v. *Becerra,* No. 6:24–CV–211–JDK, 2024 WL 4490621 (E.D. Tex. Aug. 30, 2024). Although the Secretary filed appeals in these cases, the United States Court of Appeals for the Fifth and Eleventh Circuits subsequently dismissed all appeals pursuant to motions filed after the change in administration, and HHS remains enjoined from enforcing the 2024 Section 1557 final rule's expanded interpretation of sex discrimination.

[100] The OIG definition of ''cash equivalents'' will be used, which can be found here: *https://oig.hhs.gov/faqs/general-questions-regarding-certain-fraud-and-abuse-authorities/.*

[101] OIG. (2016, December 7). *Office of Inspector General Policy Statement Regarding Gifts of Nominal Value To Medicare and Medicaid Beneficiaries. https://oig.hhs.gov/documents/special-advisory-bulletins/887/OIG-Policy-Statement-Gifts-of-Nominal-Value.pdf.* We recommend visiting the OIG's website to determine whether this policy statement is still in effect or has been updated.

[102] CMS. (2022, February 9). *Medicare Communications and Marketing Guidelines (MCMG).* Pp. 9–10. *https://www.cms.gov/files/document/medicare-communications-and-marketing-guidelines-3-16-2022.pdf.*

truthful if the figure in the advertisement did not actually endorse the product, did not actually speak the words the advertisement says they stated, or other similar behaviors. Furthermore, this behavior may violate State or Federal law on using someone's name, image, or likeness without permission.

The language we would use in proposed § 155.220(j)(3)(ii), and the behaviors we propose to list in new § 155.220(j)(3)(iii), would better align Exchange requirements with MA requirements and help protect consumers. Aligning marketing rules for agents, brokers, and web-brokers across the Exchanges would ensure uniformity in enforcement and enhance regulatory compliance, thus creating consistent consumer information. We also believe these proposals would help ensure advertisements about the Exchanges are accurately providing consumers information about the Exchanges prior to providing their PII and enrolling in a health plan. Accurate advertisements help ensure more consumers enroll on time and provide required supporting documentation in a timely manner, leading to more consumers being enrolled in coverage. The integrity of the Exchange would be improved by reducing the amount of misleading information being provided to consumers, helping foster an environment where enrollees trust the agents, brokers, and web-brokers providing Exchange enrollment support, as they play an integral role in facilitating enrollments and providing consumers information about the Exchange.

Current §§ 155.220(j)(2)(ii)(A)(2) and 155.220(j)(2)(iii)(C) state HHS or our designee may periodically monitor and audit an agent, broker, or web-broker to assess their compliance with applicable requirements. These requirements allow HHS to request and review eligibility application information and consent documentation to determine compliance with applicable regulations. Therefore, consistent with these other standards of conduct and documentation requirements, we propose to include the same language in new proposed § 155.220(j)(3)(iv) that agents, brokers, and web-brokers must produce any marketing material upon request in response to monitoring, audit, and enforcement activities conducted consistent with paragraphs (c)(5), (g), (h), and (k) of this section. We do not believe a record retention requirement, similar to what is in place in §§ 155.220(j)(2)(ii)(A)(2) and 155.220(j)(2)(iii)(C), is necessary because we would already have access to the marketing materials.

We believe it is the responsibility of all agents, brokers, and web-brokers to ensure advertisements bearing their name or directing consumers to them for Exchange enrollment assistance do not contain misleading information and follow all regulatory requirements. Accordingly, at § 155.220(j)(3)(v), we propose that an individual or entity described in paragraph (j)(1) of this section would be responsible for ensuring that all marketing-related materials created, written, released, or otherwise produced by the individual or an entity or on their behalf adhere to the requirements of § 155.220(j)(3)(ii)–(iii) and to make all such marketing-related materials available to HHS upon request in accordance with § 155.220(j)(3)(iv). An entity working on an agent, broker, web-broker's behalf under § 155.220(j)(3)(v) could be an agent or broker working for another agent or broker that has been tasked with creating marketing materials, a third-party marketing organization with whom an agent or broker has contracted to create marketing materials on the agent or broker's behalf, or other similar parties. This proposal would support HHS compliance actions against agents, brokers, and web-brokers whose marketing materials do not comply with § 155.220(j)(3)(ii)–(iii) when necessary.

In summary, we are proposing to redesignate § 155.220(j)(3) as § 155.220(j)(4) and at new § 155.220(j)(3), to clarify standards of conduct for marketing. We are also proposing at § 155.220(j)(3)(iv) to require that an individual or entity described in § 155.220(j)(1) must produce marketing materials to HHS upon request in response to monitoring, auditing, or enforcement activities. Finally, we are proposing at § 155.220(j)(3)(v) to establish that an individual or entity described in paragraph (j)(1) of this section is responsible for ensuring that all marketing-related materials created, written, released, or otherwise produced by the individual or entity or on their behalf adhere to the requirements of § 155.220(j)(3)(ii)–(iii) and, at § 155.220(j)(3)(iv), to produce to the HHS any marketing-related materials upon request in response to monitoring, audit, and enforcement activities.

We seek comment on all aspects of these proposals. Specifically, we seek comment on additional marketing standards of conduct we should consider for agents, brokers, web-brokers, and third-party marketing organizations to address deceptive marketing practices while minimizing administrative burden.

7. Removal of the Vendor Program (§ 155.222)

We propose to remove § 155.222, which currently governs the vendor program to provide agent and broker training on an annual basis for a given plan year. Removal of this regulation would effectively sunset the vendor program.

The vendor program was established through § 155.222 to be implemented in PY 2016 and beyond to allow the possibility for certain training and information verification functions to be provided by HHS-approved vendors. In the 2016 Payment Notice (80 FR 10749), we outlined in § 155.222(a) the application and approval process for vendors seeking recognition as HHS-approved vendors for FFE training and information verification for agents and brokers. Section 155.222(b) outlines the standards that an entity must meet to be approved by HHS as a vendor and to maintain their status as an approved vendor, and § 155.222(c) provides that the approved list of vendors will be published on an HHS website. Section 155.222(d) describes how vendors will be monitored for ongoing compliance with the standards outlined in § 155.222(b). Section 155.222(e) describes the appeals process available to vendors whose applications are denied, or whose approvals to offer training and information verification are revoked.

The vendor program is an underutilized program with static growth. Since the program's inception in PY 2016, only six entities have participated as vendors, with only two or three participating in any given plan year. Additionally, agents and brokers who utilize the program only account for 9.3 percent (9,138) of registered agents and brokers in PY 2025. Moreover, since 2015, training completions by agents and brokers through vendors have never surpassed 10 percent. Importantly, eliminating the vendor program would save the Federal Government approximately $300,000 each plan year.

If this proposal to discontinue the vendor agent/broker training program is finalized, it would affect neither the quality of nor access to agent/broker annual training. Agents and brokers would continue to have the ability to access training through CMS' existing Marketplace Learning Management System (MLMS) platform. The proposal to discontinue the vendor agent/broker training program only proposes to remove the option of this alternate

training platform—one that, as noted, has been historically underutilized.

In summary, we propose to terminate the vendor program, which allows approved third-party entities to facilitate the annual agent and broker training and registration process for the Exchange, through removal of § 155.222.

We request comment on the proposal to remove § 155.222 and eliminate the vendor program.

8. Limit APTC Eligibility to ''Eligible Noncitizens'' (45 CFR 155.20; 45 CFR 155.305(f)(1); 45 CFR 155.320(c)(3) and 42 CFR 600.5)

Section 71301 of the WFTC legislation established new eligibility requirements for the PTC. Specifically, section 71301 of the WFTC legislation amends 26 U.S.C. 36B(e) to provide that a PTC is allowed for the coverage of a lawfully present noncitizen only if he or she is an ''eligible alien.'' Section 71301 of the WFTC legislation defines ''eligible alien'' as an individual who is either lawfully admitted for permanent residence (sometimes referred to as a ''lawful permanent resident'' or ''green card holder''); an individual who has been granted the status of Cuban-Haitian Entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980; or an individual who is lawfully residing in the United States in accordance with the Compacts of Free Association (COFA) as defined at 8 U.S.C. 1612(b)(2)(G) (sometimes referred to as a ''COFA migrant''). Section 71301 of the WFTC legislation also makes conforming amendments to sections 1411(a)(1), 1411(a)(2), 1411(b)(3), 1411(c)(2)(B)(ii), and 1412(d) of the Affordable Care Act. These amendments require Exchanges to collect attestations regarding ''eligible alien'' status for applicants applying for APTC, to verify such attestations with the Secretary for the Department of Homeland Security, and to determine eligibility for APTC under section 36B of the Code based on whether an applicant is an ''eligible alien.'' Section 1402(g)(2) of the Affordable Care Act specifies that CSRs are only allowed for applicants who are also eligible for PTC. While section 71301 of the WFTC legislation does not amend section 1402(g)(2) of the Affordable Care Act, because section 71301 limits PTC eligibility for applicants who are ''eligible aliens,'' section 1402(g)(2) requires that CSR eligibility also be limited to only those who are ''eligible aliens.''

To align Exchange eligibility and verification rules with section 71301 of the WFTC legislation's amendments to sections 1411 and 1412 of the Affordable Care Act, we propose to add a new definition of ''eligible noncitizen'' at § 155.20, providing that the term ''eligible noncitizen'' would have the same meaning as the term ''eligible alien,'' as defined in 26 U.S.C. 36B(e)(2)(B), which was newly defined in section 71301 of the WFTC legislation.

We further propose a technical update to § 155.305(f)(1)(ii) to cross-reference 26 CFR 1.36B–1(d). Currently, § 155.305(f)(1)(ii) States that a tax filer may be eligible for APTC if the Exchange determines that one or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse, meets QHP enrollment eligibility requirements and is not eligible for MEC during the coverage month. Our proposed edits amend this section to State that a tax filer is eligible for APTC if the Exchange determines that one or more applicants who is a member of the tax filer's family, as defined at 26 CFR 1.36B–1(d), meets QHP enrollment eligibility requirements and is not eligible for MEC during the coverage month. This proposed change better aligns with existing Treasury regulations regarding PTC eligibility, and provides a clearer description of the individuals on whose behalf a tax filer may be allowed APTC, given that taxpayers can no longer claim personal exemptions on their Federal income tax returns.[103]

Additionally, we propose to add § 155.305(f)(1)(ii)(C) to provide that an Exchange must grant eligibility for APTC to individuals who are U.S. citizens, U.S. nationals, or eligible noncitizens. To align with the new eligibility requirements for APTC for ''eligible noncitizens'' established by section 71301 of the WFTC legislation, we propose to add verification regulations at § 155.320(c)(3)(ix). This proposal would establish Exchange verification requirements for applicants who attest to having an eligible noncitizen immigration status as defined at § 155.20. Specifically, it would require Exchanges to attempt to verify eligible noncitizen immigration status using data from the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) program and proceed with the inconsistency process outlined in § 155.315(f)(1) through (4) when the Exchange cannot verify the information using SAVE data.

As a part of this regulatory update, we also propose to remove duplicative language and correct the lack of headings in § 155.320(c)(3) by removing the first occurrence of § 155.320(c)(3)(viii) and adding headings to § 155.320(c)(3)(vii) and (viii). We believe that the redundancy resulted from an oversight in previous rulemaking, as both provisions were intended to define ''family size'' to align with definitions in the Code and related Treasury Regulations. The first provision referenced 26 CFR 1.36B–1(d), while the second referenced section 36B(d)(1) of the Code. We believe that the regulatory definition in 26 CFR 1.36B–1 is more appropriate for use in our regulations.

Additionally, we note that section 71301 of the WFTC legislation will impact Federal payments to States that operate BHPs for individuals enrolled in the BHP who are lawfully present noncitizens but who are not ''eligible aliens,'' as defined in 26 U.S.C. 36B(e)(2)(B). To align BHP program regulations with this statutory change, we propose to add a definition of ''eligible noncitizen'' at 42 CFR 600.5, cross-referencing the definition of the same term at 45 CFR 155.20. The definition's proposed update, which is relevant for Federal funding to States that operate BHP programs, would not impact underlying eligibility for BHP; rather it would provide clarity in future guidance regarding the payment methodology for the BHP. The underlying statutory provisions at section 71301 of the WFTC legislation apply to plan years beginning on or after January 1, 2027. Accordingly, our proposed regulatory amendment would be effective beginning with plan years starting on or after January 1, 2027.

Under section 1331(d)(3)(A)(i) of the Affordable Care Act and 42 CFR 600.605(a), Federal BHP payments to States include 95 percent of both the PTC under section 36B of the Code and the CSR that would have been provided for the fiscal year to eligible individuals enrolled in BHP standard health plans in the State if such eligible individuals had been enrolled in QHPs through an Exchange. Currently, Congress has not funded CSR payments. Therefore CMS assigns a value of zero to the CSR portion of the BHP payment rate calculation and States receive no BHP funding attributable to that portion.

While section 71301 of the WFTC legislation eliminates eligibility for PTC for lawfully present noncitizens who are not ''eligible aliens,'' such individuals remain eligible for enrollment in the BHP, provided they meet the eligibility requirements of section 1331(e) of the

[103] The personal exemption reduction was reduced to zero for tax years 2018 through 2025 by Section 11041 of the Tax Cuts and Jobs Act (Pub. L. 115–97). This reduction was made permanent by Section 70103 of the WFTC legislation.

Affordable Care Act and 42 CFR 600.305. However, Federal BHP payments to States that operate a BHP attributable to such enrollees will cease beginning with plan years starting on or after January 1, 2027.

We are proposing to update §§ 155.20, 155.305(f)(1), and 155.320(c)(3)(ix) to align Exchange regulations with section 71301 of the WFTC legislation. Section 71301 of the WFTC legislation amended section 36B of the Code to provide that a PTC is allowed for lawfully present noncitizen only if he or she is an ''eligible alien'' and made conforming amendments to section 1411 of the Affordable Care Act requiring Exchanges to verify applicants' ''eligible alien'' status. Accordingly, we propose to add a new definition in § 155.20, update our APTC eligibility regulations at § 155.305(f)(1), and add to our verification regulations in § 155.320(c)(3)(ix) to align Exchange eligibility and verification rules with section 71301 of the WFTC legislation.

We seek comment on these proposals.

9. Disallow APTC for Individuals Who Are Ineligible for Medicaid Due to Their Immigration Status and Have Income Below 100 Percent of the FPL (§ 155.305(f)(2))

Section 71302 of the WFTC legislation amended 26 U.S.C. 36B(c)(1) by striking subparagraph (B) which provided that an individual could be considered an applicable taxpayer, and therefore eligible for PTC, if they had household income under 100 percent of the FPL and were a noncitizen lawfully present in the United States who was ineligible for Medicaid due to their immigration status. Because 26 U.S.C. 36B(c)(1)(B) was repealed, such noncitizens are no longer eligible for PTC. Under section 1402(g) of the Affordable Care Act, which provides that an individual is only eligible for CSRs if they are also eligible for PTC for that month, such noncitizens are also no longer eligible for CSRs. This provision is effective for taxable years beginning after December 31, 2025.

We propose to remove § 155.305(f)(2) to align regulations with section 71302 of the WFTC legislation. Section 155.305(f)(2) currently requires an Exchange to determine a tax filer eligible for APTC if the Exchange determines that the tax filer is expected to have household income of less than 100 percent of the FPL for the benefit year for which coverage is requested, the tax filer or one or more applicants for whom the tax filer expects to be eligible for a personal exemption is lawfully present and ineligible for Medicaid due to their immigration status, and the tax filer otherwise meets APTC eligibility requirements. Section 71302 of the WFTC legislation amended section 36B of the Code such that PTC is no longer allowed for this population. Removing § 155.305(f)(2) would align Exchange APTC eligibility rules with the Code's PTC eligibility rules, as required by section 1411(a)(2)(A) of the Affordable Care Act.

We also propose conforming amendments to the verification regulations at § 155.320(c)(3)(iii)(A) and to SEP regulations at § 155.420(d)(13), to remove references to § 155.305(f)(2) and to the population described in that provision.

Additionally, we note that section 71302 of the WFTC legislation will impact Federal payments to States that operate BHPs for individuals enrolled in the BHP who are ineligible for Medicaid due to their immigration status and with incomes below 100 percent of the FPL. As stated above, under section 1331(d)(3)(A)(i) of the Affordable Care Act and 42 CFR 600.605(a), Federal BHP payments to States include 95 percent of the PTC under section 36B of the Code. Following the repeal of 26 U.S.C. 36B(c)(1)(B) by section 71302 of the WFTC legislation, noncitizens who are lawfully present, ineligible for Medicaid due to immigration status, and have household income below 100 percent of the FPL are no longer eligible for PTC. Therefore, States will stop receiving Federal BHP payments attributable to members of this population who are BHP enrollees as of January 1, 2026.[104]

Section 71302 of the WFTC legislation is applicable beginning January 1, 2026. Section 71302 is self-effectuating and Exchanges are required to operationalize the changes required to implement these new statutory requirements beginning with eligibility determinations for the PY 2026 even though conforming changes to Exchange regulations will not yet have been finalized.

We are proposing to remove § 155.305(f)(2) and make conforming updates to §§ 155.320(c)(3)(iii)(A) and 155.420(d)(13) to align Exchange regulations with section 71302 of the WFTC legislation. Removing § 155.305(f)(2) and updating § 155.320(c)(3)(iii)(A) would align Exchange APTC eligibility and verification rules with the statutory changes enacted by section 71302 of the WFTC legislation. We further propose conforming amendments to § 155.420(d)(13) to remove the SEP triggering event for individuals with household income under 100 percent of the FPL who did not enroll in coverage while waiting for HHS to verify their citizenship or immigration status, as the intent of this SEP was to provide an enrollment opportunity for individuals described at § 155.305(f)(2) who were not able to verify their eligibility for APTC within their original enrollment window.

We seek comment on this proposal.

10. Failure To File and Reconcile (FTR) Policy (§ 155.305)

We propose to amend paragraph § 155.305(f)(4) so that in PY 2028 and beyond, all Exchanges may not determine a tax filer or their enrollee eligible for APTC if: (1) HHS notifies the Exchange that APTC were paid on behalf of the tax filer, or their spouse if the tax filer is a married couple, for 1 year for which tax data would be utilized for verification of household income and family size, and (2) the tax filer, or the tax filer's spouse if the tax filer files jointly, did not comply with the requirement to file a Federal income tax return and reconcile APTC for that year (referred to as the ''1-tax year FTR'' process). We also propose that, at the option of the Exchange, an Exchange may choose to early adopt the 1-tax year FTR policy in PY 2027 if it has the resources and capability to do so, or it can continue to administer a 2-tax year FTR process until PY 2028. If this proposal is finalized, Exchanges on the Federal platform would adopt the 1-tax year FTR process in PY 2027, as HHS has the resources available to do so.

As background, consumers who receive APTC are required to file income taxes pursuant to section 6011(a) of the Code and regulations prescribed by the Secretary of Treasury. Section 36B(f) of the Code requires taxpayers to reconcile their APTC under section 1412 of the Affordable Care Act with their PTC allowed under section 36B of the Code. FTR regulations, implemented pursuant to the Secretary of HHS's general rulemaking authority under section 1321(a) of the Affordable Care Act, facilitate compliance with those requirements and were implemented as part of the 2012 Exchange Establishment Rule (77 FR 18352 through 18353). Exchange enrollees whose tax filer fails to comply with the requirement to file an income tax return and reconcile APTC as described in § 155.305(f)(4) are referred to as having failed to ''file and reconcile.'' These individuals are referred to as having an FTR status, and the Exchanges conduct the FTR process to identify such individuals.

[104] CMCS Informational Bulletin, December 10, 2025, ''Basic Health Program; Federal Funding Methodology for Program Year 2026,'' available at *https://www.medicaid.gov/federal-policy-guidance/downloads/cib12102025.pdf.*

In the Exchange Establishment Rule, we finalized the FTR policy in part to prevent a primary tax filer or spouse who has failed to comply with tax filing rules from accumulating additional Federal tax liabilities due to overpayment of APTC. FTR was originally finalized and implemented as a 1-tax year FTR policy and HHS began FTR operations in late 2015. FTR continued as a 1-tax year policy until it was paused in 2021 during the COVID–19 public health emergency (PHE). FTR operations were paused due to concerns that consumers who had filed and reconciled would lose APTC due to IRS processing delays resulting from IRS processing facility closures and a corresponding processing backlog of paper filings.[105]

During the PHE pause, we amended the FTR process such that an Exchange could not determine a tax filer or their enrollee ineligible for APTC until they have failed to file a Federal income tax return and reconcile APTC for 2-consecutive tax years in the 2024 Payment Notice (88 FR 25814). Specifically, this 2-tax year FTR policy prohibits an Exchange from determining a tax filer or their enrollee eligible for APTC if: (1) HHS notifies the Exchange that APTC were paid on behalf of the tax filer, or their spouse if the tax filer is a married couple, for 2 consecutive years for which tax data would be utilized for verification of household and family size, and (2) the tax filer did not comply with the requirement to file a Federal income tax return and reconcile APTC for those years. We made this change to address operational challenges that required Exchanges to determine someone ineligible for APTC without having up-to-date information on the tax filing status of tax filers, to help consumers who may be confused or may have received inadequate education on the requirement to file and reconcile, to promote continuity of coverage for consumers who may not be aware of the requirement to file and reconcile, and to reduce the administrative burden on HHS.

When we adopted this 2-tax year FTR process, we acknowledged it could place consumers at risk of increased tax liability. To mitigate this concern, in the 2025 Payment Notice (89 FR 26298 through 26299), we required Exchanges to issue FTR warning notices for enrollees in Exchanges who have not filed and reconciled for 1-tax year. We further mitigated this concern when, in the 2026 Payment Notice (90 FR 4424), we also required Exchanges to issue associated warning notices for enrollees in Exchanges who have been identified as not filing and reconciling for 2 consecutive tax years. When we implemented the 2-tax year FTR policy, we also acknowledged the risk for improper enrollment by consumers who know they can ignore their FTR status for an additional year but concluded these instances would be limited as the majority of enrollees comply with FTR. Despite the potential for large tax liabilities and the risk of improper enrollment, we concluded that this policy would have a positive impact on consumers, while still ensuring program integrity as it would provide better continuity of coverage for consumers who may not be aware of the requirement to file and reconcile. We noted that we would continue to monitor the implementation of this new policy, including whether certain populations continue to experience large tax liabilities, and would consider whether additional guidance, or any additional policy changes in future rulemaking, are necessary.

In the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074), we finalized a return to the 1-tax year FTR process. Specifically, we finalized at § 155.305(f)(4)(iii) that, through the end of PY 2026, Exchanges would be required to find tax filers (or their enrollees) ineligible for APTC if they had a 1-tax year FTR status for PY 2026 only. The finalized regulation provided that Exchanges would revert to the 2-tax year FTR process beginning in PY 2027. We did so for a number of reasons. First, we stated in the 2025 Marketplace Integrity and Affordability final rule that we believe the prior 2-tax year FTR process places a substantially higher number of tax filers at a greater risk of accumulating increased tax liabilities when filing their Federal income taxes. Second, we stated that we believe that the 2-tax year FTR process could incentivize tax filers to not file and reconcile because they would be allowed to keep APTC eligibility for an additional year without filing their Federal income tax return and reconciling APTC. This policy was stayed by the District Court for the District of Maryland in *City of Columbus et al.* v. *Kennedy et al.,* on August 22, 2025. The judge stayed this particular provision after concluding the plaintiffs were likely to succeed in arguing the 1-tax year FTR policy is contrary to law. Due to the Court's decision, the 2-tax year policy remained in place for PY 2026 for all Exchanges.

Under section 36B(b)(1) of the Code, no PTC is allowed for any month that is not a ''coverage month.'' On July 4, 2025, Congress passed and President Trump signed the WFTC legislation which, under section 71303, amended the definition of ''coverage month'' under section 36B(c) of the Code for taxable years after December 31, 2027, to provide that ''coverage month'' will not include, with respect to any individual enrolled in a QHP through an Exchange, any month for which the Exchange does not meet the requirements of § 155.305(f)(4)(iii), as added by the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074). Section 155.305(f)(4)(iii) reflects the 1-tax year FTR policy proposed in this rule. Thus, under section 71303 of the WFTC legislation, for taxable years beginning after December 31, 2027, no APTC is payable on behalf of any enrollee in an Exchange for any month in which the Exchange has not implemented a 1-tax year FTR policy.

We propose that for PY 2028, an Exchange must determine a tax filer or their enrollee ineligible for APTC, and that, at an Exchange's option, an Exchange may make such a determination for PY 2027 if: (1) HHS notifies the Exchange that APTC was paid on behalf of the tax filer, or their spouse if the tax filer is married, for a year for which tax data would be utilized for verification of household income and family size; and (2) the tax filer, or their spouse if the tax filer is married, did not comply with the requirement to file a Federal income tax return and reconcile APTC payments with PTC the tax filer is allowed to claim on their tax return for that year. If the Exchange does not choose to adopt the 1-tax year FTR policy for PY 2027, they must determine a tax filer or their enrollee ineligible for APTC if: (1) HHS notifies the Exchange that APTC was paid on behalf of the tax filer, or their spouse, if the tax filer is a married couple, for 2 consecutive tax years for which tax data would be utilized for verification of household income and family size; and (2) the tax filer, or their spouse if the tax filer is a married couple, did not comply with the requirement to file a Federal income tax return and reconcile APTC payments with PTC the tax filer is allowed to claim on their tax return for those 2 consecutive years.

We propose to amend the language at § 155.305(f)(4) to clearly reflect an

[105] Please see, CMS. (2021, July 23). Failure to File and Reconcile (FTR) Operations Flexibilities for Plan Years 2021 and 2022—Frequently Asked Questions (FAQ). Available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/FTR-flexibilities-2021-and-2022.pdf.* See also, CMS. (2022, July 18). Failure to File and Reconcile (FTR) Operations Flexibilities for Plan Year 2023. Available at *https://www.cms.gov/cciio/resources/regulations-and-guidance/ftr-flexibilities-2023.pdf.*

Exchange's option to implement either the 1-tax year FTR policy or 2-tax year FTR policy for PY 2027 and the 1-tax year FTR policy for PY 2028 and beyond. We are proposing to reorganize paragraph (f)(4) to include three sections—Definitions, APTC eligibility, and Notices. We also propose to revise the language to ensure that notices are sent to consumers that reflect whether the Exchange is implementing the 1-tax year or 2-tax year FTR policies for PY 2027 coverage, and that the Exchange will implement the 1-tax year FTR policy for PY 2028 coverage. In addition, we are making non-substantive changes to improve the readability and clarity of the regulatory text. We believe this change is important because it would be imprudent for Exchanges to implement the 2-tax year FTR policy in PY 2028 and thereafter due to the impacts on the definition of coverage month under section 36B(c) of the Code, and allowing Exchanges to voluntarily adopt the 1-tax year policy for PY 2027 gives Exchanges the operational flexibility they need to navigate the vast pre-enrollment verification changes also imposed in section 71303 of the WFTC legislation.

While the revised definition of coverage month that compels Exchanges to implement the 1-tax year FTR policy is scheduled to take effect for PY 2028 under the WFTC legislation, we believe it is important to begin implementing this policy in PY 2027 to protect people from accumulating tax liabilities. Until 2026, the amount of APTC that consumers were required to repay when filing their Federal income tax return and reconciling their APTC was limited by section 36B(f)(2)(B) of the Code based on their income level as a percentage of the FPL. Section 71305 of the WFTC legislation eliminated those excess APTC recapture limits for consumers who have received APTC in the prior year for tax years beginning after December 31, 2025. As a result, consumers with excess APTC will have their tax liability increased by the entire amount of the excess APTC. Given this, we are even more concerned about the potential for high tax liabilities that could accumulate if consumers do not file their Federal income tax returns and reconcile APTC. The current 2-tax year FTR process could potentially provide up to 18 months after an initial FTR notice is received for a tax filer to comply with the requirement to file and reconcile their APTC, which would expose the tax filer to up to 18 additional months of excess APTC if the tax filer does not file and reconcile. We previously concluded in the Marketplace Integrity and Affordability final rule (90 FR 27074) that this does not provide reasonable protection against accumulating tax liabilities.[106] By switching from a 2-tax year FTR process to a 1-tax year FTR process for PY 2027, our hope is that consumers would not inadvertently be responsible for repaying the entirety of 18 months of excess APTC if they do not file and reconcile, which is likely a significant financial hardship for many consumers receiving APTC.

The Marketplace Integrity and Affordability final rule reinstated the 1-tax year FTR policy, but to balance competing concerns, the rule sunsets the policy automatically after the end of PY 2026. At the time, we concluded that the 1-tax year FTR policy was needed immediately to reduce the number of improper APTC payments in Exchanges on the Federal platform. However, we also concluded its utility is less apparent in the context of the expiration of the expanded subsidies and fully-subsidized benchmark plans, which removes much of the incentive for unscrupulous agents and brokers to fraudulently enroll consumers into Exchange coverage who then may not know they need to file Federal income taxes and reconcile APTC. While we have made progress in reducing improper unauthorized enrollments over the past year, we remain concerned there is substantial number of unauthorized enrollments on the Federal platform and therefore believe there is still an immediate need for the 1-tax year FTR.

When we finalized the sunset of the 1-tax year policy in the finalized 2025 Marketplace Integrity and Affordability rule, commenters also expressed the following concerns: (1) that the 1-tax year FTR process may result in coverage losses because the tax filing process is complex and consumers are not fully aware of the requirements to file and reconcile, (2) that the 1-tax year FTR process could have a negative impact on the risk pool, and (3) that the 1-tax year process negatively impacts low-income consumers who have a more difficult time predicting and verifying income due to the unpredictable nature of their income. While we acknowledge these concerns, we believe that for plan year 2027, the overriding policy need for the Federal Exchange is to be able to remove unauthorized enrollments from the Marketplace, and the 1-tax year FTR policy enables us to do that better than a 2-tax year FTR policy. As for State-Based Exchanges, which do not all face the same problem in regards to unauthorized enrollments, we believe that the flexibility to be able to nimbly respond to whatever the Court decides in regards to the final decision in *City of Columbus et al.* v. *Kennedy et al.,* as well as during the implementation of all the other requirements imposed by the WFTC legislation, is the utmost policy goal for PY 2027. However, for PY 2028, due to the requirement of Exchanges to operate the 1-tax year FTR policy in order for a month to be considered a ''coverage month,'' thereby ensuring that consumers are eligible for APTC, all of our previously stated concerns, which are still valid, become secondary to the goal of ensuring that consumers are eligible for APTC, because APTC is essential for the Exchanges to function as designed in the Affordable Care Act.

HHS also understands that State Exchanges and other stakeholders may have planned their FTR operations based on the sunset of the 1-tax year policy as finalized in the 2025 Marketplace Affordability and Integrity final rule. However, due to the stay imposed by the Court, State-Based Exchanges have not implemented the 1-tax year FTR process for 2026. If the stay continues through PY 2026, they would have nothing to sunset in 2027 (that is, the 2-tax year FTR policy would continue). Alternatively, if HHS prevails in *City of Columbus et al.* v. *Kennedy et al.* during PY 2026 and the 1-tax year FTR policy is reinstated for the remainder of the plan year, it would be a burden for Exchanges to revert to a 2-tax year FTR policy in PY 2027 and then revert back to a 1-tax year FTR policy again in PY 2028, if that component of this proposal is finalized. Taking both these potential scenarios into account, we believe it would be most prudent to allow State Exchanges the option to choose between a 1- and 2-tax year FTR process for PY 2027. Additionally, as State Exchanges do not report the same problems with unauthorized enrollments as those currently facing the FFEs, there is less reason to require the 1-tax year policy in 2027. Further, it could be overburdensome to require State Exchanges to implement the 1-tax year FTR policy due to limited operational resources while they implement other requirements of the WFTC legislation.

A review of plan selections during the 2026 open enrollment period shows 29 percent of people enrolled in fully subsidized plans through the Federal platform. Thus, there remains an opportunity for unscrupulous agents and brokers to enroll people without

[106] Marketplace Open Enrollment Period Public Use Files, *https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files.*

their knowledge. In addition, HHS removed APTC from an estimated 430,000 enrollees as of January 1, 2026 for failing to file their Federal tax return and reconcile APTC for 2 consecutive tax years (2023 and 2024 tax years) in accordance with the 2-tax year FTR policy.[107] This population is already larger than the 235,000 enrollees who lost APTC eligibility as part of FTR operations for PY 2025 [108] and this is just the first stage in the process for PY 2026. In the Marketplace Integrity and Affordability proposed rule, we stated that we believe that FTR status may provide a strong indicator that a current enrollee entering the OEP has income that makes the household ineligible for APTC. This is because, for some households, the income requirement to file a tax return is approximately 100 percent FPL which is the minimum household income to qualify for APTC.[109] People who inflate their income to qualify for APTC will often have an income low enough to, absent the receipt of APTC, not require them to file taxes. In this case, the FTR status likely reflects a lack of understanding of the need to file taxes based on the receipt of APTC which, if they still think they do not meet the filing requirement based on their income, means they are likely to have an income too low to meet the APTC eligibility threshold. In addition, someone improperly enrolled entirely without their knowledge would also not know to reconcile. Considering our prior analyses that suggest FTR status is a strong indicator that a current enrollee is ineligible for APTC and the growth in enrollees with a 2-tax year FTR status for PY2026, we remain very concerned about the number of consumers in the Exchange that were potentially improperly enrolled and remain enrolled.

Though the enforcement of the 1-tax year policy for PY 2026 was stayed after a district court concluded it would likely be found contrary to law, we continue to believe we have a strong statutory basis for applying the 1-tax year policy. In the Marketplace Integrity and Affordability proposed rule (90 FR 12961), we stated HHS's belief that the Affordable Care Act does not allow HHS to determine someone eligible for APTC if they failed to meet the requirement to file a tax return. Sections 6011 and 6012 of the Code, as implemented under 26 CFR 1.6011–8, require enrollees who receive APTC to file a tax return and reconcile the APTC. Notwithstanding, the court reasoned that the policy was likely unlawful because nothing in the statute expressly conditions eligibility on reconciling tax credits. However, our analysis of the statute has focused on the importance of filing a tax return, not reconciling APTC. That's because the tax return is a critical element of the income verification process to qualify for APTC under the statute. As such, filing a tax return is a means of verifying a condition of eligibility and not itself a condition of eligibility. As we explained in the Marketplace Integrity and Affordability proposed rule, the statute requires APTC to be set on the basis of the individual's household income for the most recent taxable year for which information is available. Therefore, the income reported on the tax return for the most recent taxable year establishes the starting point for verifying whether an applicant's income meets the requirements to qualify for APTC. As discussed previously, when the IRS does not have tax return information to verify an applicant's income, section 1412 of the Affordable Care Act requires HHS to establish alternative procedures to determine APTC when there is a change in circumstances or ''in cases where the taxpayer was not required to file a return . . .''. Because section 1412(b)(2)(B) only references cases where a tax filer was *not required* to file a return, we do not believe an applicant who fails to meet the requirement to file a return qualifies for this alternative process for determining APTC. Therefore, to determine and verify household income, it is imperative that consumers file a Federal income tax return when they are required to do so.

While we had previously intended to sunset the 1-tax year policy in PY 2026, due to both the inability to implement it in PY 2026 due to a judicial stay in *City of Columbus et al.* v. *Kennedy et al.,* as well as the WFTC legislation preventing consumers from receiving APTC in any Exchanges not implementing the 1-tax year policy beginning in PY 2028, we believe it is best to implement the 1-tax year policy for PY 2028 for all Exchanges, with the option for Exchanges to early adopt for PY 2027 or continue operating the 2-tax year policy for PY 2027. As mentioned previously, we are giving Exchanges the option to continue operating the 2-tax year policy during PY 2027 because, while the Federal Exchange has the resources to early adopt the 1-tax year FTR policy in 2027, many State-Based Exchanges face different financial constraints. This may be particularly true in 2027 when States will have to also implement the other pre-enrollment verification changes required by the WFTC legislation. Therefore, in light of these considerations, we are proposing to revise § 155.305(f)(4) to require Exchanges to find consumers ineligible for APTC after they or their tax filer have been determined to have failed to file and reconcile for 1 tax year beginning in PY 2028, or in PY 2027 at the option of the Exchange. We are also proposing in § 155.305(f)(4) that an Exchange must operate the 2-tax year FTR process in PY 2027 if they do not elect to operate the 1-tax year FTR process.

We seek comment on this proposal.

11. Comment Solicitation on Eligibility Verification Provisions of the WFTC Legislation, Section 71303

Section 71303(a) and (b) of the WFTC legislation imposes new requirements on Exchanges related to eligibility verification effective with PY 2028.

Section 71303(a) of the WFTC legislation adds a new paragraph (5) to section 36B(c) of the Code, establishing that a month is not a coverage month for an applicant, and therefore no PTC is allowed for the applicant's coverage for that month, if the month begins before the Exchange verifies the applicant's eligibility to enroll in a QHP and for APTC, ''using applicable enrollment information that shall be provided or verified by the applicant.'' Section 71303(a) of the WFTC legislation also:

- Specifies a minimum set of ''applicable enrollment information'';
- Clarifies that a past month may be treated as a coverage month if an Exchange later verifies the applicant's eligibility;
- Specifies that these verification requirements do not impact eligibility to enroll in a QHP;
- Permits the Secretary of the Department of the Treasury to waive these verification requirements when an individual qualifies for an SEP based on a change in family size; and
- States that Exchanges are permitted to use ''any data available to the Exchange and any reliable third-party sources in collecting information for verification by the applicant.''

Section 71303(b) of the WFTC legislation amended section 36B(c)(3)(A) of the Code such that any

[107] CMS. (2026, January 28). CMS Actions to Protect Consumers and Strengthen Exchange Program Integrity. Available at *https://www.cms.gov/newsroom/fact-sheets/cms-actions-protect-consumers-strengthen-exchange-program-integrity.*

[108] CMS. Failure to File and Reconcile (FTR) Methodology available at *https://www.cms.gov/files/document/failure-file-and-reconcile-data-plan-year-2025.xlsx.*

[109] Information regarding the income amount that requires one to file is available on the IRS website at *https://www.irs.gov/individuals/check-if-you-need-to-file-a-tax-return#amount-to-file.*

plan enrolled in through an Exchange is not considered a QHP, and therefore no PTC is allowed for enrollment in the plan, unless, no later than August 1 of the preceding year, Exchanges provide ''a process for pre-enrollment verification'' that permits any applicant to verify their household income and eligibility for enrollment in such plan for the upcoming plan year.

We plan to issue regulations, guidance, technical assistance, and educational materials in the future to facilitate implementation of these provisions of section 71303 of the WFTC legislation. In this proposed rule, we seek comment on considerations for future policy development and implementation of these provisions of section 71303 of the WFTC legislation. We seek comment on topics including but not limited to: operational considerations for State Exchanges, issuers, agents and brokers, navigators and assisters, and consumers; and effective rollout and communications. We seek input from interested parties regarding the required timelines to comply with the law, including the requirement that Exchanges establish a pre-enrollment verification process no later than August 1, 2027. We also seek input on the anticipated complexity, costs, burden, enrollment impacts, and any State-specific considerations.

Section 71303 of the WFTC legislation also adds new paragraph (6) to section 36B(c) of the Code, regarding failure to file and reconcile; please see section III.D.10 of this proposed rule for discussion on our proposals regarding failure to file and reconcile.

12. Income Verification Policy When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))

To support improved payment integrity measures throughout the Exchanges, we finalized a series of income verification provisions in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27121), including revisions to § 155.320(c)(3), to require the submission of documents to verify income when an applicant's attested projected household income is at or above 100 percent of the FPL and trusted data sources indicate the consumer's household income is below 100 percent of the FPL. This policy was a resumption of the requirement to verify income for this subset of consumers that was first finalized in the 2019 Payment Notice (83 FR 16985), a regulation that was later vacated by the U.S. District Court for the District of Maryland in *City of Columbus* v. *Cochran.*[110] Following HHS's discovery of a massive volume of improper enrollments in 2023 and 2024, HHS re-proposed and finalized this policy in the 2025 Marketplace Integrity and Affordability Rule based on its assessment that additional eligibility verifications were necessary to prevent improper enrollments and payments of APTC, and to guard against improper enrollment behaviors by agents, brokers, and web-brokers. Based on commenters' concerns, HHS finalized this rule to sunset at the end of PY 2026 to provide further opportunities to monitor the policy's effects instead of codifying it to be applicable indefinitely. This policy was also sunset with the expectation that the reduction in fully-subsidized plans would reduce the urgency of its program integrity features and in response to commenter feedback that the measure was not necessary in State Exchanges that had not experienced high levels of improper enrollments. HHS believed that implementing this policy through the end of PY 2026, when paired with existing program integrity measures and additional measures finalized in the 2025 Program Integrity Rule, would strike the right balance between urgent program integrity concerns and long-term enrollment efficiencies. In August 2025, the U.S. District Court for the District of Maryland stayed enforcement of the regulation based on its conclusion that HHS did not meaningfully engage with challenges to the data and reports it used to justify the regulation.[111]

Since the finalization of the 2025 Marketplace Integrity and Affordability final rule and the issuance of the August 2025 court stay, HHS has continued to focus on finding and stopping improper enrollments, including those supported by inaccurate income estimations. Without the implementation of the stayed income verification regulation requiring documentation of income when an applicant attests to household income above 100 percent FPL and trusted Federal data sources indicate household income is below 100 percent FPL, the use of inflated incomes could have resulted in consumers being improperly enrolled in Marketplace coverage, oftentimes without their knowledge. Between October 2025 and the time of publication of this proposed rule, the Federal Exchange continued to detect improper enrollments that included suspect attestations of income. For example, the Federal Exchange has received reports that agents, brokers, and web-brokers may be using artificial intelligence to impersonate consumers and falsely attest to household income that could potentially qualify the consumers for decreased APTC and CSR benefits now that the enhanced subsidies have expired, something that we were not aware of when we finalized the 2025 Marketplace Integrity and Affordability final rule. Inaccurate household attestations can lead to consumers experiencing hardship when they go to use health coverage and find out they are enrolled in a plan they were unaware of.

Verifying an applicant's household income could result in HHS detecting improper enrollments before APTC can be paid. We continue to uncover improper enrollments through reports from consumers, agents and brokers, and, in particular, issuers. As mentioned in the fact sheet on CMS actions to strengthen program integrity and protect consumers,[112] in 2025, the Federal Marketplace cancelled 250,000 unauthorized enrollments. Additionally, the Federal Marketplace stopped APTC for 500,000 enrollees who were found to be concurrently enrolled in Exchange coverage with APTC and other coverage. The proposed policy, if finalized, could go far in protecting Federal funds from being paid to support improper enrollments for those who do not qualify for APTC or those who never intended to enroll in Exchange coverage, especially those who are already enrolled in Medicaid coverage and therefore did not need coverage through the Exchange. HHS is of the view that these circumstances present sufficient risk to Exchanges' ability to accurately verify eligibility determinations for APTC. HHS is of the view that it cannot continue to ignore the obvious risk presented by circumstances under which APTC and CSR eligibility is granted, notwithstanding that trusted data sources indicate that an applicant's household income is below 100 percent FPL, making them ineligible for receiving APTC or CSRs. We believe it is reasonable, necessary, and not unduly burdensome to require individuals to submit documentation to resolve these inconsistencies.

Moreover, submitting documentation to verify income is now even more important to protect applicants from accumulating tax liabilities due to

[110] *City of Columbus* v. *Cochran,* 523 F. Supp. 3d 731 (D. Md. 2021).

[111] *See City of Columbus* v. *Kennedy,* 796 F. Supp. 3d at 168.

[112] CMS. (2026, January 28). CMS Actions to Protect Consumers and Strengthen Exchange Program Integrity. Available at *https://www.cms.gov/newsroom/fact-sheets/cms-actions-protect-consumers-strengthen-exchange-program-integrity.*

misestimating or misreporting their income. As we explained in relation to the FTR policy in section III.D.10. of this proposed rule, the WFTC legislation was enacted after the finalization of the 2025 Marketplace Integrity and Affordability rule which removes limitations on repayment of the APTC beginning with plan year 2026. Under section 71305 of the WFTC legislation, repayment caps on excess APTC payments will discontinue starting in PY 2026. Under this proposed policy, households would likely receive an income DMI that would require them to submit documents to verify their annual household income and, if they do not verify with documents, would result in the loss of APTC after the 90-day DMI period and protect them from accumulating substantial tax liabilities.

We note that Congress did not limit HHS's authority under section 1411 of the Affordable Care Act to verify income under the circumstances targeted by the policy, but granted HHS broad authority and discretion to design verification procedures the HHS Secretary determines appropriate. Section 1411(c) of the Affordable Care Act provides that applicant household incomes for taxable year for second calendar year preceding the year the plan year begins upcoming plan year reported on an Exchange application must be submitted to the Secretary of the Treasury for verification. Section 1411(d) of the Affordable Care Act directs HHS or an Exchange to verify the accuracy of information that is not required to be submitted to Treasury, Homeland Security, and Social Security. Income information provided to verify eligibility when there are ''changes in circumstances'' is not required to be submitted to Treasury. Therefore, under 1411(d), HHS or Exchanges must verify this income information, which includes verifying income through other trusted data sources. If no trusted data source can verify income, section 1411(e)(4) of the Affordable Care Act requires the HHS Secretary to notify the Exchange of the inconsistency and the Exchange to take reasonable steps to resolve the inconsistency, including by contacting the applicant or by taking any additional actions as the HHS Secretary may identify through regulation or other guidance. If the inconsistency remains unresolved, the Exchange must give the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the Secretary of the Treasury. The policy we propose in this rulemaking reflects Congress' directives in section 1411(e)(4) of the Affordable Care Act. Given Congress' directive under section 1411(e) of the Affordable Care Act to collect documentation of applicant income in appropriate circumstances, as well as the discretion it granted to the HHS Secretary under the same section, it is difficult to pinpoint circumstances under which a requirement to verify or reconcile inconsistent data would be deemed unreasonable. Accurate income attestation and verification from households has long-ranging implications for payment integrity in the Exchange, with impacts to consumer protection, appropriate agent/broker compensation, data integrity, and the expenditure of tax dollars. Increased repayment responsibilities now makes these further verifications an essential protection against accumulating tax liabilities. Given HHS's authority, the ongoing need to strengthen program integrity and protect enrollees from accumulating tax liabilities, we propose to require Exchanges to comply with the requirement in 1411(e)(4) of the Affordable Care Act to set a 90-day inconsistency period for instances where the applicant's attested annual household income cannot be verified by data sources for verifications of eligibility for 2027 coverage and beyond. While we acknowledge that such a change may impose burden to State Exchanges and other interested parties, particularly in consideration of work that may have been done to support the 2025 Marketplace Integrity and Affordability final rule, we believe this proposal is a reasonable exercise of the authority and discretion that Congress vested in the HHS Secretary under section 1411 of the Affordable Care Act and is necessary given the payment integrity and tax liability issues noted above. Furthermore, we believe that the long-term program integrity savings of this change outweigh the operational costs to the Exchanges, as outlined in the Collection of Information Requirements in section IV. of this proposed rule.

With this in mind, section 1412 of the Affordable Care Act describes the process for determining eligibility for APTC using the process described section 1411 of the Affordable Care Act. Specifically, section 1412(b)(2) of the Affordable Care Act gives the Secretary authority to define additional verification procedures where a consumer's application reflects a change in the consumer's circumstances when compared to data for the most recent taxable year that is available from the Secretary of the Treasury. In cases, as described previously, where an applicant attests to annual household income at or above 100 percent of the FPL but the IRS indicates it is below 100 percent of the FPL, the Exchange would use this authority to determine whether they may be eligible for APTC using their attested annual income amount, given the 'changes in circumstances' from their tax data. In cases where trusted data sources cannot verify their income under these circumstances, we propose to specify that Exchanges on the Federal platform would follow the procedures established under 1411(e)(4) and implemented in § 155.315(f)(1) through (4) to create an annual income DMI for these consumers.

Beyond statutory authority, there are concerns regarding program integrity that continue to validate enhanced scrutiny for consumers whose annual household income is indicated by tax data as below 100 percent of the FPL. As we noted in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27121), a GAO study on improper payments determined our control activities, such as income verification policies, related to the accuracy of APTC calculations were not properly designed.[113] While we originally proposed temporarily instituting this policy in part due to lack of new data around this problem, a more recent GAO study published after the 2025 Marketplace Integrity and Affordability final rule (90 FR 27121) illustrates that this continues to be a problem. Specifically, this recent GAO study described issues that persist in the payment integrity protections of the Exchange, including vulnerabilities related to potential SSN misuse as well as negative impacts resulting from unauthorized enrollment changes from agents and brokers.[114] The study utilized 20 fictitious applicants to identify program integrity control issues, of which 18 remained improperly enrolled as of September 2025. The GAO argued that these cases highlighted vulnerabilities in verification processes that can contribute to APTC reconciliation issues. We find that continued issues on the Exchange with accurately determining APTC eligibility as highlighted in this study present ongoing risks to the financial integrity

[113] GAO. (2016 Nov.). Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period, GAO–17–78. *https://www.gao.gov/products/gao-17-78*.

[114] GAO. (2025 Dec.) Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist, GAO–26–108742. *https://www.gao.gov/products/gao-26-108742*.

for the Exchanges and create opportunities for agent, broker, and web-broker-driven improper conduct. This gives further weight to the necessity of the continuation of this income verification policy beyond 2027.

A notable driver of these continued payment integrity concerns, as evidenced by the 2025 GAO findings, is agent, broker, and web-broker behavior. In the 2025 Marketplace Integrity and Affordability final rule (90 FR 27121), we provided evidence connecting agent, broker, and web-broker actions to consumers misrepresenting or overestimating their income and the rise in unauthorized enrollments. We observed that some agents, brokers, and web-brokers and applicants are taking advantage of weaknesses in the Exchanges' eligibility framework to enroll consumers in coverage with APTC without their knowledge, even when the consumers are not eligible. The persistence of agent, broker, and web-broker actions to undermine payment integrity highlight the need for continued changes to address improper enrollment and improve the accuracy of income attestations. In recently identified internal data, we found that nearly 80 percent of income DMIs were generated for households who worked with an agent, broker, and/or web-broker in PY 2024. This underscores that there continues to be broad miscalculations in household income attestation and resulting APTC assessment for applications assisted by agents, brokers, and web-brokers across Exchanges on the Federal platform, which the additional income verification outlined within this provision will help address.

We seek comment on this proposal.

13. Removal of the Requirement To Accept Attestations of Household Income When Tax Data is Unavailable (§ 155.320(c)(5))

In the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074), we removed the requirement for all Exchanges to accept an applicant's annual household income attestation when IRS is successfully contacted but the IRS returns no tax data. We finalized the policy to sunset after PY 2026, requiring Exchanges to resume acceptance of applicant attestations of their household income where the IRS, on behalf of the Treasury Secretary, reports that it has no data in response to a verification request under section 1411(c) of the Affordable Care Act. In this rule, we propose to permanently rescind the requirement under § 155.320(c)(5) that Exchanges accept attestations under the current rule, in favor of requiring Exchanges, beginning with applications for coverage for the 2027 PY, to collect documentation from applicants to verify an applicant's household income when the IRS returns no data.

There were many reasons that we opted to temporarily pause the requirement for Exchanges to accept household income attestation when tax data is unavailable. As outlined in the 2025 Marketplace Integrity and Affordability final rule, we believed that this policy may have helped contribute to the weakening of the Exchange eligibility system, which some agents, brokers, and web-brokers took advantage of enrolling consumers in fully-subsidized plans they may not have been eligible for, oftentimes without those consumers' knowledge. Additionally, after reassessing our reasoning for implementing the original policy, we concluded that no longer agreed that the original income verification process, including time and effort to submit verifying documents, was punitive. Given this, we concluded in the 2025 Marketplace Integrity and Affordability final rule that the administrative burden of the full income verification process was offset by program integrity benefits that reinstating this policy would have.

We finalized this provision in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074) because we recognized that the imminent program integrity concerns were being driven by the existence of fully-subsidized plans. We noted that the expiration of the enhanced subsidies coupled with the temporary program integrity requirements enacted by the rule could alleviate the need for ongoing higher levels of program integrity policies beyond PY 2026. We stated that as the level of improper enrollments decreased in 2026, we expected the lower subsidy levels to appropriately deter future levels of improper enrollments from ever growing so high again, diminishing the returns of the temporary policies we enacted in that rule. In other words, the burden of continuing the temporary policy would reach a point at which it outweighed any benefits.

After further consideration, we are proposing to remove § 155.320(c)(5), effectively eliminating the requirement to accept an applicant's household income attestation if IRS does not return any tax data so that for PY 2027 and beyond, Exchanges must generally follow the existing income verification process when the IRS returns no data. We are proposing to continue this policy based on our statutory authority and new consideration of impacts from the WFTC legislation.

Section 1411(b)(3)(A) of the Affordable Care Act requires consumers applying for APTC to provide income information described in the Code for the tax year ending the second year preceding the plan year. However, as APTC is determined based on annual household income for the plan year for which they are applying for coverage, when the consumer applies during the open enrollment period, they provide their projected income for the plan year rather than the income from the second year preceding the plan year. Section 1411(c)(3) of the Affordable Care Act requires HHS to submit this income information provided under section 1411(b)(3)(A) of the Affordable Care Act to the IRS for verification without exception. Section 1411(d) of the Affordable Care Act then requires HHS or the Exchanges to verify information submitted on the application that is not required to be submitted to the IRS. This includes income information on ''changes in circumstances'' under section 1411(b)(3)(B) of the Affordable Care Act as described in section 1412(b)(2) of the Affordable Care Act. Section 1412 of the Affordable Care Act outlines the process for determining APTC. Section 1412(a) directs the Secretary of HHS in consultation with the Secretary of Treasury to establish a program for determining APTC eligibility, and section 1412(b)(2) allows the Secretary of HHS to provide procedures for determining APTC eligibility when a change in circumstance has occurred, which includes substantial changes in income and when the household was not required previously to file a tax return. Finally, section 1412(c)(2)(1) of the Affordable Care Act requires the Secretary of Treasury to provide APTC to issuers on a monthly basis for the plan year.

Historically, given the inconsistency between the statutory requirement for HHS to develop an APTC eligibility process that generally uses income verified by the IRS from the second tax year preceding the plan year, and the fact that HHS must determine eligibility for APTC for the plan year (which occurs significantly after the tax year for which income is used for verification), we have interpreted section 1412(b)(2) of the Affordable Care Act to require households to provide projected annual household income to allow the Secretary of HHS to determine whether a change in circumstance has occurred since the second tax year preceding the plan. In instances where Exchanges receive IRS data as defined in

1411(b)(3)(A) of the Affordable Care Act, the applicant's projected annual household income is compared to that IRS data to determine if it aligns (within certain thresholds) or if there has been a change in circumstance. The Secretary then determines APTC based on projected income per section 1412(b)(2) of the Affordable Care Act if a change in circumstance has occurred and if a change in circumstance has not occurred, meaning the IRS data is aligned with the projected household income, the Exchange is effectively determining APTC based on IRS data for the second tax year preceding the plan year. Furthermore, section 1412(b)(2)(B) allows for instances in which an applicant was not required to file a tax return for the second preceding year to also be considered a change in circumstance, which is one reason why IRS data may not be returned for an applicant. When the IRS cannot verify income and there is a change in circumstance, HHS or the Exchanges then turn to verify income through additional trusted data sources under section 1411(d) of the Affordable Care Act.

In a situation where neither IRS data under section 1411(c)(3) of the Affordable Care Act nor additional trusted data sources under section 1411(d) of the Affordable Care Act cannot verify income, HHS must then follow the process in 1411(e)(4) of the Affordable Care Act to both require Exchanges to make a reasonable effort to determine the cause of the inconsistency and then allow the applicant the opportunity to correct the inconsistency within a 90-day period. In a situation in which an applicant lacks additional documentation or other supporting evidence of their attested income within the applicable time period, HHS would generally be compelled by statute to deny eligibility for APTC and CSRs based on the inconsistency with IRS data after the 90-day period has ended. In scenarios where IRS does not return income information for a household after the Exchange completes a data request, the statutory framework just outlined establishes additional verifications. When the Exchange's attempt to receive IRS information as stipulated in 1411(b)(3)(A) of the Affordable Care Act is not successful, we believe that simply considering that attested annual household income fully verified is insufficient to the authority in section 1411(d) of the Affordable Care Act to verify change in circumstance information stipulated in section 1411(b)(3)(B) of the Affordable Care Act and determine the method of verification, as it does state that the Secretary ''shall verify'' that information. Absent IRS data, CMS believes that it is necessary to proceed with further verification of this information in order to comply with the requirement in section 1411(d) of the Affordable Care Act to verify it, which would be more than simply accepting attestation.

Therefore, upon further review and consistent with our discussion in the 2025 Marketplace Integrity and Affordability proposed rule (90 FR 12968), we believe the best method of verification to be the current established verification processes for annual income, and that accepting attestation without further verification is not compliant with the requirement to, in some way, verify the information.

Finally, since newly applicable policy from the WFTC legislation provides much stronger motivation to verify consumer income information more stringently than previous practice. Under section 71305 of the WFTC legislation, repayment caps on excess APTC payments will discontinue starting in PY 2026. Absent this proposed policy, households for whom IRS returns no data will have their annual household income verified by their attestation of projected household income and, if eligible based on this income, would receive APTC for the duration of the plan year (unless there is a change in eligibility). In contrast, under this proposed policy such household incomes would likely be verified against additional trusted data sources and, if this verification fails, receive an income DMI that would require them to submit documents to verify their annual household income and, if they do not, would result in the loss of APTC after the 90-day DMI period. Previously, Exchanges instituted a repayment cap on the maximum amount of APTC that a household was responsible for paying back upon Federal income tax filing based on their income. In general, this capped repayments for people with incomes below 400 percent of FPL. Absent the proposed policy and with the removal of the repayment caps, tax filers whose APTC continues uninterrupted and whose actual household income is higher than their projected household income may have excess PTC and, if so, must pay back the full difference between their APTC and PTC, regardless of their income level. Therefore, the proposed policy, which ends APTC for consumers who cannot verify their income with documentation, provides an important protection for consumers against significant tax liabilities.

This is particularly important for consumers whose income is intentionally or unintentionally misrepresented by agents, brokers, web-brokers, or other intermediaries for enrollment on the Exchange. For example, many of these agents, brokers, and web-brokers intentionally estimate a household's attested income to receive the maximum amount of APTC possible in order to, even with the expiration of the enhanced subsidies, get consumers into low cost plans that they may not otherwise be eligible for at the price point provided. While we previously stated in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074) that we believe that unauthorized enrollments will decrease as a result of $0 benchmark plans no longer being available due to the expiration of the enhanced subsidies, the removal of the repayment caps necessitates this policy becoming permanent to protect consumers from significant tax liabilities.

For these reasons, we believe that the justifications for sunsetting this policy in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074) starting in Plan Year 2027 are now outweighed by the loss of the repayment caps. We had previously stated that the removal of the enhanced subsidies, and likely subsequent decrease in unauthorized enrollments, would mean that the corresponding Exchange costs and consumer burden for additional income verification, potential negative risk pool impact, and potential loss of coverage for low-income consumers would be greater than the positive program integrity benefits of making this policy permanent. However, we now believe that the tax liability changes for these consumers outweigh those concerns, and providing that protection is necessary even with the costs, burdens, and coverage impacts this policy could result in. We reiterate that applicants whose income is not returned by IRS will benefit from other verification procedures, including the Exchange checking other data sources beyond IRS and having 90 days to submit documentation to verify their attested annual household income.

We seek comment on this proposal.

14. Comment Solicitation on Premium Payment Threshold (§ 155.400)

We are seeking comment on whether HHS should permanently discontinue regulatory options allowing QHP issuers to implement a fixed-dollar and gross percentage-based premium payment threshold for PY 2027 and beyond. In

the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074), we finalized for PY 2026 that issuers are only able to implement a net percentage-based premium threshold for PY 2026 and, effective January 1, 2027, issuers will be permitted to implement the fixed-dollar threshold and either the net or gross premium percentage-based thresholds.

In the 2017 Payment Notice (81 FR 12271 through 12272), in which HHS established the option for issuers to implement a percentage-based premium payment threshold, we received comment requesting that issuers be allowed to establish a fixed-dollar threshold. At that time, we did not consider implementing a fix-dollar threshold because there can be cases where, due to the payment of APTC on behalf of an enrollee, even a low, flat-dollar amount could represent a large percentage of an enrollee's portion of the premium (81 FR 12272).

In the 2026 Payment Notice (90 FR 4475 through 4478), we implemented an option for issuers to establish a fixed-dollar premium payment threshold policy, under which issuers could consider an enrollee to have paid all amounts due in the following circumstance: the enrollee pays an amount that is less than the total premium owed and the unpaid remainder of which is equal to or less than a fixed-dollar amount of $10 or less, adjusted for inflation, as prescribed by the issuer. In addition, we implemented a gross percentage-based premium payment threshold policy, under which issuers could consider an enrollee to have paid all amounts due when the enrollee pays an amount that is equal to or greater than 98 percent of the gross premium, including payments of APTC, as prescribed by the issuer. If an enrollee satisfies the fixed-dollar or gross percentage-based premium payment threshold policy, the issuer may avoid triggering a grace period for non-payment of premium or avoid terminating the enrollment for non-payment of premium. However, these premium payment thresholds may not be applied to the binder payment.

We stated in the 2025 Marketplace Integrity and Affordability final rule, which was published after the 2026 Payment Notice, that, due to program integrity concerns stemming from the enhanced subsidies, offering these optional threshold flexibilities to issuers could enable a consumer to stay enrolled in a plan they are unaware of after payment of binder. At that time, we finalized modifications to § 155.400(g) that paused through the end of PY 2026 QHP issuers' ability to implement a fixed-dollar or gross percentage-based premium payment threshold. We specified that QHP issuers would regain authority to implement a fixed-dollar or gross-premium threshold after December 31, 2026. We explained that allowing the provision to sunset on December 31, 2026, would address the urgent improper enrollment concerns previously noted without permanently dismantling these premium threshold options.

Overall, HHS observed an increase in the number of unauthorized enrollment (UE) complaints made in 2024 compared to 2025; 229,734 were made in 2024 vs. 341,906 in 2025. However, although HHS continues to see noncompliant behaviors resulting in improper enrollments, we believe that program integrity measures implemented over the past year, in addition to the expiration of enhanced APTCs that took effect on January 1 of this year, are likely to lead to a decrease in the number of UE complaints received. Data from the beginning of this year already demonstrate a substantial decrease, with 46,099 UE cases reported in January 2025 compared to 24,053 for January 2026, and this trend is likely to continue.

We have also continued working to implement policies to quickly resolve cases where a consumer may be dually enrolled in Medicaid and a QHP with financial assistance without their consent (referred to as ''Medicaid UEs''). We have also implemented multiple data cleanup efforts and have worked with issuers to identify and resolve UEs. We continue to monitor complaints received and UEs resolved to ensure that program integrity concerns continue to decrease.

However, in addition to erroneous and improper enrollment data, there is evidence that consumers in many instances are unaware that they remain in coverage. For example, in a recent internal analysis of claims data from 2019 through 2024, we found that among silver plans offered on- and off-Exchange, a significantly higher percentage (34 percent from PY 2023 through PY 2024) of on-Exchange silver enrollments were associated with no claims as compared to off-Exchange silver enrollments (18 to 23 percent from PY 2019 through PY 2024) across all years examined, with the greatest difference occurring in PY 2023 and 2024. This trend was reflected in the percentage of zero claim enrollments in each metal level and was even reflected among enrollees in 94 percent of CSR plans, where out-of-pocket costs are mostly covered by insurers, and where utilization is generally expected to be higher as compared to plans with lower or no cost-sharing assistance available. In addition to this, as we explained in the 2025 Marketplace Affordability and Integrity final rule (90 FR 27140), continued access to zero-dollar bronze plans after the application of APTC increases the risk of fraudulent enrollments and consumers continuing to be enrolled in coverage they do not want. Despite the discontinuation of enhanced APTCs, it is estimated that 27 percent of enrollees can select a PY 2026 QHP with an after-APTC premium of $0, and 60 percent can select a PY 2026 QHP with an after-APTC premium of less than $50.

The FFE does not collect data from issuers on whether they have implemented a premium payment threshold policy (nor the threshold type), but we have observed that of all auto re-enrolled consumers who had a $0 premium in 2024 but who newly had a non-zero premium in 2025 (1,831,739 consumers), 19.2 percent owed $10 or less for their monthly premium (171,382 consumers owed >$0–$5, and $180,469 consumers owed >$5–$10), while 27.6 percent of consumers owed >$10–$25.[115] This suggests that while these premium thresholds prevent some consumers from being placed in a grace period, they likely also exacerbate the problem of consumers unknowingly remaining in coverage they did not or no longer want, since many consumers have premiums that fall below the threshold and could avoid delinquency without making paying premiums. With the expiration of enhanced subsidies for PY 2026 and the continued availability of zero-dollar and lower cost plans after application of APTC, HHS is of the view that it may be reasonable and necessary to continue to limit the fixed-dollar and gross-premium percentage-based thresholds beyond PY 2026.

Under the 2025 Marketplace Integrity and Affordability final rule, we finalized that issuers would re-gain the authority to implement fixed-dollar and gross-premium percentage-based thresholds after the end of the 2026 PY. This policy responded to commenter concerns that rescinding QHP-issuer flexibility to implement fixed-dollar and gross-premium percentage thresholds could create barriers to coverage for low-income enrollees who struggle to pay

[115] Source: Internal CMS enrollment data. CMS reviewed net premium changes for consumers who had a $0 premium for PY2024 and a subsequent >$0 premium for PY2025. The analysis shows how many consumers had net premiums of >$0–$5, >$5–$10, >$10–$15, >$15–$20, >$20–$25, >$25–$50, >$50–$100, >$100–$300, >$300–$500, and >$500.

premiums and that consumers with chronic conditions might be able to utilize either the gross-premium percentage-based or fixed-dollar thresholds to avoid coverage gaps. It also acknowledged comments from State Exchanges and State-specific advocacy organizations that limiting this flexibility was unnecessary in States served by State Exchanges that experienced lower rates of improper enrollments.

While we recognize the additional flexibility these policies might provide to consumers who may struggle in some months to pay their full share of their premium, we still believe it may be necessary to limit flexibilities to ensure that enrollees do not remain in coverage for extended periods of time without paying at least some of the premium owed. We stated at the time that this policy increases the risk that improper enrollments remain undetected, since the enrollee is less likely to receive invoices, and a delinquency or termination notice alerting them to the improper enrollment in the case that the individual or entity submitting the improper enrollment used false contact information. In addition, we stated that an enrollee who stops paying premiums in the belief that this would lead to termination of coverage may instead find that the coverage has continued for several months due to the issuer having implemented a fixed-dollar or gross percentage-based premium threshold, with the additional risk that the enrollee has accumulated a large amount of debt if the issuer has adopted a gross premium percentage-based threshold and the enrollee's gross premium is much higher than the de minimis $10 fixed-dollar threshold. We noted that, in contrast, this is not the case with the long-established net percentage-based threshold, under which enrollees must always pay at least some premium to avoid delinquency or loss of coverage.

As such, we are concerned that allowing the rescission of the fixed-dollar and gross-premium percentage-based threshold flexibilities to sunset for PY 2027 may exacerbate the risks we have outlined. We seek comment from interested parties on whether we should take no regulatory action and allow the policies to sunset at the end of PY 2026, or whether we should amend § 155.400 to rescind these policies for another fixed period of time or permanently in the interest of maintaining program integrity, as the fixed-dollar and gross percentage-based thresholds may hinder efforts at program integrity by allowing consumers to remain enrolled in unwanted coverage after payment of binder. In addition, we seek comment on whether it would be appropriate to grant State Exchanges the flexibility to adopt one or both of these thresholds, even if they remain unavailable for Exchanges on the Federal platform. We also seek comment on any other feedback interested parties may have on other changes HHS can make to the premium payment threshold policy.

15. Extend the Removal of the 150 Percent FPL SEP Beyond Plan Year 2026 (§ 155.420(d)(16))

To align Exchange regulations with section 71304 of the WFTC legislation, we propose to remove § 155.420(d)(16) such that all Exchanges will continue to be prohibited from offering the 150 percent FPL SEP after PY 2026. In addition to removing § 155.420(d)(16), we also propose conforming amendments to remove §§ 155.420(a)(4)(ii)(D) and 155.420(b)(2)(vii), and to revise § 155.420(a)(4)(iii).

The ''150 percent FPL SEP'' refers to a monthly SEP that was available, at the option of the Exchange, to individuals who were eligible for APTC and who had household income no greater than 150 percent FPL. This SEP enabled qualified individuals to enroll in an Exchange plan at any time and to change their Exchange plan up to once per month. We originally established the 150 percent FPL SEP in regulation, at the option of the Exchange, in part 3 of the 2022 Payment Notice (86 FR 53412). At the time, we stated that the primary objective of the 150 percent FPL SEP was to ''make affordable coverage available to more consumers,'' by making it easier for individuals to access the enhanced tax credits provided by section 9661 of the ARP (86 FR 53432). As finalized in part 3 of the 2022 Payment Notice, a consumer was required to have an applicable percentage of zero, meaning that they had access to a silver plan with a zero-dollar monthly premium after the application of APTC, to qualify for the SEP. In the 2025 Payment Notice (89 FR 26218), we removed the requirement that an individual have an applicable percentage of zero to qualify for the 150 percent FPL SEP. In this rulemaking, we cited a commitment to ''ensuring that affordable Exchange coverage is available for individuals with lower household incomes,'' and required that an individual be eligible for APTC to qualify for the SEP (89 FR 26320).

In the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074), we finalized a policy that prohibited Exchanges from offering the 150 percent FPL SEP, effective from August 25, 2025, until the end of PY 2026, at which time the prohibition would ''sunset'' and Exchanges could begin offering the 150 percent FPL SEP again. We stated that pausing the availability of the 150 percent FPL SEP was necessary due to a rise in improper enrollments, including misuse of the SEP by agents, brokers, and web-brokers (90 FR 27114). Exchanges would have been permitted to begin offering the 150 percent FPL SEP again in PY 2027, and this pause was finalized in part due to significant concerns raised by commenters regarding the impact of a wholesale repeal of the SEP on low-income Americans who properly use this SEP pathway (90 FR 27114). We reasoned that after the enhanced subsidies expired and individuals were exposed to greater premium costs, the ability of individuals or actors on behalf of individuals to improperly enroll would be diminished, mitigating the risk of allowing Exchanges to offer the 150 percent FPL SEP (90 FR 27114).

The 2025 Marketplace Integrity and Affordability final rule was finalized on June 25, 2025. Shortly thereafter, on July 4, 2025, the WFTC legislation was signed into law. Section 71304 of the WFTC legislation amended section 36B of the Code such that a plan is not considered a QHP, and therefore no PTC is allowed for coverage under the plan, if the plan is enrolled in through an SEP that is based solely on the basis of the relationship of an individual's expected household income to the FPL and not on a change in circumstance (an ''income-based SEP''). This provision is effective January 1, 2026.

Section 1411(a)(2)(A) of the Affordable Care Act provides that for, an individual who is claiming APTC or CSRs, the Secretary must determine whether the individual meets the income and coverage requirements of section 36B of the Code and section 1402 of the Affordable Care Act, respectively. HHS has interpreted section 1411(a)(2)(A) of the Affordable Care Act to require an Exchange to align its APTC eligibility rules with the Code's PTC eligibility rules. Therefore, HHS interprets section 71304 of the WFTC legislation to prohibit an Exchange from paying APTC for anyone enrolled in a plan if any individual enrolls in the plan through an income-based SEP, like the 150 percent SEP, that is not in connection with the occurrence of an event or change in circumstances specified by the Secretary.

Under the regulations finalized in the Marketplace Program Integrity Rule (90 FR 27074), Exchanges would be permitted to resume offering the 150 percent FPL SEP beginning in PY 2027.

However, due to requirements established by section 71304 of the WFTC legislation, we have determined that permitting Exchanges to offer the 150 percent FPL SEP would provide no additional value and could potentially harm consumers. Throughout prior rulemaking on this topic, we have consistently stated that the primary goal of the 150 percent FPL SEP was to increase consumers' access to affordable coverage (see 86 FR 53432 and 89 FR 26320). Because consumers who enroll through the 150 percent FPL SEP are no longer allowed APTC for their coverage, permitting Exchanges to offer the 150 percent FPL SEP can no longer achieve this stated objective. Additionally, permitting Exchanges to offer the 150 percent FPL SEP could harm APTC-eligible consumers who enroll through the SEP, as section 71304 of the WFTC legislation prohibits payment of APTC to a plan if any enrollee in that plan enrolled through an income-based SEP.

For the reasons described in this section, we propose to eliminate the ''sunset'' of the prohibition on Exchanges offering the 150 percent FPL SEP after PY 2026. To accomplish this, we propose to remove the paragraph currently at § 155.420(d)(16). We further propose conforming amendments to remove the paragraphs currently at § 155.420(a)(4)(ii)(D) and § 155.420(b)(2)(vii), which relate to plan category limitations and effective dates for the 150 percent FPL SEP, respectively. Finally, we propose a conforming amendment to § 155.420(a)(4)(iii), related to plan category limitations, to remove a reference to the 150 percent FPL SEP.

We seek comment on this proposal.

16. Special Enrollment Period Verification (§ 155.420(g))

In the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074), we finalized the removal of the restriction for Exchanges on the Federal platform to only conduct Special Enrollment Period Verification (SEPV) for Loss of Minimum Essential Coverage (MEC) at § 155.420(g). This allowed the Federal Exchange to conduct SEPV for additional SEPs. We also finalized a regulation that required Exchanges on the Federal platform to conduct SEPV for at least 75 percent of new enrollments. The final rule included a provision that both of these provisions were set to sunset on December 31, 2026.

We are reproposing these provisions in this rule as their implementation was stayed by the Court in *City of Columbus et al.* v. *Kennedy et al.* on August 22, 2025.[116] In reproposing these provisions following the Court's stay, this proposal reflects changes in circumstances and new supporting information since the original policy was established. This includes the passage of the WFTC legislation and additional insights from the resumption of SEPV for Loss of Minimum Essential Coverage (MEC) that occurred on May 16, 2025 in compliance with current SEP in verification regulations at § 155.420(g) for Exchanges on the Federal platform. Our proposal for the two SEPV policies does not include a sunset provision.

We included the sunset provision in the 2025 Marketplace Integrity final rule because we recognized that the then-imminent program integrity concerns were being driven by the existence of fully-subsidized plans. We noted that the expiration of the enhanced subsidies coupled with the temporary program integrity requirements enacted by the rule would right-size Exchange enrollment in PY 2026 and would obviate the need for ongoing higher levels of program integrity policies. We stated that as the excess levels of improper enrollments are reduced in PY 2026, we expected the lower subsidy levels to appropriately deter future levels of improper enrollments from ever growing so high again, diminishing the returns of the temporary policies we are enacting in the rule. In other words, the burden of continuing such policies would have reached a point at which they would outweigh any benefits.

We now believe reproposing these policies (without a sunset) is necessary to ensure integrity in the Exchanges and help limit fraudulent enrollments. The proposal to require Exchanges on the Federal platform to conduct SEPV for the loss of MEC SEP is a return to a previous policy that was implemented pursuant to the 2017 Marketplace Stabilization rule. The SEP verification policy in the 2017 rule was driven in part by a 2016 GAO undercover test study of SEPs. The study observed that self-attestation could allow applicants to obtain subsidized coverage they would otherwise not qualify for and then found 9 out of 12 of GAO's fictitious applicants were approved for coverage on the Federal and selected State Exchanges.[117] As a result we implemented verification for the largest SEPs on the Federal exchange.

Once SEPV was implemented, we studied how the consumer experience was impacted. For PY 2017, a report showed that we averaged a response time of 1-to-3 days to review consumer-submitted documents. In addition, the vast majority (over 90 percent) of SEP applicants who made a plan selection and were required to submit documents to complete enrollment were able to successfully verify their eligibility for the SEP. We conducted additional research for the following plan years through 2021. Based on data from PY 2019, the last year prior to the COVID–19 PHE, which greatly impacted SEPV processing, the majority of consumers (73 percent) were able to submit documents within 14 days of their SEP verification issue (SVI) being generated. Also, we found that the majority of consumers (63 percent) were able to fully resolve their SVI within 14 days of it being generated. That resolution percentage increased to 86 percent by 30 days.[118] We also found that for PY 2019, only approximately 14 percent or 75,500 individuals were unable to resolve their SVI out of the total population of SEP consumers who received an SVI. The data shows that the value of SEPV processing and the program integrity benefits it provides to the Exchanges is greater than the minimal burdens those same processes place on individuals.

We are proposing the 75 percent verification threshold for new SEP enrollments because we believe that most Exchanges would be able to meet it by verifying at least two or three of their largest SEP types based on current SEP volumes. The determination of how many enrollments would constitute 75 percent would be required to be based on enrollment through all SEPs in the prior plan year. This would provide Exchanges with implementation flexibility so they can continue to decide which special enrollment types to verify and the best way to conduct that verification. We are not proposing to require Exchanges to verify eligibility for all SEPs, because we have determined that the cost to verify eligibility for SEPs with very low utilization rates could be greater than the benefit of verifying eligibility for them.

For SEPs that are being verified, the Exchange would ''pend'' the consumer's enrollment, meaning that it would not be effectuated until the Exchange verified eligibility for enrollment through the SEP. If the Exchange is unable to verify such eligibility, then the consumer would not be eligible for enrollment through the Exchange under that SEP, and any plan selection under

[116] *City of Columbus* v. *Kennedy,* 796 F. Supp. 3d at 160.

[117] GAO. (2016 Nov.). *Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period,* GAO–17–78. *https://www.gao.gov/products/gao-17-78.*

[118] More consumers resolve passed 30 days due to extensions that they are eligible to receive.

that SEP would be canceled (meaning, terminated before coverage is effectuated) and would not result in enrollment.

Verification for the loss of MEC SEP, which is required under § 155.420(g), was paused through the Covid-19 PHE to ensure consumers could maintain access to continuous coverage. This pause in verification ended on May 16, 2025. After resuming verification for the Loss of MEC SEP on May 16, 2025, we noticed shifts in enrollment trends begin to occur.[119] Prior to the resumption of verification, in April of 2025, the Loss of MEC SEP accounted for approximately 330,000 SEP enrollments which was 48 percent of all SEP enrollments at that time in Exchanges that use the Federal platform. As of September 2025, the Loss of MEC SEP accounted for 95,000 SEP enrollments, which was down to 27 percent of all SEP enrollments at that time.[120] We also noticed during this same period that several other SEP types had their overall percentage of SEP enrollments increase quite substantially. For example, the Move SEP went from 1 percent to 21 percent of all SEPs, and the Medicaid/CHIP Denial SEP increased from 8 percent to 24 percent of all SEP enrollments. This data suggests that consumers shifted their SEP attestation so as not to have to provide verification of eligibility for the SEP.

We acknowledge that some shift in SEP volumes was expected due to our best SEP logic, which is a set of hierarchy rules that Exchanges on the Federal platform use to determine what the ''best SEP'' is for a consumer (generally based on the most advantageous coverage effective date for the qualifying life event experienced by the consumer, verifiable with documents as required), in the event that they attest to multiple SEP qualifying events, such as losing MEC, while also gaining a dependent. Essentially, consumers are often eligible for more than one SEP type and, once verification resumed, another SEP type may become the best SEP for a consumer. However, the substantial shift cannot be explained by that logic alone as these trends do not match any of our historical SEP enrollment data.

When SEPV was first implemented in 2017 and 2018, we noticed shifts in SEP enrollment patterns that resulted in non-verified SEPs making up a larger portion of the total SEP population. For example, the overall portion of consumers granted an SEP for acquiring a status that made them eligible for the Exchange increased from 2.5 percent in 2017 to 10 percent in 2018. During that same period, the Loss of MEC SEP decreased from 60 percent of all SEPs in 2017 to 54 percent in 2018, and the Medicaid/CHIP Denial SEP decreased from 24 percent in 2017 to 19 percent of all SEPs in 2018. From 2019 to 2024, although SEP enrollment volume increased drastically, the proportion of enrollment though each SEP stayed relatively similar. The introduction of the under 150 percent FPL SEP did result in the volume of other non-verified SEPs decreasing. The only notable changes were that the total portion of loss of MEC SEPs increased 5 percent and Medicaid/CHIP denial decreased 6 percent. Given the mass shift away from the loss of MEC SEP throughout 2025 and the significant growth in non-verified SEPs during the same time frame, we believe there is a high likelihood action is being taken to intentionally avoid SEP verification. We believe this trend is being driven primarily by agent and broker activity as 86 percent of SEP enrollments are through agents and brokers.

In addition to trying to mitigate the concern that individuals are attesting to SEPs they are not eligible for in order to avoid verification, we believe SEP verification will also help deter bad actors and those who are ineligible to enroll in coverage from gaining access to the Exchanges. We believe that this will help to reduce rates by preventing individuals who are waiting until they are sick to enroll from utilizing SEPs for which they may be ineligible. As we explained in the 2025 Marketplace Affordability and Integrity rule, we believe that continued access to zero-dollar bronze plans increases the risk of fraudulent enrollments and ineligible individuals gaining access to coverage through SEPs that do not require verification. We believe that increased SEP verification, as we stated in that rule, would reduce the risk of fraud and ineligible enrollments related to zero-dollar bronze plans in the FFE.

For the reasons provided above, we are reproposing without a sunset at § 155.420(g), the provision to remove the restriction for Exchanges on the Federal platform to only conduct SEPV for Loss of MEC, and the provision to require Exchanges on the Federal platform to conduct SEPV for at least 75 percent of new enrollments.

We seek comment on this proposal.

17. Expansion of Hardship Exemption Eligibility (§ 155.605(d)(1))

We propose to amend § 155.605(d)(1) to codify the expansion of hardship exemption eligibility to individuals who are ineligible for APTC or CSR due to projected household income below 100 percent or above 250 percent FPL.

Section 5000A(e)(5) of the Code establishes an exemption from the individual shared responsibility payment based on hardship or lack of affordability, and section 1302(e) of the Affordable Care Act limits eligibility for catastrophic coverage to individuals under age 30 at the start of the plan year or those who have received a hardship or affordability exemption. Under § 155.605(d), hardship exemptions include circumstances that prevent an individual from obtaining coverage through a QHP. Section 155.605(d)(1) states that the Exchange must grant a hardship exemption to an individual for at least the month before, the month or months during which, and the month after a specific event or circumstance, if the Exchange determines that: (1) the individual experienced financial or domestic circumstances, including an unexpected natural or human-caused event, such that he or she had a significant, unexpected increase in essential expenses that prevented him or her from obtaining coverage under a QHP; (2) the expense of purchasing a QHP would have caused the individual to experience serious deprivation of food, shelter, clothing or other necessities; or (3) the individual has experienced other circumstances that prevented him or her from obtaining coverage under a QHP.

State Exchanges may choose to process exemptions, or they may delegate exemption processing to HHS. Most State Exchanges currently delegate hardship exemption processing to HHS.[121] HHS published guidance on September 4, 2025, that expanded eligibility for a hardship exemption to individuals ineligible for APTC or CSRs due to projected household income for consumers in FFE States, SBE–FP States, and State Exchange States that delegate their exemption processing to HHS.[122] The proposal to amend § 155.605(d)(1) would expand hardship exemption eligibility to consumers

[119] We note that it is too soon for CMS to observe these trends as of the date the Program Integrity final rule was published on June 25, 2025.

[120] These numbers are derived from internal FFE SEP enrollment data.

[121] California, Connecticut, Maryland, and the District of Columbia currently do not delegate hardship exemption processing to HHS.

[122] CMS. (2025, September 4). Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-sharing Reductions Due to Income, and Streamlining Exemption Pathways to Coverage. Available at *https://www.cms.gov/files/document/guidance-hardship-exemptions.pdf*.

ineligible for APTC or CSRs due to projected household income in all States. We propose to make this change to improve access to affordable coverage to consumers in all States as we believe there are a substantial number of consumers for whom purchasing a QHP relative to a catastrophic plan could cause a financial hardship. From the year before the Affordable Care Act's main regulations took effect in 2013 to 2026, average monthly premiums on the individual market jumped from $244 to $779—a 219 percent increase, with premiums increasing by 26 percent in 2026 alone.[123] By comparison, inflation since 2013 increased by 39 percent and average hourly earnings for private sector employees increased by 53 percent.[124] As these data show, premiums continue to outpace income growth, creating affordability challenges even for consumers who may not qualify for financial assistance. We believe the substantial premium increases accumulated since 2013, and the recent spike in 2026, warrant a broad nationwide hardship exemption to allow individuals aged 30 and older to enroll in catastrophic coverage, if otherwise eligible under the proposed household income parameters. We propose applying this exemption uniformly across all States to ensure consistent consumer protection and access to catastrophic coverage.

To avoid confusion and inequities for consumers, States that currently process exemptions independently may implement the expanded criteria within their existing systems or delegate processing to HHS. This proposal does not preempt State authority under section 1321 of the Affordable Care Act, which provides States flexibility in the operation and enforcement of Exchanges and related requirements. States retain discretion to determine how to operationalize this policy—either by adopting the expanded criteria or continuing to delegate exemption processing to HHS. We would provide technical assistance to support implementation and ensure that States can exercise this flexibility while maintaining consistent consumer protections nationwide.

We seek comment on the proposal to amend § 155.605(d)(1) to codify and expand hardship exemptions for individuals ineligible for APTC or CSRs due to projected household income. If finalized as proposed, the expanded hardship exemption policy would take effect on the effective date of the final rule.

18. Amending Exchange Network Adequacy Standards (§ 155.1050)

Given our network adequacy review proposals at § 156.230 and § 155.1050(d) (which are described in greater detail later and in section III.E.10. of this proposed rule), we propose, for plan years beginning on or after January 1, 2027, to restore network adequacy authority back to the State Exchanges and SBE–FPs through the removal of requirements at § 155.1050(a)(2)(i) and (ii) which require State Exchanges and SBE–FPs to establish and impose quantitative time and distance network adequacy standards that are at least as stringent as standards for QHPs on the FFEs. We propose to amend § 155.1050(a)(2) to return to the requirement that State Exchanges and SBE–FPs ensure that each QHP provides sufficient access to providers in a manner that meets applicable standards specified in § 156.230(a)(1)(ii) and (iii) for network plans, or proposed § 156.236(a) for non-network plans, as applicable. These proposals seek to align § 155.1050 with the proposed changes in § 156.230.

In the 2025 Payment Notice (89 FR 26218), we finalized § 155.1050(a)(2)(i)(A) to require that, for plan years beginning on or after 2026, State Exchanges and SBE–FPs must establish and impose quantitative time and distance network adequacy standards for QHPs that are at least as stringent as standards for QHPs participating on the FFEs under § 156.230. We also finalized § 155.1050(a)(2)(i)(B) which requires that, for plan years beginning on or after January 1, 2026, State Exchanges and SBE–FPs conduct quantitative network adequacy reviews to evaluate a plan's compliance with network adequacy standards under § 156.230(a)(1)(ii), (a)(1)(iii), and (a)(2)(i)(A) prior to certifying any plan as a QHP, while providing a QHP certification applicant the flexibilities described under § 156.230(a)(2)(ii) and (a)(3) and (4).

We propose to remove these requirements to align with our proposals to add § 155.1050(d) and revise § 156.230 throughout to specify its applicability to QHP issuers that use a provider network in FFE States, including States performing plan management, that do not elect to conduct their own provider access reviews or that HHS has determined have not demonstrated sufficient authority and the technical capacity to conduct network adequacy reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program as described later in this section and in section III.E.10. of this proposed rule. We also propose these changes in recognition of the longstanding authority State Exchanges and SBE–FPs previously had to develop and enforce network adequacy standards and, given this past authority and experience, their network adequacy review capabilities and expertise to date.

The proposal also seeks to restore the authority that State Exchanges and SBE–FPs originally had in establishing network adequacy standards for their QHPs and issuers, acknowledging that State Exchanges and SBE–FPs have demonstrated they have the experience and expertise to be the best positioned entities to develop network adequacy standards for their distinct consumer markets.

Through our recent assessment of State Exchange and SBE–FP implementation of the network adequacy policy finalized in the 2025 Payment Notice, many State Exchanges and SBE–FPs demonstrated they have network adequacy standards and reviews in place that met or exceeded the requirements finalized in the 2025 Payment Notice. We are aware that some State Exchanges made updates in the lead up to PY 2026. State Exchanges and SBE–FPs provided us with detailed answers to a survey on existing authorities and policies in place and we met with each State Exchange and SBE–FP to discuss in detail what they were currently doing to assess network adequacy and any modifications they were working toward prior to PY 2026. State Exchanges and SBE–FPs described a wide variety and varying mixes of approaches including assessing compliance with time and distance standards, as was required in the 2025 Payment Notice, assessing compliance with time or distance individually due to geographical considerations, appointment wait times, or provider enrollee ratios.

The variety amongst the State Exchanges and SBE–FPs regarding how they chose to implement their unique approaches underscored the importance of restoring authority to State Exchanges and SBE–FPs, since these States can better take into consideration the needs of specific enrollee populations stemming from factors such as provider supply shortages and topography. Indeed, while some State Exchanges and SBE–FPs made modifications or updates to their network adequacy policies in the lead-up to implementation, we ultimately determined that most State

[123] Average enrollment weighted monthly premium from MLR data for 2013, and from unified rate review template (URRT) filings for 2026.

[124] BLS CPI–U and Current Employment Statistics Survey.

Exchanges and SBE–FPs were either already aligned with the requirements described at § 155.1050(a)(2)(i) or were granted the exception described under § 155.1050(a)(2)(ii), meaning we determined that the State established and imposed time and distance standards at least as stringent as those for QHPs on the FFEs, or that the State established and enforces alternate quantitative network adequacy standards that are reasonably calculated to ensure a level of access to providers that is as great as that ensured by the Federal network adequacy standards established for QHPs under § 156.230(a)(1)(iii), (a)(2)(i)(A), and (a)(4).

This proposal also seeks to align with proposed § 155.1050(d) and removes an unnecessary, redundant, layer of Federal regulatory burden on State Exchanges and SBE–FPs while maintaining consumer protections through the existing, robust State-level processes for setting network adequacy requirements for issuers and reviewing QHP network adequacy within their respective State Exchange or SBE–FP that such State Exchanges and SBE–FPs demonstrated to us were already in place prior to PY 2026. Due to the well-established, long-existing approaches that State Exchanges and SBE–FPs demonstrated to us were already in place, with many State Exchanges and SBE–FPs demonstrating through the surveys and subsequent conversations that they were already conducting network adequacy reviews in compliance with § 155.1050(a)(2)(i) and the remainder of State Exchanges and SBE–FPs were conducting network adequacy reviews that satisfied the criteria for an exception described at § 155.1050(a)(2)(ii), we have a high level of confidence that restoring § 155.1050(a)(2) to the requirements in place prior to 2025 would not result in consumers losing reasonable access to services without unreasonable delay.

Separately, concurrent with the proposal to amend § 156.230, to implement changes to reviews of network adequacy for QHP issuers in FFE States that demonstrate sufficient authority and the technical capacity to conduct such reviews and elect to do so, we propose the addition of § 155.1050(d) which would establish an Effective Provider Access Review Program.

We propose at § 155.1050(d)(1) that, beginning PY 2027, we would defer provider access reviews of QHP issuers' plans, with or without a provider network, applying for certification to be offered as a QHP through an FFE, to States that elect to conduct such provider access certification reviews, provided the State has demonstrated sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program under proposed § 155.1050(d)(2) through (d)(4). We propose at § 155.1050(d)(2) to clarify that FFE States considered to have an Effective Provider Access Review Program must ensure that a QHP issuer that uses a network of providers ensures that the in-network providers, as available to all enrollees, include essential community providers (ECPs) in accordance with § 156.235, and maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay. The QHP issuer's provider network must also be consistent with the rules for network plans in section 2702(c) of the PHS Act.

At § 155.1050(d)(3), we propose that FFE States considered to have an Effective Provider Access Review Program must ensure that a QHP issuer that does not use a network of providers (a non-network plan) provides access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full, including ECPs and providers that specialize in mental health and substance use disorder services, to ensure that services will be accessible without unreasonable delay.

At § 155.1050(d)(4), we propose the factors necessary for a State operating on the FFE to be considered to have an Effective Provider Access Review Program. We also propose to revise § 155.1050(a)(1) to clarify that an FFE State that has elected to conduct provider access reviews and has been determined to have an Effective Provider Access Review Program must ensure that each QHP provides sufficient access to providers in a manner that meets the standards specified in § 156.230(a)(1)(ii) and (a)(1)(iii) for network plans, or proposed § 156.236(a) for non-network plans, as applicable. A detailed discussion of this proposal can be found in section III.E.10. of this proposed rule. Additionally, we would encourage State Exchanges and SBE–FPs to use their network adequacy authority to conduct similar provider access reviews that consider criteria consistent with those outlined at § 155.1050(d)(2) through (d)(4) and described in section III.E.10. of this proposed rule.

In summary, we propose to amend § 155.1050(a)(2) to eliminate, for plan years beginning on or after January 1, 2027, the requirements under § 155.1050(a)(2)(i) and (ii) for State Exchanges and SBE–FPs. Instead, we propose to revise § 155.1050(a)(2) to require that State Exchanges and SBE–FPs ensure that each QHP provides sufficient access to providers in a manner that meets applicable standards specified in § 156.230(a)(1)(ii) and (a)(1)(iii) for network plans, or proposed § 156.236(a) for non-network plans, as applicable. We also propose the addition of § 155.1050(d), which is described in greater detail in section III.E.10. of this proposed rule.

We seek comment on this proposal. We also seek comment on what level of transparency is necessary and appropriate to safeguard public trust in Effective Provider Access Review Programs. While we are not specifically contemplating any particular form of new disclosure in this space at this time, we are interested in public feedback on which elements of process and which outputs of Effective Provider Access Review Programs should be subject to public disclosure.

19. Effective Essential Community Provider Review Program (§ 155.1051)

Beginning PY 2027, we propose to allow FFE States, including States performing plan management, to elect to conduct their own ECP certification reviews of an issuer's plans with or without a provider network in their State applying for certification as a QHP to be offered through an FFE. We would allow FFE States to conduct such ECP certification reviews provided the State demonstrates sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria established by HHS to be considered to have an Effective ECP Review Program, which we propose to implement at § 155.1051. This proposal is discussed in more detail in section III.E.11. of this proposed rule.

20. General Program Integrity and Oversight Requirements (§ 155.1200)

We propose to amend § 155.1200 to add new paragraph (e) to permit State Exchanges to satisfy certain requirements of the independent external programmatic audit, as outlined in paragraph (d), by completing the proposed State Exchange Improper Payment Measurement (SEIPM) process that would be established at 45 CFR part 155, subpart Q. We also propose to amend § 155.1200(d) to reduce duplication between the proposed State Exchange SEIPM program described in

proposed subpart Q and the annual independent external programmatic audit requirements and standards described at § 155.1200(c) and (d).

The Payment Integrity Information Act of 2019 (PIIA) (Pub. L. 116–117) requires Federal agencies to annually estimate and report on improper payments in the programs they administer that have been determined to be susceptible to significant improper payments. Pursuant to the PIIA, we propose to establish a SEIPM program, as we have determined that APTC payments administered by State Exchanges are susceptible to significant improper payments and are subject to additional oversight.[125] The PIIA defines significant improper payments as those exceeding either $100 million or exceeding $10 million and 1.5 percent of the program outlays. The proposed SEIPM program requirements are set forth in new proposed subpart Q, as discussed in section III.D.21. of this proposed rule.

The proposed SEIPM program would specify a methodology to develop State Exchange improper payment estimates and provide for the accurate calculation, and subsequent reporting, of an improper payment rate in HHS' Agency Financial Report (AFR). To ensure the accurate and consistent calculation of improper payments via the SEIPM program, we propose to require that State Exchanges provide HHS with access to certain State Exchange data, including eligibility determinations and enrollment information. We further propose that State Exchanges found to have significant improper payments could, to correct improper payment root causes, be required to develop corrective action plans (CAPs).

Our authority to oversee the State Exchanges arises from the program integrity and oversight requirements they must meet that are specified at section 1313(a) of the Affordable Care Act and at §§ 155.1200 and 155.1210. Key annual State Exchange reporting requirements at § 155.1200(b) include the annual submission of: (1) a financial statement in accordance with generally accepted accounting principles; (2) an annual report showing compliance with Exchange requirements; and (3) performance monitoring data.

Pursuant to § 155.1200(c) and (d), each State Exchange is also required to engage or contract with an independent qualified auditing entity that follows generally accepted government auditing standards to perform annual independent external financial and programmatic audits that address compliance with 45 CFR part 155, subparts D and E, or other 45 CFR part 155 requirements as specified by HHS. State Exchanges must provide HHS the audit results, including CAPs to address any audit-identified material weaknesses or significant deficiencies, and we monitor these CAPs until findings are resolved, pursuant to § 155.1200(c)(2). These audits allow us to oversee State Exchange compliance with eligibility and enrollment standards. In sub-regulatory guidance, we specify that the scope of the audits must also include 45 CFR part 155, subparts C and K.[126]

We propose to amend § 155.1200(d) to reduce duplication between the proposed SEIPM program described in subpart Q and the annual independent external programmatic audit requirements and standards described at § 155.1200(c) and (d). We propose to add § 155.1200(e) to permit a State Exchange to satisfy certain annual independent external programmatic audit requirements, as described at § 155.1200(d), by completing the proposed required annual SEIPM program process. These certain audit requirements would be limited to compliance with 45 CFR part 155, subparts D and E, and would be specified in guidance we would issue. We also propose to amend § 155.1200(d) to cross-reference proposed § 155.1200(e) to minimize duplication between the annual programmatic audit requirement and proposed SEIPM program. This would allow us to continue to require an annual independent programmatic audit of other subparts beyond eligibility and enrollment, while reducing duplication for oversight of eligibility and enrollment provisions.

We believe this policy would reduce duplicative efforts and burden on State Exchanges that would otherwise be required to fully comply with the programmatic audit requirements and SEIPM, while also maintaining the programmatic audits for requirements not reviewed as part of SEIPM.

We seek comment on these proposals.

21. State Exchange Improper Payment Measurement (SEIPM) (§§ 155.1600 Through 155.1650)

Under this proposed rule, we propose to establish the SEIPM, pursuant to the PIIA,[127] to measure improper payments of APTC administered by a State Exchange. To codify the proposed SEIPM requirements, we propose to establish a new subpart Q at 45 CFR part 155. The PIIA requires Federal agencies to periodically review programs and activities to identify those susceptible to significant improper payments, and to report improper payment estimates for such programs. The PIIA defines significant improper payments as those exceeding $100 million or those exceeding $10 million and more than 1.5 percent of program outlays. In FY 2016, we conducted improper payment risk assessments for the Health Insurance Exchange programs and concluded that the APTC program is susceptible to significant improper payments. Between FY 2017 and FY 2019, we developed and piloted activities for measuring improper payments of APTC, which led to developing the Exchange Improper Payment Measurement Program for Exchanges administered through the FFE. Through that initiative, HHS began annual reporting of improper payment estimates in the FY 2022 Annual Financial Report (AFR) for APTC administered through the FFE.[128] However, due to our lack of regulatory authority to collect the same information from State Exchanges, we could not do the same for APTC administered through State Exchanges.

As a result, we proposed in the 2023 Payment Notice proposed rule (87 FR 584) to establish the SEIPM program, which would have required State Exchanges to submit certain information to HHS so that HHS could report an improper payment estimate of APTC administered by State Exchanges. We proposed that it would begin in calendar year 2024, but a significant volume of public comments stating that State Exchanges would need additional time and guidance to prepare for SEIPM persuaded us not to finalize that proposal. Subsequently, in the 2024 Payment Notice (88 FR 25740), we finalized the Improper Payment Pre-Testing and Assessment Program (IPPTA). The purpose of that program is to: (1) prepare State Exchanges for the planned measurement of improper payments, (2) test processes and procedures that support HHS' review of determinations of APTC made by State Exchanges, and (3) provide a mechanism for HHS and State

[125] HHS has already implemented an Exchange Improper Payment Measurement (EIPM) process to review potential improper APTC payments in the Federally-facilitated Exchange.

[126] *State-based Marketplace Independent External Audit Technical Assistance. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/independent_external_audit_ta.pdf.*

[127] 31 U.S.C. 3352 (2020).

[128] CMS. Exchange Improper Payment Measurement (EIPM). Available at *https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/exchange-improper-payment-measurement-eipm.*

Exchanges to share information that will aid in developing an efficient measurement process. HHS is continuing IPPTA through the end of 2026.

IPPTA is currently underway and the first cohort of eight State Exchanges have completed all of the information submission requirements for ten or more sampled tax households. We have completed the review process for the first cohort of State Exchanges and have communicated the findings to those State Exchanges. For the ten States Exchanges in the second cohort, as of this time, data collection has been completed for four of the States Exchanges and the remaining six State Exchanges are in the process of preparing the review data. The information submission is expected to be completed by March of 2026. The main challenge associated with IPPTA, which would carry through to SEIPM, relates to the quantity of data that the State Exchange must submit in order for HHS to accurately determine whether each payment of APTC was proper or improper. For each tax household, there may be multiple QHP policies, and multiple enrollees who were determined eligible for APTC, all of which invoke specific requirements for determining eligibility. These factors cause considerable volume and complexity in the data that would be required for SEIPM.

Additionally, each State Exchange operates its own platform with a unique data architecture, making it challenging to develop a unified process by which State Exchanges could submit the requisite information. For the purposes of IPPTA, we developed a Data Request Form (DRF) to collect the information that proved to be an effective tool for six of the eight State Exchanges in the first cohort. For the other two State Exchanges, some of the data was collected manually and not through the DRF. HHS collected some of the data manually for those two State Exchanges because they were unable to successfully submit all of the data required for measurement in the DRF format and structure. As a lesson learned from that data collection process, we are proposing to allow a more flexible mechanism for data collection in SEIPM. For the second cohort of 10 State Exchanges, it is too early in the IPPTA cycle to determine if alternate means of collecting the data will be necessary. However, given our success with the first cohort, we expect to collect the data that is necessary for the completion of IPPTA.

To mitigate these challenges, we have automated the data validation process that allows us to assess each submitted DRF and to coordinate with the State Exchanges to correct data when inconsistencies are identified. For SEIPM, we would use the DRF while also allowing flexibility in data submissions where there are conflicts in structure between the DRF and the State Exchange data architecture. In these instances, we would allow data to be submitted in native formats, which would lessen the burden on State Exchanges.

We now propose to establish a new subpart Q at 45 CFR part 155 (containing §§ 155.1600 through 155.1650) to codify the SEIPM requirements. We propose to require State Exchanges to annually submit to HHS the information required for HHS to produce an estimate of improper payments in accordance with OMB Circular No. A–123 requirements.[129] We propose to measure all State Exchanges annually unless we specify otherwise and to report the calculated estimate of improper payments in the HHS AFR. State Exchanges already are required to conduct annual independent external programmatic audits, so we propose to minimize duplication of those audit requirements with the proposed SEIPM program, as described in proposed § 155.1200(e). We additionally propose that any State Exchange in its first year of operation would be required to participate in a 1-year SEIPM preparation phase prior to being required to satisfy the SEIPM requirements. The proposed regulations at subpart Q would be applicable beginning in January 2027.

This proposal would address a critical gap in improper payment oversight, as the PIIA requires Federal agencies to estimate and report on improper payments in programs determined to be susceptible to significant improper payments. While we have established an improper payment measurement for the FFE, (that is, the Federal Exchange Improper Payment Measure or FEIPM),[130] State Exchanges have operated without comparable systematic measurement of APTC improper payments. The FFE's improper payment measurement is overseen by the Payment Accuracy and Reporting Group (PARG), within the CMS Office of Financial Management (OFM), which has developed comprehensive methodologies and systems to ensure accurate measurement and reporting. By extending similar measurement methodologies to State Exchanges through SEIPM, HHS would ensure consistent oversight and accountability across all exchange types, promoting parity in program integrity efforts nationwide.

a. Purpose and Scope (§ 155.1600)

We propose to add a new subpart Q to 45 CFR part 155, which would establish State Exchange responsibilities.

We propose to add a new § 155.1600 that would convey the purpose and scope of the SEIPM. At § 155.1600(a), we propose the SEIPM would be an initiative through which HHS measures improper payments of APTC that are administered by State Exchanges, described in more detail in proposed § 155.1610. We propose to use the results of SEIPM to produce an estimate of improper payments of APTC aggregated across State Exchanges.

At § 155.1600(b), we propose that unless specified otherwise by HHS, all State Exchanges on an annual basis would be required to submit information that is necessary to support the SEIPM processes. The data and information we would require from State Exchanges would be essential for us to conduct accurate improper payment measurement, as it is not available through any other existing sources or systems. Unlike the FFE where we have direct access to enrollment and payment data, State Exchanges operate independent systems that contain eligibility determinations, enrollment records, and APTC calculation data necessary for HHS to make improper payment assessment under the SEIPM. Without State Exchanges submitting the proposed information, we would be unable to fulfill our statutory obligations under the PIIA to measure and report improper payments. The proposed annual submission requirement would ensure that we have access to the most current and complete data necessary to produce statistically valid improper payment estimates and identify areas for program improvement.

At § 155.1600(c), we propose that HHS would publish in its AFR an estimate of improper payments aggregated across all State Exchanges. Publication in the HHS AFR would ensure that APTC improper payment estimates are subject to the same transparency and accountability standards as other major HHS programs.

[129] OMB. (2021, March 5). Transmittal of Appendix C to OMB Circular A–123, Requirements for Payment Integrity Improvement. Available at *https://www.whitehouse.gov/wp-content/uploads/2021/03/M-21-19.pdf.*

[130] CMS. Exchange Improper Payment Measurement (EIPM). Available at *https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/exchange-improper-payment-measurement-eipm.*

b. Applicability Date (§ 155.1605)

In this section, we propose to add new § 155.1605, which would establish SEIPM's applicability date.

At proposed new § 155.1605(a), we propose that this subpart would be applicable beginning January 1, 2027, which we believe would provide State Exchanges with sufficient time to begin the SEIPM. For State Exchanges that have participated in IPPTA, the proposed January 1, 2027, applicability date would mean that those State Exchanges would submit the proposed required information and would be subject to improper payment measurement under the SEIPM beginning in 2027 for PY 2026, with the improper payment estimate being reported for the first time in 2028. This proposed timeline would allow State Exchanges to establish the operational infrastructure and baseline processes to support the SEIPM, such as conducting comprehensive system assessments to identify data collection and reporting capabilities; developing or modifying existing information systems to capture and transmit the required the SEIPM data elements; establishing internal policies and procedures for data validation and quality assurance; training staff on the SEIPM requirements and reporting protocols; and conducting testing and validation of new systems and processes before the effective date. Additionally, the foundational framework established through IPPTA would have provided State Exchanges with sufficient experience and understanding of their data capabilities and measurement processes to support the transition to SEIPM by January 1, 2027. Any technical adjustments, data collection refinements, or procedural clarifications identified during the IPPTA implementation could be incorporated into the SEIPM through sub-regulatory guidance, allowing for improvements without requiring additional rulemaking or timeline extensions. State Exchanges in the first year of operation would undergo the preparation phase proposed in § 155.1640 and would begin the Measurement Year in 2028 for PY 2027.

c. Definitions (§ 155.1610)

We propose to add § 155.1610 to codify the following definitions that would be used in this subpart that are specific to SEIPM and key to understanding its processes and procedures:

- *Annual Program Schedule* would mean the document issued by HHS to each State Exchange that would prescribe the dates for which key SEIPM milestones must be met.
- *Administrative Appeal* would mean the process by which a State Exchange may request HHS to review and reconsider a Difference Resolution Decision. The appeal would be the second and final level for a State Exchange to contest findings of error or improper payment as it relates to APTC.
- *Administrative Appeal Decision* would mean the HHS final appeal decision resulting from a State Exchange's request for an appeal of one or more error or improper payment findings that are documented in a Sampled Unit Assessment Package.
- *Corrective Action Plan* (*CAP*) would mean the plan a State Exchange develops to correct errors resulting in improper payments identified through SEIPM.
- *Difference Resolution* would mean the process by which a State Exchange may initially request HHS to reconsider one or more error or improper payment findings documented in a Sampled Unit Assessment Package. The Difference Resolution would be the first level of review.
- *Difference Resolution Decision* would mean the HHS decision resulting from a State Exchange's request for a Difference Resolution of one or more findings that are documented in a Sampled Unit Assessment Package.
- *Error* would mean a finding by HHS that a State Exchange did not correctly apply a requirement of subparts D and E of this part related to: (1) eligibility for, and enrollment in, a QHP; (2) eligibility for APTC, and calculated amount of APTC; (3) redeterminations of eligibility during a plan year; (4) eligibility redeterminations for the purposes of re-enrollment.
- *Measurement Year* would mean the calendar year in which the processes described in § 155.1625 would be initiated. The Measurement Year immediately follows the plan year and would be the second year of the SEIPM Cycle.
- *Reporting Year* would mean the calendar year in which HHS would report the improper payment rate for State Exchanges as required under § 155.1625(c), following completion of the measurement processes for the applicable plan year. The Reporting Year would immediately follow the Measurement Year and would be the last year of the SEIPM Cycle.
- *Sampled Unit Assessment Package* would mean the collection of findings and supporting documentation that HHS would prepare in order to record errors at the tax household level using the process described § 155.1625.
- *State Exchange Improper Payment Measurement* or *SEIPM* would mean the process by which HHS would estimate improper payments of APTC that are administered by State Exchanges as required under the PIIA, which would include a review of a State Exchange's determinations regarding (1) eligibility for and enrollment in a QHP; (2) eligibility for APTC, and calculated amount of APTC; (3) redeterminations of eligibility determinations during a plan year; (4) eligibility redeterminations for purposes of re-enrollment.
- *SEIPM Cycle* would mean the 3-year period consisting of the plan year, Measurement Year, and Reporting Year during which the complete APTC-related improper payment measurement and reporting processes would occur.
- *Tax household* would mean the applicant, the applicant's spouse if the applicant is married and files a joint return, and all individuals who are dependents of the applicant or spouse as defined in 26 U.S.C. 152.

d. Information Submission (§ 155.1615)

We propose to add § 155.1615 to specify what information State Exchanges would be required to submit under the SEIPM program. The collection of such information would be necessary to allow HHS to produce a statistically valid estimate of improper payments of APTC. The general framework of this proposed provision would be that the information submission would consist of three parts: (1) the program documentation that would be used to inform the review criteria; (2) the universe, which would be a summary listing of the tax households that received APTC payments for the respective plan year, from which HHS would select a random sample; (3) tax household data which would be the detailed level of data for each sampled tax household necessary for making a determination as to whether each APTC payment was proper or improper.

At § 155.1615(a), we propose that HHS would issue an Annual Program Schedule to all State Exchanges no later than January 5th of the Measurement Year. We propose that the Annual Program Schedule would specify the dates for which all the proposed information required under this section would be due to HHS. This timeline would ensure that State Exchanges receive clear guidance and sufficient advance notice of their submission requirements at the beginning of each Measurement Year, enabling State Exchanges to plan and allocate appropriate resources for compliance

with the program's data collection and documentation requirements.

At § 155.1615(b), we propose that, on an annual basis, each State Exchange would be required to submit or make available to HHS the information specified in paragraphs (b)(1) through (b)(3).

At § 155.1615(b)(1), we propose that each State Exchange would be required to submit or make available to HHS program documentation that would consist of policy, operational, and technical documentation concerning business rules and APTC calculations that pertain to enrollment and eligibility processes of the State Exchange, as well as information that describes the data system architecture of the State Exchange such as entity relationship diagrams and data dictionaries. Additional parameters for the information described would be communicated in sub-regulatory guidance. The program documentation would be essential for establishing the improper payment measurement framework for each State Exchange because it would enable us to assess whether the State Exchange's policies and procedures align with Federal requirements and would be used to develop State-specific review criteria that reflect each State Exchange's unique operational framework.

We propose at § 155.1615(b)(2) that a State Exchange would be required to submit or make available to HHS the universe of data from which HHS would draw the sample. That universe would, for the plan year being reviewed, consist of a listing of the population of tax households that have associated QHP enrollments and payments of APTC. We propose that for each tax household within the universe, the State Exchange would be required to submit or make available to HHS the following information: (1) Exchange assigned policy identifier; (2) tax household grouping identifier; (3) SSN inconsistency indicator; (4) citizenship inconsistency indicator; (5) lawful presence inconsistency indicator; (6) annual income inconsistency indicator; (7) non-employer sponsored minimum essential coverage inconsistency indicator; (8) employer sponsored minimum essential coverage inconsistency indicator; (9) incarceration inconsistency indicator; (10) residency inconsistency indicator; (11) number of tax household members; and (12) APTC amount paid over the duration of the plan year. The inconsistency indicators would be a data value for each tax household identifying the presence or number of data match inconsistencies of the specified type. As an example, for the first tax household in the universe, if the data within the State Exchange established that the consumer's attested citizenship status did not match the source of record to which the Exchange is required to verify citizenship status, the citizenship inconsistency indicator would be populated to show that an inconsistency existed for that tax household.

Statistical validity requires that the sample be drawn from a comprehensive and accurately defined population to ensure that the resulting estimates are representative of the entire APTC program within each State Exchange. This provision would be necessary because without access to the complete universe of tax households having QHP enrollments and APTC payments, we would be unable to establish sampling strata or to calculate the sampling weights that would inform the aggregate improper payment rate. Additionally, information about eligibility verification inconsistencies within the universe would allow for risk-based stratification, ensuring that tax households with recorded inconsistencies would appropriately be represented in the sample to improve the precision and accuracy of error rate calculations. For instance, the improper payment risk may be higher in tax households with recorded inconsistencies because it would trigger additional required enrollment and eligibility verification processes that State Exchanges would need to conduct manually, leaving them susceptible to human error.

The total APTC payment amounts for each tax household in the universe would be necessary to calculate proper monetary weights for the improper payment estimates, ensuring that the financial impact of errors would be accurately reflected in the final statistics. This comprehensive approach would enable HHS to produce improper payment estimates meeting the requirements of PIIA.

At § 155.1615(b)(3), we propose that a State Exchange would be required to submit or make available to HHS tax household data for each sampled tax household. The tax household data would consist of the comprehensive information that is necessary for HHS to use in conducting the processes described at § 155.1625.

At § 155.1615(b)(3)(i), we propose that State Exchanges would be required to submit or make available to HHS, for each sampled tax household, information pertaining to the calculation of the APTC benefits paid, including monthly enrollment premium amounts, monthly APTC payment amounts, monthly Second Lowest Cost Silver Plan Premium amounts, and the amount of each monthly premium that is attributable to EHB. This information would be essential for us to verify the accuracy of APTC calculations and ensure that APTC were computed correctly based on the applicable benchmark plan and EHB requirements. We propose at § 155.1615(b)(3)(ii) that State Exchanges would be required to submit or make available to HHS enrollment information that would include information relevant to dates and amounts of effectuation payments, premium payment amounts, and policy start and end dates. This enrollment data would enable HHS to confirm that APTC payments were made for valid coverage periods and that the timing and amounts of payments align with policy effectuation and premium payment requirements. We further propose, at § 155.1615(b)(3)(iii), that State Exchanges would be required to submit or make available to HHS information relevant to the determination of eligibility for a SEP, where applicable, which would include information collected by the State Exchange about consumer attestations and representations regarding SEP eligibility criteria, copies of documentary evidence submitted by applicants, electronic verification information, and timing information. This SEP-related information would allow HHS to assess whether APTC payments were appropriately authorized during SEPs and whether proper verification procedures were followed to confirm SEP eligibility.

At § 155.1615(b)(3)(iv), we propose that State Exchanges would be required to submit or make available to HHS information about the timing of QHP certification or approval, the coverage area of the associated QHP, and the timing of any QHP decertification or suppression. This QHP certification information would be necessary to verify that APTC payments were made only for QHPs that were properly certified and available in the consumer's coverage area during the relevant time periods.

At § 155.1615(b)(3)(v), we propose that, to the extent applicable, for each person who is included in the APTC payment calculation, the State Exchange would submit or make available to HHS: (A) information collected by the State Exchange about consumer attestations regarding QHP and APTC eligibility factors and demographic information relevant to initial QHP enrollment and eligibility; (B) APTC eligibility and payment determinations, including evidence of required data verifications,

and which could also include the electronic source consulted, the timing of required verifications, and the results of the verification; (C) information relevant to QHP and APTC manual eligibility verifications and the resolution of electronic verification inconsistencies, which could include copies of documentary evidence submitted by QHP enrollees, the timing of submissions, the timing of adjudication, and information about good faith extensions; and (D) information relevant to QHP and APTC eligibility redeterminations, such as information about automatic annual redeterminations, the timing and results of periodic examinations of data sources, and policy or application changes initiated by the consumer and resultant electronic or manual eligibility verifications. This comprehensive individual-level information would enable HHS to reconstruct and validate the complete eligibility determination process for each household member, ensuring that APTC payments were based on accurate demographic information and proper verification procedures, and were made through appropriate eligibility determinations and redeterminations.

These data elements have been proven effective through their use in the FFE improper payment measurement program, where they have enabled reliable assessment of APTC payment accuracy and identification of root causes of improper payments, and demonstrated they provide the necessary information to conduct comprehensive improper payment reviews. Additionally, through IPPTA, we have completed the collection of this data for the first cohort of eight State Exchanges for 10 or more sampled tax households. In making the transition from IPPTA to SEIPM, we believe that each State Exchange would be able to use the automation developed during IPPTA to scale the process for submitting data for a larger number of samples. We seek comments on whether there are additional data elements that would be required under this section to support accurate improper payment measurement, or whether any of the proposed data categories would present operational challenges for State Exchanges. We also solicit comments on alternative data submission mechanisms that could streamline the process while maintaining data security and integrity, including comments on the feasibility of automated data transmission methods, preferred file formats, or technical specifications that would facilitate efficient data exchange between State Exchanges and HHS.

At § 155.1615(b)(3)(vi), we propose that the State Exchange would submit or make available to HHS any consumer submitted documents that were used to establish new or continued eligibility for enrollment in a QHP and APTC.

e. Sampling Procedures (§ 155.1620)

We propose to add § 155.1620 to address the sampling procedures. At § 155.1620(a), we propose that at the beginning of each calendar year, HHS would calculate a sample size in aggregate across all State Exchanges. The sampling methodology would be designed to achieve two complementary objectives: produce a highly precise aggregate estimate for all State Exchanges and generate individual State Exchange estimates for program management purposes. While some individual State Exchange estimates might have wider confidence intervals than others due to smaller sample sizes, they would meet minimum statistical validity thresholds and provide valuable insights for State-specific program improvements and oversight activities.

We propose that we would aggregate the estimated dollar amounts of improper payments from each State Exchange to calculate a total estimated amount of improper payments for all participating State Exchanges. This aggregation process would mathematically combine the individual State Exchange improper payment estimates to produce a comprehensive national estimate. The aggregated estimate would be weighted by State Exchange size, such that a State with $5 billion in APTC would be weighted more heavily in the aggregate State Exchange improper payment rate than a State with $1 billion in APTC. This weighting approach would ensure that the aggregate State Exchange improper payment rate would accurately reflect the relative financial impact of each State Exchange's improper payment performance on the overall APTC program.

This dual-purpose sampling approach would balance statistical rigor with practical program management needs, ensuring that HHS could meet Federal reporting requirements for precise program level estimates while providing State Exchanges with actionable data for program improvement efforts. The methodology would recognize that perfect precision at the individual State Exchange level would require prohibitively large sample sizes, while the primary statutory requirement is for accurate improper payment measurement and reporting at a program level.

At § 155.1620(a)(1), we propose that the sample size would be calculated to estimate an improper payment rate. That rate would be estimated across all Exchanges using Generally Accepted Accounting Principles (GAAP).

At § 155.1620(a)(2), we propose to develop sample sizes specific to each State Exchange, which would take into consideration several factors in determining each State Exchange's sample size for the current SEIPM cycle. The first factor, at § 155.1620(a)(2)(i), would be overall APTC expenditures associated with the State Exchange; higher APTC expenditures would generally warrant larger sample sizes as they would represent greater financial risk to the Federal Government and have more significant impact on aggregate national improper payment estimates. The relative amount of a State Exchange's APTC payments amplifies the importance of accurate measurement. For example, if a single State Exchange accounts for 20 percent of overall APTC payments made across all State Exchanges, any improper payments within that State would have a proportionally larger impact on the aggregate national improper payment rate. The large share of total APTC payments would necessitate a larger sample size to meet the statistical precision goals and also would not introduce excessive uncertainty into the national aggregate estimate.

At § 155.1620(a)(2)(ii), we propose to take into consideration a second factor, State-level precision goals for current SEIPM cycle. Precision goals would establish the acceptable margin of error for improper payment rate estimates at the State level. We propose that we would set precision targets that balance statistical reliability with operational feasibility, taking into account factors such as State-specific APTC volumes, available resources, and the need for meaningful measurement. We propose that precision goals could vary by State based on Exchange size, with larger Exchanges held to tighter precision standards due to their greater impact on aggregate national estimates. These precision goals would ensure that State-specific improper payment rates would be statistically meaningful and could support targeted corrective actions while balancing measurement accuracy with resource constraints.

At § 155.1620(a)(2)(iii), we propose to consider a third factor, the improper payment rate from the State Exchange's previous SEIPM cycle. State Exchanges that are measured as having higher improper payment rates could require

larger sample sizes to achieve the same level of statistical precision and confidence as State Exchanges that are measured as having lower improper payment rates. Additionally, State Exchanges that demonstrate high variability in their previous cycle measurements could need increased sampling to establish more reliable baseline estimates. Conversely, State Exchanges with consistently low and stable improper payment rates could support smaller sample sizes to maintain adequate precision and confidence, which would allow for efficient resource allocation across the SEIPM program.

At § 155.1620(a)(3), we propose that we would establish minimum and maximum sample sizes to ensure statistical validity while maintaining operational feasibility across State Exchanges of varying sizes. While the sampling methodology design would produce statistically valid improper payment estimates at both the aggregate State Exchange level and individual State Exchange levels, we recognize that the precision of improper payment estimates at the State Exchange level would vary based on State Exchange size and corresponding sample sizes. State Exchanges with smaller APTC populations may have smaller sample sizes resulting in wider confidence intervals and higher margins of error for their individual estimates. Despite these precision limitations, individual State Exchange estimates would meet minimum statistical validity thresholds and would provide meaningful data for program oversight and improvement purposes. SEIPM's primary focus would remain producing a precise and reliable estimate for all State Exchanges, where individual State Exchange results would provide State-specific insights within the constraints of their respective sample sizes.

At § 155.1620(b), we outline proposed sample selection procedures. We propose that, on an annual basis, HHS would select random samples of tax households from the data provided by each State Exchange as described in § 155.1615(b)(2). We propose to use the tax household as the sampling unit because a tax household encompasses all individuals whose income and circumstances are considered together for APTC purposes, which would make it the most appropriate and meaningful unit for measuring payment accuracy.

At § 155.1620(c), we outline proposed State Exchange coordination and notification procedures that would be necessary to support SEIPM. We propose at § 155.1620(c)(1) that, following receipt of the universe data from State Exchanges as described in § 155.1615(b)(2), HHS would notify each State Exchange of the specific records selected for review. Such notification would include: (i) the total number of sampled tax households selected for the State Exchange; (ii) a unique identifier for each sampled tax household; and (iii) any specific instructions or requirements needed to facilitate HHS' review of the sampled records. This information would be intended to give State Exchanges the information necessary to provide the documentation required. This process would help ensure that State Exchanges have clear notification of the specific tax households that have been sampled. This would also help foster efficiencies and accurate submission of the tax household data required under § 155.1615(a)(3).

We would protect all data exchanged during the SEIPM process in accordance with the Federal Information Security Modernization Act of 2014 (FISMA), which mandates comprehensive security controls for Federal information systems, and the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules (45 CFR parts 160 and 164), which require administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and availability of all electronically protected health information. Additionally, all data transmissions would utilize encryption protocols compliant with National Institute of Standards and Technology (NIST) Special Publication 800–53 security controls and our Acceptable Risk Safeguards (ARS) framework, with access restricted to authorized personnel only through role-based access controls and continuous monitoring as required under the Federal Information Security Management Act.

At § 155.1620(c)(2), we propose that HHS would provide the sampled records notification described in paragraph (c)(1) of this section no later than 60 calendar days after receipt of the universe data from all State Exchanges. This 60-day timeframe would ensure that HHS would have sufficient time to complete the sampling process across all participating State Exchanges. The proposed timeline would account for the complexity of coordinating sampling activities across multiple State Exchanges with varying data submission schedules and allow for quality assurance review of the sampling methodology before notification. This approach would balance the need for thorough sampling coordination with the operational requirements for timely completion of improper payment measurement processes.

At § 155.1620(c)(3), we propose to establish procedures for extending the sampling notification timeline when unforeseen circumstances would warrant additional time for HHS to complete the sampling process. We propose at § 155.1620(c)(3)(i) that HHS could extend the 60-day timeline specified in paragraph (c)(2) of this section under three specific circumstances: when technical issues would prevent completion of the sampling process within the standard timeframe; when data quality issues would require additional coordination with State Exchanges before sampling can be completed; or when other circumstances beyond HHS' control would necessitate additional time to ensure accurate sampling methodology.

We propose at § 155.1620(c)(3)(ii) to establish notification and transparency requirements when HHS would determine an extension would be necessary. Under paragraph (c)(3)(ii), HHS would: (A) notify all affected State Exchanges in writing of the extension and the revised notification date; (B) provide the reason for the extension; and (C) confirm the impact, if any, on subsequent SEIPM cycle timelines. This provision would reflect that unforeseen technical or operational challenges potentially could arise when coordinating complex sampling across multiple State Exchanges. Where not properly addressed, such challenges could compromise the sampling methodology accuracy or completeness, so this provision would balance the need for timely program milestone progress with the requirement for statistically sound sampling procedures. By limiting extensions to specific, defined circumstances and requiring transparent communication with State Exchanges, this approach would maintain accountability while providing necessary operational flexibility to ensure the integrity of the SEIPM measurement process.

The notification requirements proposed at § 155.1620(c)(3)(ii)(A) through (C) would also ensure that State Exchanges would remain informed of any timeline adjustments and could plan for the case documentation preparation activities. This transparency would support the collaborative nature of the SEIPM program while maintaining predictable timelines for all participating parties.

f. Determining Payment Errors (§ 155.1625)

Proposed new § 155.1625 outlines the process by which HHS would determine payment errors. At § 155.1625(a), we propose procedures for HHS' review of records obtained through SEIPM and identification of payment errors from such records. We propose at § 155.1625(a)(1) that HHS would, for each sampled record, conduct a comprehensive review using standardized review criteria designed by HHS. This approach would ensure consistency in methodology across all participating State Exchanges while accommodating necessary variations in review procedures where State Exchanges have effectuated State-specific operational approaches. We would design the criteria to minimize reviewer variability while maintaining the flexibility needed to address State-specific operational differences for which Federal regulations allow. The review criteria would be established using the requirements described in this part in conjunction with the program documentation that would be submitted by each State Exchange. We would make available a general overview of the review methodology on the CMS website.

At § 155.1625(a)(2), we propose to conduct reviews using the tax household information provided under § 155.1615(b)(3), including any relevant consumer-submitted documents that would be gathered by the State Exchange as part of the enrollment process and provided to HHS. This approach would ensure that HHS reviews would be based on the same information that was available to State Exchanges at the time of their original APTC-related determinations.

At § 155.1625(a)(3), we propose that the review would identify whether the State Exchange made any errors related to the following resulting in improper payment of APTC: (i) enrolling or re-enrolling a consumer into a QHP for which APTC was paid; (ii) consumer eligibility for APTC being paid on their behalf; (iii) calculating the APTC amount that was paid on the consumer's behalf; (iv) taking required actions upon changes to a consumer's application that would affect APTC-related eligibility or payment amount. This approach would ensure that HHS could identify and measure all types of improper payments related to APTC, providing a complete assessment of payment accuracy meeting Federal improper payment measurement requirements under the PIIA while supporting program integrity objectives.

At § 155.1625(a)(4), we propose to apply consistent review standards based on the APTC-related determination requirements established in 45 CFR part 155, subparts D and E, and other applicable provisions of part 155. By anchoring review standards in existing regulations, we would ensure that the State Exchange's performance would be evaluated against the same statutory and regulatory framework that governs their APTC-related determinations. This regulatory framework would ensure that any identified errors would be based on clear violations of established requirements rather than subjective interpretations of the program's goals.

We propose at § 155.1625(b) how HHS would evaluate each error to determine an improper payment amount. At § 155.1625(b), we propose that, for each error identified, we would: (1) calculate the correct APTC amount, based on the requirements of section 36B of the Internal Revenue Code and the applicable implementing regulations; (2) determine an improper APTC payment amount, which is the difference between the amount paid and the correct amount; (3) document the error within a Sampled Unit Assessment Package and provide the Sampled Unit Assessment Package to the State Exchange; (4) extrapolate the identified improper payments from the sample to estimate the total improper payment amount for the State Exchange's entire universe of APTC payments, using statistically valid methodologies that comply with OMB Circular No. A–123 guidance on improper payment estimation.

At § 155.1625(c), we propose how HHS would report improper payment rates. We propose at § 155.1625(c) that HHS would make available to the public in the AFR: (1) an aggregate improper payment rate estimated across the FFE and all State Exchanges; and (2) an aggregate improper payment rate estimated across all State Exchanges, pursuant to 31 U.S.C. 3352(c)(1)(B); and also that HHS would provide to each State Exchange a report that would document the State-specific improper payment rate and error analysis. This reporting approach would ensure PIIA compliance while providing State Exchanges with actionable data to improve their program operations and reduce future improper payments. The State-specific reports would facilitate corrective action planning, while the aggregate public reporting would support congressional oversight and public accountability for the overall integrity of the APTC program.

g. Difference Resolution and Administrative Appeal Process (§ 155.1630)

In new § 155.1630, we propose procedures for Difference Resolution and administrative appeals of SEIPM findings. This section proposes a process that would allow State Exchanges to challenge HHS determinations regarding error findings and associated determinations of improper payments. This comprehensive dispute resolution framework would ensure that State Exchanges receive fair consideration of their challenges to SEIPM findings while maintaining the integrity and efficiency of the improper payment measurement process. The proposed procedures would provide State Exchanges with meaningful opportunities to present evidence and legal arguments, while also supporting HHS' statutory obligations to produce timely and accurate improper payment estimates under PIIA. Additionally, the structured approach would promote consistency in how disputes would be handled across all State Exchanges, while reducing administrative burden and ensuring that legitimate concerns about error classifications or methodological applications would receive appropriate review and consideration.

At § 155.1630(a), we propose the Difference Resolution process. We propose at § 155.1630(a)(1) that the State Exchange could make a written Difference Resolution request to HHS in accordance with proposed § 155.1630(c) to dispute HHS' error and improper payment findings within 30 calendar days after the issuance of a Sampled Unit Assessment Package. The proposed 30-day timeframe for State Exchanges to submit written Difference Resolution requests would balance the need to give State Exchanges sufficient time to review the Sampled Unit Assessment Package with the need for administrative efficiency and timely resolution of the SEIPM process.

At § 155.1630(a)(2), we propose procedures for HHS' review of Difference Resolution requests. We propose that upon receipt of a Difference Resolution request, HHS would: (i) engage with the State Exchange in a collaborative process to examine the disputed findings and any additional documentation provided by the State Exchange, (ii) evaluate the disputed findings by applying the same protocol used in the original review while considering whether the State Exchange's position was supported by the existing or newly provided

evidence, and (iii) prepare the Difference Resolution Decision. This collaborative approach would ensure that State Exchanges would have a meaningful opportunity to present their perspective and provide additional context that may not have been available during the initial assessment, while maintaining consistency in evaluation standards. The process would balance the need for thorough consideration of State Exchange concerns with administrative efficiency, promoting fair resolution of disputes while preserving the integrity of the SEIPM measurement methodology.

We propose at § 155.1630(a)(3) that HHS would communicate the Difference Resolution Decision to a State Exchange within 90 calendar days of receiving the written request for a Difference Resolution. The Difference Resolution Decision would include a summary of the analysis and rationale that informed the decision. This timeline would balance the need for thorough review of a State Exchange's dispute with administrative efficiency requirements, and allow sufficient time for comprehensive analysis while ensuring timely resolution.

Proposed § 155.1630(b) would establish an internal agency administrative appeal process for HHS' Difference Resolution Decision. At § 155.1630(b)(1), we propose that, for a finding that the State Exchange and HHS could not resolve through Difference Resolution, the State Exchange could make a written request for an administrative appeal to HHS in accordance with proposed § 155.1630(c) within 15 business days after the issuance of the Difference Resolution Decision. We believe the 15 business day timeline for filing an administrative appeal would strike an appropriate balance between providing State Exchanges adequate time to prepare comprehensive administrative appeals while ensuring prompt resolution of disputes and maintaining administrative efficiency. This shorter appeal period, compared to the initial 30-day timeline to request Difference Resolution, would reflect that the basis of the administrative appeal would have been established and well-described during the Difference Resolution phase, and that the State would not be able to submit new evidence or documentation that had not already been submitted during the Difference Resolution process, although it could provide additional context to clarify evidence that had been submitted. As a result, we expect that fifteen business days would provide State Exchanges with sufficient opportunity to review the Difference Resolution Decision and prepare a focused administrative appeal that would build upon the previously established record. Furthermore, the administrative appeal timeframe would help ensure that the overall SEIPM cycle would remain on schedule, preventing delays that could affect HHS' ability to meet Federal improper payment reporting deadlines and provide timely program oversight.

At § 155.1630(b)(2), we propose that upon receipt of an administrative appeal request, HHS would (i) assign the administrative appeal request to one or more qualified reviewers who were not part of the State Exchange team; (ii) conduct a comprehensive review of the disputed findings using the administrative record established during the Difference Resolution process; (iii) evaluate the disputed findings by applying the same protocol used in the original review while considering whether the State Exchange's position is supported by the evidence; and (iv) prepare the administrative appeal decision for the completed review based on a preponderance of the evidence. At § 155.1630(b)(3), we propose that HHS would issue the administrative appeal decision within 90 calendar days of receipt of the written request for administrative appeal. The administrative appeal decision would include a summary of the analysis and rationale that informed the decision.

HHS would utilize internal staff to conduct administrative appeal adjudications under this provision. The agency would assign qualified internal reviewers who possess appropriate expertise in Federal eligibility and payment requirements and who had not been involved in the original review to ensure objectivity in the administrative appeals process. These reviewers would independently review the appeal, without consultation with the individuals who had executed the dispute resolution. This approach would maintain program consistency while providing State Exchanges with an independent review of disputed findings. The internal agency administrative appeal process described in this section would be an administrative review conducted by agency staff, not a judicial proceeding or formal adjudication requiring an Administrative Law Judge.

The 90-day timeline would provide sufficient opportunity for thorough analysis of complex eligibility and payment determinations while ensuring timely resolution that would support the overall SEIPM cycle schedule. The requirement to include analysis and rationale in the administrative appeal decision would promote transparency and enable State Exchanges to understand the basis for final determinations, supporting both accountability and potential future process improvements.

We propose at § 155.1630(c) that all Difference Resolution and appeal requests would be required to contain the following: (1) a clear statement of the specific finding(s) being challenged; (2) all factual and legal bases for filing the request; and (3) evidence directly related to the finding(s), which could include: (i) clarifying information regarding data interpretation; or (ii) legal citations supporting the State Exchange's position. These submission requirements would ensure that HHS would receive sufficient information to conduct meaningful review of disputed findings while enabling State Exchanges to present their strongest arguments and supporting evidence in a structured format that would promote efficient dispute resolution.

We propose at § 155.1630(d) the treatment of pending Difference Resolution Requests and appeal requests. At § 155.1630(d)(1), for Difference Resolution Requests or administrative appeals resolved in favor of the State Exchange during the current SEIPM cycle, we propose that: (i) HHS would adjust the affected improper payment rate calculations for the SEIPM cycle; and (ii) updated aggregate rates would be reflected in current cycle reporting. This approach would ensure that corrections identified through the Difference Resolution or appeals process would be incorporated into the current measurement cycle's results, providing the most accurate and complete improper payment estimates for public reporting and program management purposes. By adjusting calculations and updating aggregate rates, HHS could maintain the integrity and reliability of SEIPM findings while ensuring that legitimate State Exchange concerns would be reflected in the final reported statistics for the applicable measurement period.

We propose at § 155.1630(d)(2) provisions for Difference Resolution Requests or administrative appeals resolved in favor of the State Exchange after completion of the SEIPM cycle. At § 155.1630(d)(2), we propose that, should the decision result in material changes to aggregate rates, HHS would publish amended aggregated improper payment rates in subsequent AFRs or other appropriate public reporting mechanisms as well as notifying affected State Exchanges of any amendments to previously published rates. Should a decision not result in

material changes to aggregate rates, no action would be taken. This framework would ensure that significant corrections identified through post-cycle Difference Resolution Requests or administrative appeals would be incorporated into the public record through amended reporting, maintaining the accuracy and integrity of published improper payment data while avoiding unnecessary administrative burden for minor adjustments that would not materially affect aggregate statistics. The notification requirement for affected State Exchanges would promote transparency and enable States to understand how successful challenges would impact previously published rates, support ongoing program improvement efforts, and maintain the integrity of the SEIPM measurement process.

At § 155.1630(e), we propose that for good cause HHS could extend the timelines for accepting a Difference Resolution request or administrative appeal request or for issuing a Difference Resolution Decision or Administrative Appeal Decision. Good cause would be established for situations including but not limited to: (1) the need for additional technical analysis or consultation with subject matter experts to resolve complex eligibility determination issues; (2) delays in receiving necessary supplemental information or clarification from the State Exchange; (3) the volume or complexity of the dispute requiring additional time to ensure a thorough and accurate decision; or (4) unforeseen circumstances, including system failures, staffing constraints, or other administrative challenges that could materially impact HHS' ability to complete the review. HHS's failure to timely issue a Difference Resolution or Administrative Appeal decision would not indicate an acceptance of the State Exchange's position and would not be a basis to decide in favor of the State Exchange.

h. Corrective Action Plan (CAP) (§ 155.1635)

We are proposing to add § 155.1635 to, at our discretion, require a State Exchange to develop and submit a CAP to correct errors identified through the SEIPM process. Our goal would be to establish a set of minimum requirements, using the standards provided at Appendix C to OMB Circular No. A–123, to support State Exchanges in developing, implementing, and monitoring a CAP. Should this provision be finalized as proposed, we would issue future sub-regulatory guidance to further detail CAP requirements and processes, and finalize an approved SEIPM CAP Paperwork Reduction Act (PRA) package following future notice-and-comment rulemaking. Should these provisions be finalized as proposed, the first improper payment report would be published in the Fall 2028 AFR and we would anticipate the first SEIPM CAP(s) would be due in early 2029.

At § 155.1635(a), we propose that HHS could, at its discretion, require a State Exchange to develop and submit a CAP to correct errors identified through the SEIPM process. We would not anticipate that SEIPM CAP standards and requirements would markedly differ from the standards employed by other improper payment measurement programs, such as the Medicaid and CHIP Payment Error Rate Measurement program.

At § 155.1635(b), we propose that a State Exchange's CAP would need to address errors that would be included in the State Exchange improper payment report described in § 155.1625(c)(2). At § 155.1635(b)(1), we propose that, in developing a CAP, a State Exchange would be required to conduct an error analysis, which could include reviewing causes, characteristics, and frequency of errors that are associated with improper payments. We propose that a State Exchange would be required to review the findings of the analysis to determine specific programmatic causes to which errors would be attributed, if any, and to identify root improper payment causes. Further, at § 155.1635(b)(2), we propose that the State Exchange would be required to determine the corrective actions that would be implemented to address improper payment root causes and prevent recurrence. Finally, at § 155.1635(b)(3), we propose that the CAP would be required to incorporate measurable milestones, accountability mechanisms, regular monitoring and validation of progress, documentation of implemented corrective actions, and regular status updates. We propose that the CAP would be required to include all of the following items for each identified error: (1) the specific corrective action; (2) status of the corrective action; (3) scheduled or actual implementation date of the corrective action; (4) key personnel that would be responsible for implementing each corrective action; and (5) a plan for monitoring the effectiveness of the corrective action.

At § 155.1635(c), we propose that a State Exchange would be required to develop a CAP implementation schedule, implement the CAP in accordance with that schedule, and regularly evaluate whether the initiatives were effective at reducing or eliminating error causes. It would be critical that a State Exchange maintain regular communication with HHS regarding any evaluation findings, particularly to ensure that the State Exchange would determine specific programmatic causes to which errors would be attributed. Therefore, we propose that a State Exchange would be required to provide updates on CAP implementation progress in a manner and frequency specified by HHS, but at least annually.

At § 155.1635(d), we propose that if a State Exchange would: (1) fail to submit a CAP when one had been required; (2) submit an incomplete CAP that would fail to address all parts of a CAP as specified at 155.1635(b)(3); (3) fail to implement a CAP; or (4) submit a CAP otherwise found unacceptable by HHS following technical assistance provided by HHS, that HHS could determine that a State Exchange had failed to substantially comply with SEIPM requirements and could take actions outlined in § 155.1650 to ensure program integrity and effectiveness.

i. SEIPM Preparation Phase (§ 155.1640)

We propose new § 155.1640 to create a SEIPM preparation phase. At § 155.1640(a), we propose that any State Exchange in its first year of operation would be required to participate in a 1-year SEIPM preparation phase prior to participating in SEIPM. The proposed preparation phase would be designed to familiarize State Exchanges with the SEIPM processes and requirements. At the beginning of the following year, or, in other words, the second year of operation for the State Exchange, we propose that the State Exchange would undergo SEIPM to measure improper payments for the preceding plan year, its first year of operation. This implementation timeline would ensure that newly operating State Exchanges would have the opportunity to participate in the preparation phase before undergoing full SEIPM measurement, thereby preparing the State Exchange for the SEIPM measurement. In essence, HHS would ensure that a State Exchange would test processes and procedures to prepare for SEIPM.

We propose at § 155.1640(b) that, to satisfy the requirements of the SEIPM preparation phase, a State Exchange would be required to: (1) complete the information submission requirements in § 155.1615(b)(1) and (3) using information from the most current plan year for a sample size not to exceed 10

unique tax households that address scenarios specified by HHS; (2) undergo the review procedures in 155.1625(a) and (b); and (3) participate in HHS' technical assistance activities, which could include: (i) training on SEIPM requirements and procedures, (ii) system readiness assessments, (iii) data quality validation exercises, and (iv) process improvement recommendations. Such a preparation phase approach would promote administrative efficiency by ensuring State Exchanges would have adequate time and resources to develop robust improper payment measurement capabilities before full implementation. Without such a preparation period, State Exchanges could struggle to produce the data that would be necessary for determining accurate measurements.

At § 155.1640(c), we propose that, at the beginning of each calendar year, HHS would provide any State Exchange that would be subject to this section with a schedule that would span a 12-month period and that would specify when the requirements of this section would have to be completed.

j. Minimizing Potential Duplicate Audit Requirements (§ 155.1645)

We propose to add new § 155.1645 to permit HHS, to the extent possible, to minimize duplication between the requirements of the SEIPM program described in subpart Q and the annual independent external programmatic audit requirements and standards under § 155.1200(c) and (d). Under § 155.1200(c) and (d), each State Exchange is required to engage or contract with an independent qualified auditing entity to perform an annual independent external programmatic audit to review compliance with 45 CFR part 155 subparts D (eligibility) and E (enrollment), and other requirements under part 155, as specified by HHS, and to provide the audit results to HHS.

Among other things, this external auditing process allows HHS to oversee compliance with eligibility and enrollment standards to ensure that State Exchanges are conducting accurate eligibility determinations and enrollment transactions, including requirements across multiple State Exchange operational areas that exceed the scope of review under the SEIPM program because they do not involve payments of APTC. Section 155.1200(d) further requires that a State Exchange complete an audit to ensure appropriate financial and operational safeguards are in place to avoid making inaccurate eligibility determinations and enrollment transactions, which would include those related to administering APTC and CSRs.

We note that §§ 155.1200 and 155.1210 were not intended to serve as the type of measurement program contemplated by the PIIA. Program integrity audits completed under § 155.1200(c) and (d), especially as they relate to requirements under subparts D and E, focus on reviewing the processes and procedures that a State Exchange has established to verify that a qualified individual meets eligibility requirements. These programmatic audits do not review, estimate, or report on the amounts or rates of improper payments resulting from inaccurate eligibility determinations and enrollment transactions. SEIPM would both ensure a review of the accuracy of State Exchange eligibility verification processes and identify improper APTC payments resulting from inaccurate eligibility determinations and enrollment transactions.

To meet the requirements of the PIIA, reduce burden on State Exchanges, and ensure consistency across State Exchanges in terms of our review methodology, we propose that a State Exchange's participation in SEIPM would satisfy certain duplicative annual independent external programmatic audit requirements, particularly the review of compliance with provisions of subparts D and E that may result in improper payment of APTC. Should this provision be finalized as proposed, we would issue sub-regulatory guidance to identify which programmatic audit requirements could be satisfied through completion of SEIPM for a given plan year. We believe this policy would reduce duplicative efforts and burden on State Exchanges that would otherwise be required to fully comply with programmatic audit requirements and SEIPM, while also maintaining the programmatic audits for requirements not reviewed as part of SEIPM.

k. Failure To Comply (§ 155.1650)

We propose to add new § 155.1650 that would address what would happen should a State Exchange fail to comply with the SEIPM requirements. This proposed section would create clear criteria for determining when a State Exchange had failed to substantially comply with SEIPM requirements and would establish appropriate remedial measures to ensure program integrity and effectiveness.

At § 155.1650(a), we propose to establish a general principle that would govern improper payment classification throughout the SEIPM program. We propose that HHS would classify APTC payments as improper when a State Exchange failed to provide adequate documentation demonstrating that such payments were made in accordance with applicable Federal requirements. This principle would align with Federal improper payment measurement standards established under PIIA which require agencies to classify payments as improper when there is insufficient documentation to determine if a payment is proper or improper. The burden of providing adequate supporting documentation would rest with State Exchanges as the entities responsible for making APTC eligibility determinations and payment calculations, ensuring that Federal funds were distributed in accordance with Federal requirements.

We propose to specify at § 155.1650(b)(1) through (5) when HHS would determine a State Exchange had failed to substantially comply with this subpart by providing specific, measurable criteria addressing the most critical aspects of State Exchange participation in SEIPM, which would consist of the following: (1) failure to submit required data or documentation within the timelines specified in the Annual Program Schedule; (2) submitting data or documentation found to be incomplete, inaccurate, or in a format that would reasonably prevent effective review; (3) failure in the CAP process; or (4) a pattern, that is more than five instances during a SEIPM cycle, of non-response within 30 calendar days to HHS requests for clarification or additional information.

Such a proposed compliance framework would balance the need for clear, enforceable standards with recognition that State Exchanges operate complex systems and may encounter operational challenges. The proposed criteria would focus on substantial compliance failures that would genuinely impact the integrity and effectiveness of the SEIPM program as opposed to minor technical violations that would not materially affect improper payment measurement activities. Such standards would ensure that State Exchanges would provide necessary information within established timeframes to support the overall SEIPM cycle and enable HHS to meet Federal improper payment reporting obligations, while maintaining data quality sufficient to support reliable measurement results. The framework would promote accountability and ensure effective program administration across all participating State Exchanges, while maintaining the collaborative relationship necessary for successful SEIPM implementation. By establishing

clear expectations for data submission timeliness, quality standards, corrective action implementation, and ongoing communication, these proposed compliance criteria would support the accuracy of improper payment estimates and the overall integrity of the APTC program oversight process.

At § 155.1650(c), we propose to establish a process to provide State Exchanges notice and opportunity to address compliance deficiencies before HHS would implement remedial measures. We propose that before implementing measures under paragraph (d) of this section, HHS would provide written notice to the State Exchange specifying the nature of the noncompliance and the potential consequences, and allow the State Exchange a reasonable opportunity to cure the noncompliance or demonstrate that compliance has been achieved. This notice and cure provision would promote collaborative problem-solving between HHS and State Exchanges. The written notice requirement would ensure that State Exchanges would have clear understanding of the specific compliance deficiencies and the potential consequences of continued noncompliance, and would enable them to take appropriate corrective action. HHS would set the cure period to be commensurate with the complexity of the compliance issue.

At § 155.1650(d), we propose to establish a framework of remedial measures that HHS could implement should a State Exchange fail to substantially comply with SEIPM requirements and such failures undermine or prohibit HHS' efficient administration of Exchange improper payment measurement activities. This provision would provide HHS with appropriate enforcement tools to secure State Exchange compliance while maintaining program integrity and ensuring effective oversight of APTC administration. We propose that HHS could implement measures or procedures to secure the State Exchange's compliance with the requirements of this subpart which are proposed to include: (1) enhanced monitoring and reporting; (2) mandatory implementation of specific operational procedures or controls; and (3) on-site visits to State Exchange facilities to assess operational procedures, data systems, and compliance with program requirements.

This graduated enforcement approach would recognize that different compliance failures may require different remedial responses, allowing HHS to tailor interventions to the specific nature and severity of the noncompliance. Enhanced monitoring and reporting requirements would provide ongoing oversight for State Exchanges experiencing compliance difficulties, while mandatory operational procedures or controls would address systemic deficiencies that could be contributing to improper payment risks. On-site visits would enable HHS to conduct comprehensive assessments of State Exchange operations, identify root causes of compliance failures, and provide targeted technical assistance to support improvement efforts.

At § 155.1650(e), we propose that HHS could initiate proceedings to revoke a State Exchange's authority to operate if a State Exchange continues to fail to comply after implementation of initial remedial measures under paragraph (d) of this section. Revoking a State Exchange's authority to operate would represent the most serious enforcement action available and would be reserved for cases where other remedial measures had failed to secure the State Exchange's compliance, and the State Exchange's continued operation would pose unacceptable risks to program integrity and enrollee protection.

We seek comment on these proposals.

E. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. FFE and SBE–FP User Fee Rates for the 2027 Benefit Year (§ 156.50)

For the 2027 benefit year, we propose an FFE user fee rate of 2.5 percent of total monthly premiums and an SBE–FP user fee rate of 2.0 percent of total monthly premiums.

Section 1311(d)(5)(A) of the Affordable Care Act permits an Exchange to charge assessments or user fees on participating health insurance issuers as a means of generating funding to support its operations. If a State does not elect to operate an Exchange or does not have an approved Exchange, section 1321(c)(1) of the Affordable Care Act directs HHS to operate an Exchange within the State. Accordingly, in § 156.50(c), we state that a participating issuer offering a plan through an FFE or SBE–FP must remit a user fee to HHS each month that is equal to the product of the annual user fee rate specified in the annual HHS notice of benefit and payment parameters for FFEs and SBE–FPs for the applicable benefit year and the monthly premium charged by the issuer for each policy where enrollment is through an FFE or SBE–FP. OMB Circular No. A–25 established Federal policy regarding user fees and what the fees can be used for.[131] OMB Circular No. A–25 provides that a user fee charge will be assessed against each identifiable recipient of special benefits derived from Federal activities beyond those received by the general public.

a. FFE User Fee Rate for the 2027 Benefit Year

Based on estimated costs, enrollment in the FFEs (including anticipated enrollment loss due to certain States transitioning from the FFE to SBE–FPs or from SBE–FPs to State Exchanges), and premiums for the 2027 benefit year, we propose a 2027 user fee rate for all participating FFE issuers of 2.5 percent of total monthly premiums.

Section 156.50(c)(1) provides that, to support the functions of FFEs, an issuer offering a plan through an FFE must remit a user fee to HHS, in the timeframe and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy where enrollment is through an FFE. As in benefit years 2014 through 2026, issuers seeking to participate in an FFE in the 2027 benefit year will receive two special benefits not available to issuers offering plans in State Exchanges: (1) the certification of their plans as QHPs; and (2) the ability to sell health insurance coverage through an FFE to individuals determined eligible for enrollment in a QHP. For the 2027 benefit year, issuers participating in an FFE will receive special benefits from the following Federal activities:

- Provision of consumer assistance tools;
- Consumer outreach and education;
- Management of a Navigator program;
- Regulation of agents and brokers;
- Eligibility determinations;
- Enrollment processes; and
- Certification processes for QHPs (including ongoing compliance verification, recertification, and decertification).

Activities performed by the Federal Government that do not provide issuers participating in an FFE with a special benefit are not covered by the FFE user fee.

The proposed user fee rate reflects our estimates for the 2027 benefit year of costs for operating the FFEs, premiums, enrollment, and transitions in Exchange

[131] *See* OMB. (n.d.) Circular No. A–25 Revised. *https://www.whitehouse.gov/wp-content/uploads/2017/11/Circular-025.pdf.*

models from the FFE and SBE–FP models to either the SBE–FP or State Exchange models. The total enrollment in Exchanges in States anticipated to transition from operating an SBE–FP to a State Exchange model represents premiums for which we will no longer collect user fees, and the total enrollment in Exchanges in States anticipated to transition from an FFE to an SBE–FP model represents premiums for which we will assess user fees at the lower SBE–FP rate. Thus, these anticipated transitions impact our total projected collections, may affect the FFE and SBE–FP user fee rates, and are considered as part of our calculation of our proposed user fee rates.

To develop the proposed 2027 benefit year FFE user fee rate, we considered a range of costs, premiums, and enrollment projections. For the proposed 2027 benefit year user fee rates, we estimated that budget costs would be lower in 2027 than the budget costs that we used to project the 2025 and 2026 benefit year FFE user fee rates. Specifically, while we expect that small increases in costs from the 2026 benefit year to the 2027 benefit year would be due to the structure of contracts and inflationary pressure, recent efficiency exercises have reduced baseline cost structures that were used in the projection of budgets for benefit years 2025 and beyond.

We took several factors into consideration in choosing which premium and enrollment projections would inform the proposed 2027 FFE user fee rate. First, for our estimated premium trend rate projections, we expect premiums will increase in 2026. We also expect that while the rate of premium increase will be smaller in benefit year 2027, increases in premiums will persist.

For the 2021 through 2025 benefit years, the individual non-catastrophic market risk pool in all States generally experienced increased enrollment. Our 2026 estimates accounted for projected decreased 2026 benefit year Exchange enrollment in the individual market due to the impact of the expiration of the enhanced PTC subsidies. For the 2027 benefit year, we estimate a further decrease in Exchange enrollment in the individual market due to the expiration of subsidies at the end of the 2025 benefit year as well as the effects of the WFTC legislation and the Marketplace Integrity and Affordability final rule.[132] [133]

After taking into consideration a projected reduced budget, enrollment decreases, and a higher premium trend rate, we propose a 2027 benefit year FFE user fee rate of 2.5 percent of total monthly premiums, which is the same as the 2026 benefit year FFE user fee rate. Based on our estimates, this proposed user fee rate would allow us to have sufficient funding available to fully fund user-fee-eligible FFE activities. We note that if any events occurring between this proposed rule and the final rule significantly change our estimated FFE operational costs, or if our enrollment or premiums projections change (especially based on the availability of more recent data), we may finalize FFE user fee rates that differ from these proposed rates to reflect those changes. We acknowledge that the 2026 open enrollment period closed prior to release of the proposed rule, but we did not consider that data in developing the proposed user fee rates because the data available at the time was too premature to use for our proposed rule estimates. Our intention is to reconsider the enrollment estimates for the final rule. If the actual 2026 enrollment numbers are lower than the projected enrollment numbers we used to set the proposed user fee, the final 2027 user fee rate may be higher. If the actual 2026 enrollment numbers are higher than our projected enrollment numbers, the 2027 user fee rate may be lower.

We seek comment on the proposed 2027 benefit year FFE user fee rate.

b. SBE–FP User Fee Rate for the 2027 Benefit Year

We propose to charge issuers offering QHPs through an SBE–FP a user fee rate of 2.0 percent of the monthly premium charged by the issuer for each policy under plans offered through an SBE–FP for the 2027 benefit year.

In § 156.50(c)(2), we specify that an issuer offering a plan through an SBE–FP must remit a user fee to HHS, in the timeframe and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy where enrollment is through an SBE–FP. SBE–FPs enter into a Federal platform agreement with HHS to leverage the systems established for the FFEs to perform certain Exchange functions and enhance efficiency and coordination between State and Federal programs. The benefits provided to issuers in SBE–FPs by the Federal Government include use of the FFE information technology and call center infrastructure used in connection with eligibility determinations for enrollment in QHPs and other applicable State health subsidy programs, as defined at section 1413(e) of the Affordable Care Act, and QHP enrollment functions under 45 CFR part 155, subpart E. The user fee rate for SBE–FPs is calculated based on the proportion of total FFE costs associated with Federal activities that provide SBE–FP issuers with special benefits, including costs that are associated with the FFE information technology infrastructure, the consumer call center infrastructure, and eligibility and enrollment services.

To calculate the proposed SBE–FP user fee rate for the 2027 benefit year, we used the same assumptions related to budget, enrollment, and premiums as we used for the proposed FFE user fee rate. As we explained previously in this section, the user fee rate for SBE–FPs is calculated based on the proportion of the total FFE costs associated with Federal activities that provide SBE–FP issuers with special benefits, which we continue to estimate to be approximately 80 percent of total FFE costs. These FFE costs associated with Federal activities that provide SBE–FP issuers with special benefits include the costs associated with the FFE information technology infrastructure, the consumer call center infrastructure, and eligibility and enrollment services. Additionally, the proposed user fee rate for SBE–FP issuers for the 2027 benefit year includes assumptions about States transitioning from either the FFE model to an SBE–FP, or from an SBE–FP to a State Exchange for the 2027 benefit year, which impacts the SBE–FP enrollment projections.

Based on this methodology and our projected reduced budget, enrollment decreases, and a higher premium trend rate that are described in section III.E.1.a of this proposed rule, we propose a 2027 benefit year SBE–FP user fee rate of 2.0 percent of total monthly premiums which is the same as the user fee rate we established for the 2026 benefit year. Specifically, changes in budget, enrollment and premium trends have the same impact for the SBE–FP compared to the FFE. We note that if any events occurring between this proposed rule and the final rule

[132] We considered the most recent projections from the Congressional Budget Office, as we have in prior rulemakings and our own internal data. See, for example, 89 FR 26218; see also, Congressional Budget Office. (2025, September 18). The Estimated Effects of Enacting Selected Health Coverage Policies on the Federal Budget and on the Number of People With Health Insurance. *https://www.cbo.gov/system/files/2025-09/61734-Health.pdf.*

[133] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, (June 25, 2025), 90 FR 27074.

significantly change our estimated Federal platform operational costs, or if our enrollment or premiums projections change (especially based on the availability of more recent data), we may finalize SBE–FP user fee rates that differ from these proposed rates to reflect those changes.

We seek comment on the proposed 2027 benefit year SBE–FP user fee rate.

2. Permitting Plan-Level Adjustments for Multi-Year Catastrophic Plans (§ 156.80(d)(2)(ii))

As discussed in section III.E.6 of this proposed rule, we propose to modify the requirements for catastrophic plans at § 156.155(a)(6) to specify that a catastrophic plan has a plan term of either 1 year, or of multiple consecutive years not to exceed 10 years, and are seeking comment on whether to also specify such standards for individual market metal level plans. To align with that proposal and comment solicitation, and under our authority to implement the single risk pool requirements in section 1312(c)(1) and (2) of the Affordable Care Act, we propose to amend § 156.80(d)(2)(ii) to permit issuers of multi-year catastrophic plans to make plan-level adjustments to the index rate that reflect the length of the entire term. Such plan-level adjustments would account for the benefit design characteristics of such plans, such as their deductible and maximum out-of-pocket cost structure. The proposal to codify standards for catastrophic plans to have multi-year terms of up to 10 consecutive years would clarify certain aspects of the structure of multi-year plans, such as permitting such plans to cover certain additional preventive service benefits before an enrollee satisfies their deductible and annual limitation on cost sharing. Allowing issuers of multi-year catastrophic plans to make plan-level adjustments to the index rate would permit these issuers to take such plan design features into account when developing premiums for such plans. Given that these plan design features, which are discussed in section III.E.6. of this proposed rule, would be unique to multi-year catastrophic plans, it would be appropriate for issuers to take them into account when setting premiums for such plans, in accordance with section 2701 of the Public Health Service Act. An issuer's calculation of the magnitude of this plan-level adjustment must be accurate, and therefore, must be actuarially justified.

We seek comment on all aspects of this proposal, including whether a separate plan level adjustment based on term length should be permitted for multi-year catastrophic plans, and whether and the degree to which the risk profile of multi-year catastrophic plans that are otherwise identical to single year catastrophic plans would justify plan-level adjustments over and above those that would be made to account for the different features of such plans.

3. State Selection of EHB-Benchmark Plan for Plan Years Beginning on or After January 1, 2020 (§ 156.111)

Section 1302 of the Affordable Care Act provides for the establishment of an EHB package that includes coverage of EHBs (as defined by the Secretary), cost-sharing limits, and AV requirements. Among other requirements, the law directs that the EHBs be equal in scope to the benefits provided under a typical employer plan, and that they include at least the following 10 general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

We established requirements relating to the coverage of EHBs in the EHB Rule (78 FR 12834). In the 2019 Payment Notice (83 FR 17009), we added § 156.111 to provide States with additional options from which to select an EHB-benchmark plan for plan years beginning on or after January 1, 2020. We revised the EHB-benchmark plan selection process in the 2023 Payment Notice (87 FR 27290) and the 2025 Payment Notice (89 FR 26218).

We are pausing review of State applications to select EHB-benchmark plans in accordance with § 156.111. We are actively conducting a comprehensive review of section 1302 of the Affordable Care Act, as we are considering future rulemaking to revise § 156.111 and other regulations relating to the EHBs.

4. Provision of EHB (§ 156.115(d))

We propose to revise § 156.115(d) to prohibit issuers from including routine non-pediatric dental services as an EHB.

In the EHB Rule (78 FR 12834), we finalized at § 156.115(d) that issuers of a plan offering EHBs may not include, among other services and benefits, routine non-pediatric dental services as an EHB, even if the State's current EHB-benchmark plan includes such services as covered benefits. Section 1302(b)(2) of the Affordable Care Act directs the Secretary, in defining the EHBs, to ensure that they are equal in scope to the benefits provided under a typical employer plan. In the proposed EHB Rule (77 FR 70644), in support of the proposed prohibition at § 156.115(d), we noted that routine non-pediatric dental services are not typically included in the medical plans offered by employers and are often provided as excepted benefits [134] by the employer.

In the 2025 Payment Notice, we finalized removal of this prohibition at § 156.115(d) for plan years beginning on or after January 1, 2027. In support of this policy, we noted, as we did in the 2025 Payment Notice proposed rule (88 FR 82597), that a more natural reading of section 1302(b)(2) of the Affordable Care Act is one that considers all the benefits typically covered by employers, regardless of whether such benefits are historically considered a ''health benefit'' or whether such benefits are ''typically covered'' by an employer's major medical plan. We also stated that based on recent data, it appeared that routine non-pediatric dental services were commonly covered as an employer-sponsored or other job-based benefit to a degree that warranted removing the prohibition on coverage of these services as an EHB. We further explained that oral health has a significant impact on overall health and quality of life,[135] and that removing the prohibition on issuers from including routine non-pediatric dental services as an EHB would remove regulatory and coverage barriers to expanding access to routine non-pediatric dental benefits for those plans that must cover EHBs. We further stated that this policy would allow States to work to improve non-pediatric oral health and overall health outcomes, which are disproportionately low among marginalized communities such as people of color and people with low incomes.[136]

However, to better align our regulation at § 156.115(d) with section 1302(b)(2)(A) of the Affordable Care Act, which directs that the scope of EHBs be equal to the scope of benefits provided

[134] For more information, see 45 CFR 144.103 for excepted benefits, 45 CFR 146.145(b)(3)(i) and (iii)(A) for limited scope dental benefits for group health plans, and 45 CFR 148.220(b)(1) for limited scope dental benefits in the individual market.

[135] Spanemberg, J.C., Cardoso, J.A., Slob, E.M.G.B, & Lopez-Lopez, J. (2019). Quality of life related to oral health and its impact in adults. *Journal of Stomatology, Oral and Maxillofacial Surgery, 120*(3), 234–239. *https://doi.org/10.1016/j.jormas.2019.02.004.*

[136] Northridge, M.E., Kumar, A., & Kaur, R. (2020). Disparities in Access to Oral Health Care. *Annual review of public health, 41,* 513–535. *https://doi.org/10.1146/annurev-publhealth-040119-094318.*

under a typical employer plan, we now propose to reinstate the regulatory prohibition on issuers from including routine non-pediatric dental services as an EHB. We acknowledge that in the 2025 Payment Notice proposed rule (89 FR 26342), we previously interpreted section 1302(b)(2)(A) of the Affordable Care Act as supporting a more natural reading that considers all the benefits typically covered by employers, regardless of whether such benefits are historically considered a ''health benefit'' or whether such benefits are ''typically covered'' by an employer's major medical plan. Upon further consideration of the statutory framework, we now believe a more precise interpretation of section 1302(b)(2)(A) of the Affordable Care Act should apply.

Specifically, we believe the language of section 1302(b)(1) of the Affordable Care Act, which outlines the 10 EHB categories and specifically includes, ''Pediatric services, including oral and vision care,'' strongly suggests that Congress did not view routine non-pediatric oral and vision care as an EHB at the time the Affordable Care Act passed. This language indicates Congress' intention to differentiate pediatric from non-pediatric dental services and explicitly limit EHB coverage to pediatric oral care. If Congress had intended for non-pediatric dental services to be included in the list of the 10 EHB categories it would have explicitly included these services, as it explicitly included pediatric oral care. Thus, the best reading of the statute, which only mentions pediatric oral care, indicates non-pediatric oral care was not meant to be included as an EHB.

We acknowledge that the 10 EHB categories set the floor for what constitutes EHB and that routine non-pediatric dental services could theoretically be added on top of this minimum set of EHBs. However, the EHB typicality standard at section 1302(b)(2)(A) of the Affordable Care Act requires the scope of EHB to be equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. As we stated in the 2025 Payment Notice (89 FR 26345), the statutory term ''a typical employer plan'' is ambiguous with regard to whether it references a single major medical plan, or the entire suite of benefits provided by the employer. Given Congress' intent reflected in section 1302(b)(1) of the Affordable Care Act to specifically include pediatric oral care and not non-pediatric oral care as an EHB category, and the fact that standalone non-pediatric dental plans are excepted benefits, we now interpret ''a typical employer plan'' under section 1302(b)(2)(A) to refer to an employer's major medical plan rather than the entire suite of benefits typically covered by employers. This interpretation of the typicality standard, along with the statutory framework that distinguishes pediatric from non-pediatric dental services, warrants reinstating the regulatory prohibition on issuers from including routine non-pediatric dental benefits as an EHB.

Additionally, KFF Employer Health Benefits surveys in recent years show most employers do not include dental benefits as part of their traditional medical plan. In KFF's 2019 survey, 59 percent of small firms (3–199 workers) and 92 percent of large firms (200 or more workers) offered separate dental benefits.[137] More recently in KFF's 2023 survey, 90 percent of small firms and 94 percent of large firms offered separate dental plans.[138] Since these benefits are typically offered as separate insurance products and are not included in the traditional medical plan, they should not be included in the scope of benefits used to establish the scope of the typical employer plan. Additionally, while a high percentage of large firms offer separate dental benefits, small firms are less likely to offer any dental benefits (as indicated by the KFF survey data cited above) and small firms comprise the majority of employers in the U.S.[139] The 2019 KFF survey data was cited in the 2025 Payment Notice (89 FR 26343) as evidence that routine non-pediatric dental services are commonly covered as an employer-sponsored or other job-based benefit. However, the relevant consideration is not whether routine non-pediatric dental services are commonly covered as an employer-sponsored or other job-based benefit, but whether employers offer these benefits as part of their medical plans or as separate benefits. This separation of dental benefits from medical coverage as indicated by KFF's surveys further supports the interpretation that Congress intended to omit non-pediatric dental coverage from the 10 categories of EHBs. Employers traditionally and commonly offering dental coverage as separate plans, as demonstrated by the KFF surveys, is consistent with Congress' determination that non-pediatric dental coverage should not be a part of the 10 EHB categories representing core medical benefits required to be offered in small group and individual plans.

Further, we acknowledge that oral health can have a significant impact on overall health and quality of life. We clarify that this proposed prohibition on including routine non-pediatric dental services as an EHB would not prevent States from addressing non-pediatric oral health and overall health outcomes through alternative policy mechanisms. For example, States could mandate coverage of routine non-pediatric dental services as a non-EHB and defray the cost associated with that benefit. We believe achieving better alignment of the regulatory requirements at § 156.115(d) with section 1302(b)(2)(A) of the Affordable Care Act regarding the EHB typicality standard outweighs these other policy considerations.

If this proposal to prohibit issuers from including routine non-pediatric dental services as an EHB were finalized, there would be fewer operational concerns for issuers associated with States adding routine non-pediatric dental services as an EHB. As we acknowledged in the 2025 Payment Notice (89 FR 26347), if States added routine non-pediatric dental services as an EHB, States would need to consider that some medical plans may not currently have infrastructure or experience working with Current Dental Terminology (CDT) codes that report dental procedures to dental payers. More specifically, for plans that do not directly reimburse using dental codes, the transition to new coding would require investments in technology, staff, and internal expertise. As we further explained in the 2025 Payment Notice (89 FR 26347), these investments may have led to additional premiums and an overall increase in health care spending. Under this proposal, issuers would not have to consider operational and cost concerns related to developing infrastructure around CDT codes. Additionally, as we explained in the 2025 Payment Notice (89 FR 26347), if States added routine non-pediatric dental services as an EHB, this may have required plans to establish new networks of dental providers if plans did not already have such networks available.

Furthermore, if this proposal were finalized, we believe there would be fewer impacts on cost-sharing and stand-alone dental plans (SADPs). As we stated in the 2025 Payment Notice (89 FR 26343), while section

[137] KFF, Employer Health Benefits: *2019 Annual Survey,* available at *https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/.*

[138] KFF, Employer Health Benefits: *2023 Annual Survey,* available at *https://www.kff.org/health-costs/report/2023-employer-health-benefits-survey/.*

[139] According to 2025 U.S. Bureau of Labor Statistics data, smaller firms (defined by BLS as up to 249 workers) comprise 73 percent of all firms. See U.S. Bureau of Labor Statistics, *Employment by size of establishment, private industry,* available at *https://www.bls.gov/charts/county-employment-and-wages/employment-by-size.htm.*

1302(b)(4)(F) of the Affordable Care Act permits a medical QHP sold on the Exchange to omit coverage of pediatric dental EHB services if an SADP is offered through an Exchange,[140] there is no statutory basis to extend this exception to routine non-pediatric dental services. Absent the change we are proposing, this would have meant that plans subject to an EHB-benchmark plan that includes routine non-pediatric dental services as an EHB would be prohibited from omitting such coverage on the basis that an SADP already provides such coverage through an Exchange. This would have required routine non-pediatric dental EHB services to be embedded in medical plans, which would have potentially impacted cost-sharing, as such embedded non-pediatric benefits would be subject to any applicable plan deductible, unless a State requires pre-deductible coverage. Depending on the benefits, pre-deductible coverage could have also made the plan incompatible with health savings accounts (HSAs). Additionally, requiring such embedded benefits would have conflicted with the established market structure in which non-pediatric dental services are more commonly provided through SADPs.[141] Further, as we acknowledged in the 2025 Payment Notice (89 FR 26347), there could have been impacts on SADP premiums sold on the Exchange if a State added routine non-pediatric dental benefits as an EHB, leading to potential disparities between dental plan premiums on- versus off-Exchange. Under §§ 146.145(b)(3) and 148.220(b)(1), limited-scope dental plans are considered excepted benefits that are not required to provide EHBs. Thus, if a State adds routine non-pediatric dental benefits as an EHB, SADPs are not required to cover such benefits, whether on- or off-Exchange.

In addition, we note that this proposal to prohibit routine non-pediatric dental services from being covered as an EHB would not impact the typicality test at § 156.111(b)(2)(ii), as the methodology and requirements for the typicality test remain unchanged. The typicality test is a quantitative comparison that measures whether the actuarial value of a State's proposed EHB-benchmark plan falls within the range of actuarial values of typical employer plans in the State. As we stated in the 2025 Payment Notice (89 FR 26346), nothing in regulation prohibits a State from including the quantitative value of routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia in its typicality analysis. Specifically, if a typical employer plan used in the typicality comparison includes any of these services, the actuarial value of those services may be included when calculating that employer plan's overall value for purposes of the typicality test. This does not mean, however, that these services may be covered as EHBs in the State's EHB-benchmark plan itself. In summary, while this proposal would change what services are permitted to be covered as an EHB, it would not alter how States conduct the typicality test or what may be considered when calculating the actuarial value of typical employer plans for comparison purposes. States would still be required to ensure the value of covering all the benefits in the State's proposed EHB-benchmark plan is between (or equal to) the value of the least and most generous typical employer plans in the State.

We acknowledge that under the current policy, States could have submitted applications to HHS to add routine non-pediatric dental services as an EHB by the May 7, 2025 deadline for effectiveness in PY 2027 via the EHB-benchmark update application process under § 156.111. Although no States submitted applications to make this change by the May 7, 2025 deadline, other States may have already begun work towards their applications to update their EHB-benchmark plan to add routine non-pediatric dental services as an EHB for a future plan year. This proposal, if finalized, would therefore frustrate these States' efforts.

We seek comment on the proposal to revise § 156.115(d) to prohibit issuers from including routine non-pediatric dental services as an EHB, including the impact this proposal, if finalized, would have on health insurance coverage in the individual, small group, and large group markets, as well as on self-insured plans. If finalized as proposed, this proposed policy to prohibit coverage of routine non-pediatric dental services as an EHB would be effective upon the effective date of the final rule.

5. Publication of the 2027 Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage in Guidance (§ 156.130(e))

As established in part 2 of the 2022 Payment Notice (86 FR 24238), starting with the 2023 benefit year, for benefit years in which we are not making changes to the methodology to calculate the premium adjustment percentage index (PAPI), the required contribution percentage, and maximum annual limitations on cost sharing and reduced maximum annual limitation on cost sharing, we publish these parameters in guidance annually by January of the year preceding the applicable benefit year. In the 2025 Marketplace Integrity and Affordability final rule (90 FR 27166 through 27168), we finalized a change to the methodology for calculating these parameters starting with the 2026 benefit year such that we will use private health coverage premiums (excluding Medigap and the medical portion of accident insurance [''property and casualty'' insurance]) as the definition of premiums for calculating the premium adjustment percentage and related parameters. We are not proposing to change the methodology for calculating these parameters for the 2027 benefit year. As such, these parameters are not included in this rulemaking. Instead, we published the 2027 benefit year parameters in guidance,[142] using the methodology finalized in the 2025 Marketplace Integrity and Affordability final rule.

6. Multi-Year Terms for Catastrophic Plans To Improve Health (§§ 156.130(c) and 156.155(a)(6))

We propose to codify requirements under which issuers of catastrophic coverage may enroll individuals for multiple plan or policy year terms with periods of up to 10 years. We propose modifying the requirements for catastrophic plans in § 156.155 to specify that a catastrophic plan has a plan term of either 1 plan or policy year, or of multiple consecutive plan or policy years not to exceed 10 years.

We propose that catastrophic plans with terms of at least 2 plan or policy years may utilize value-based insurance designs to offer benefits for preventive

[140] *See* section 1311(d)(2)(B)(ii) of the Affordable Care Act for more information on offering SADP benefits.

[141] Elani, H.W., Rahman, M.S., Wallace, J., Rosenthal, M.B., & Sommers, B.D. (2024). Availability Of Adult Dental Plans In The Affordable Care Act Marketplaces, 2016–23. *Health Affairs, 43*(11), 1587–1596. *https://doi.org/10.1377/hlthaff.2024.00307.*

[142] Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year. *https://www.cms.gov/files/document/2027-papi-parameters-guidance-2026-01-29.pdf.*

services pursuant to section 2713(c) of the PHS Act, without the enrollee having to first satisfy their deductible or annual cost-sharing limitation. We request comment on the proposal at § 156.130, that issuers of multi-year catastrophic plans have the option to apply the annual limitation on cost sharing for each plan year of the contract on an annual basis, or, on average, over the life of the contract. For example, as an alternative to applying the annual limitation on cost sharing on an annual basis, an issuer could opt to offer a 5 year catastrophic plan that would apply the annual limitation as follows: the average over 5 years of the annual limitation on cost sharing in the plan equals the average over 5 years of the annual limitation on cost sharing as required by statute. Alternatively, the issuer could opt to vary the annual limitation on cost sharing in the plan by disease, for example, cancer, if that disease requires treatment that spans multiple years, so long as the average over all plan participants and over years of the annual limitation on cost sharing equals the average over 5 years of the annual limitation on cost sharing as required by statute. The value of varying the annual limitation on cost sharing in the plan over time in a long-term plan is that a higher annual limitation in early years may allow the plan to lower the limitation in later years to entice participants to remain in the plan for its duration, without altering the expected actuarial value of the plan over it duration as of the plan's start date.

Finally, as more fully discussed in section III.E.2 of this proposed rule, we propose to amend § 156.80(d)(2)(ii) to allow issuers of multi-year catastrophic plans to make a plan-level adjustment to the index rate. This proposal is intended to promote innovation in health coverage plan design that could exert downward pressure on premiums and costs, while increasing access to coverage and care and improving health outcomes.

We propose that an individual who satisfies the requirements for a catastrophic plan at the time of enrollment in the plan under section 1302(e)(2) of the Affordable Care Act at the time of enrollment in the multi-year plan. We seek comments on this proposal and how it would interact with other laws.

Given the large increases in premiums for health coverage in recent years, we are interested in offering additional alternatives for individuals to enroll in less expensive options. We believe that Congress' recent decision to designate all catastrophic and bronze plans as high-deductible plans, as well as our recent broadening of the hardship exemption for individuals to qualify for catastrophic health plans,[143] is in keeping with that objective. We also believe that when individuals receive preventive services and effective disease management, those interventions can help reduce costs in the long run,[144] which in turn may ease pressure on premiums. However, issuers that do a particularly effective job of promoting these sorts of interventions often do not reap the long-term advantages of those reduced costs because they might retain those enrollees for only short durations and therefore cannot moderate premiums accordingly. This is because the single-year plan terms in the individual market promote churn where individuals cycle out of particular individual market plans, with enrollees often switching health insurance issuers on a frequent basis,[145] sometimes annually.[146] In such cases, an individual who receives such interventions while enrolled with a given issuer for 1 plan or policy year, and thereby may improve their health prospects for the future, is often not enrolled with that same issuer when those health benefits accrue. In this way, the incentives for individual market issuers differ from those for large employers, that often have an incentive to invest in the health of their long-term employees through wellness programs and offering of other workplace programs that promote physical fitness, smoking cessation, and other initiatives aimed at reducing sick days and improving long term health outcomes.

In addition to incentivizing investments in health promoting activities, health insurance contract terms that exceed a year may decrease the administrative costs associated with marketing and enrollment and encourage alternative pricing structures where administrative efficiencies are reflected in lower premiums and enrollees in plans with multi-year terms are insulated from short-term premium spikes. From the perspective of the individual, remaining enrolled with the same plan or issuer for a longer period of time might also promote adherence to disease management programs, and thus promote better overall long-term health. Because of the potential positive impacts on enrollee health and plan affordability, we propose modifying the requirements for catastrophic plans in § 156.155(a)(6) to specify that a catastrophic plan has a term of either 1 plan or policy year, or of multiple consecutive plan or policy years not to exceed 10 years. If we should finalize the proposal to codify requirements for multi-year catastrophic plans, then, depending on issuer and enrollee reaction to and experience with such plans, we would consider expanding these or other similar requirements to multi-year plans of one or several metal levels.

We note that section 1302(e)(1)(B) of the Affordable Care Act specifies benefits that catastrophic health plans are required to provide pre-deductible, including three primary care visits per year and preventive services specified in section 2713 of the PHS Act. Section 2713(a) of the PHS Act requires applicable health plans to cover: (1) evidence-based items or services that have in effect a rating of ''A'' or ''B'' in the current recommendations of the United States Preventive Services Task Force (USPSTF); (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by HRSA.

Section 2713(c) of the PHS Act allows the Secretary to develop guidelines to permit health plans to utilize value-

[143] See Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-sharing Reductions Due to Income, and Streamlining Exemption Pathways to Coverage, available at guidance-on-hardship-exemptions.pdf.

[144] *See* Musich, S., Wang, S., Hawkins, K., and Klemes, A. (2016). The Impact of Personalized Preventive Care on Health Care Quality, Utilization, and Expenditures. Population Health Management. Available at: *https://pmc.ncbi.nlm.nih.gov/articles/PMC5296930/* and Maciosek, M.V., LaFrance, A.B., Dehmer, S.P., McGree, D.A., Flottemesch, T.J., Xu, Z. Solberg, L.I. (2017). Updated Priorities Among Effective Clinical Preventive Services. Annals of Family Medicine. Available at *https://pmc.ncbi.nlm.nih.gov/articles/PMC5217840/.*

[145] *See* Hill, S.C. and Jacobs, P.D. (2024). Changes in coverage stability and churning for private, individual insurance under the Affordable Care Act. Health Affairs Scholar. Available at: *https://pmc.ncbi.nlm.nih.gov/articles/PMC11747866/* and Fang, H., Frean, M., Sylwestrzak, G., and Ukert, B. (2022). Trends in Disenrollment and Reenrollment Within US Commercial Health Insurance Plans, 2006–2018. JAMA Network Open. Available at: *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789399.*

[146] Wolf, E., Slosar, M., and Menashe, I. (2022). Assessment of Churn in Coverage Among California's Health Insurance Marketplace Enrollees. JAMA Health Forum. Available at *https://jamanetwork.com/journals/jama-health-forum/fullarticle/2799211.*

based insurance design in the context of designing health coverage for preventive services. As described above, we believe that broadening plan terms beyond a single plan or policy year for catastrophic plans would increase the value provided to consumers in the form of better incentives for the issuer to invest in the long-term health of its enrollees. As such, we are clarifying under our authority at section 2713(c) of the PHS Act that catastrophic plans with a term of at least 2 plan or policy years may utilize a value-based insurance design in the context of designing health coverage for preventive services, such that benefits related to said design may be offered prior to satisfaction of the plan's deductible and prior to satisfying the plan's cost-sharing limitation, in addition to those benefits that can be offered prior to satisfaction of the plan's deductible and cost-sharing limitation enumerated in section 1302(e)(1) of the Affordable Care Act. We seek comment on the types of benefits plans could offer under this proposal, such as benefits that are designed to improve the long-term health of enrollees. We note that any such benefits must satisfy all applicable non-discrimination requirements. While this proposal is limited to catastrophic plans, we also seeks comment on whether additional clarification or guidance specific to the group market is necessary.

We propose at § 156.130 that issuers of multi-year catastrophic plans have the option to apply the annual limitation on cost sharing for each plan year of the contract on an annual basis, or, on average, the life of the contract. For example, the limitation applicable to a specific year under each plan year of the coverage could be divided by 12 to determine the monthly limit on cost sharing under the plan.

Currently, enrollees can experience dramatic coverage changes when insurance contracts reset or change from one year to the next as deductibles and out-of-pocket limits reset. This can lead to significant shifts in cost sharing from month to month for the same services. Given that multi-year plans would not be subject to renewal at year's end (other than after the final year of the multi-year term), we believe it is appropriate to allow for a benefit structure that does not reset every 12 months. We believe that providing a consistent, predictable monthly out-of-pocket limit would reduce consumer confusion, improve financial planning, and bolster adherence to treatment plans.

Under the example above under which an issuer chooses to divide by 12 to determine the monthly limit on cost sharing, the monthly limitation on cost sharing during any plan or policy year contained in the multi-year plan, would reflect one-twelfth of the annual limitation for the plan or policy year for which the Federal annual limitation has been calculated, it is our view that this approach is consistent with how the annual limitation on cost sharing must be calculated by plans. Under this proposal to set requirements for catastrophic plans with multi-year terms, issuers would be able to choose the length of the multi-year term up to a maximum of 10 years, and could offer as many or as few such plans as desired, with different maximum terms. Issuers would not be required to offer a 1-year plan that is otherwise identical to each multi-year plan. Catastrophic plans with multi-year terms would continue to be subject to the Affordable Care Act guaranteed availability and guaranteed renewability requirements for individuals who are eligible for catastrophic plans under Federal law (as is the case for catastrophic plans with terms of 1 year). Individuals dropping coverage under a multi-year catastrophic plan, either at the end of the term or mid-term, would be treated the same as individuals dropping coverage under a 1-year policy either at the end of the year or mid-year, respectively, with respect to open enrollment and special enrollment periods. Additionally, other Federal requirements, including, but not limited to, the Mental Health Parity and Addiction Equity Act, The Women's Health and Cancer Rights Act, the Newborns' and Mothers' Health Protection Act, Michelle's Law, and the No Surprises Act, would continue to apply to such coverage.

Under current policy, an enrollee could terminate their enrollment in a multi-year catastrophic plan at any time and for any reason, without a penalty or being liable for the premium for the remainder of the multi-year term. An issuer could discontinue the product or exit the market under the same guaranteed renewability exceptions that apply generally under section 2703 of the PHS Act. That said, we understand the importance of certainty for issuers and enrollees in unlocking the aforementioned benefits of multi-year plans and the improvements in incentives they create. We seek comment on how Federal policies could promote continuous coverage in multi-year plans and defray the risk of termination by either the enrollee or issuer, including by promoting continuous coverage for individuals who churn in and out of the individual market through the use of Individual Coverage Health Reimbursement Arrangements.

All multi-year catastrophic plans would be expected to disclose that the plan has a multi-year term, and the length of that term. To the extent multi-year catastrophic plans utilize the monthly method of applying the annual limitation on cost sharing discussed earlier in this preamble, plans would be expected to include that information in marketing and enrollment materials.

Under this proposal, issuers could apply the deductible that applies in the first year of coverage on an annual basis for each year within the coverage, or divide the annual deductible by 12, and apply it equally to each month of the policy throughout the entire term of coverage, similar to how a multi-year plan could choose to apply the annual limitation on cost sharing, as discussed in this section of the rule. For example, if the plan had an annual deductible of $6,000, it could apply 1/12 of that deductible monthly ($500 per month). We seek comment on if, and the degree to which, a plan could modify the amount of the annual deductible for each year of the multi-year policy.

We acknowledge that multi-year plans in individual health insurance markets represent a novel idea that could necessitate changes to other programs and processes that affect individual and group market plans. For example, we would need to consider how to treat multi-year catastrophic plans for purposes of the HHS-operated risk adjustment program, but in order to do that we would want to consider what the benefits and drawbacks are to each option.

Therefore, we seek comments on all aspects of this proposal, including whether there are any specific plan duration terms that would incentivize enrollees to adopt longer term, health-promoting habits. We also request comment on ways that plans with multi-year terms could be a more affordable option for consumers over single-year terms, including how premiums and rating practices for these plans might differ from other catastrophic plans that have a standard 1-year term; and whether plan terms of more than 10 years would better facilitate rating and promote lower premium products. We also seek comment on if and how any terms of coverage should be permitted to change over the course of the multi-year term, such as reduced deductibles or other cost-sharing, or reduced maximum cost-sharing requirements, and in what intervals could such changes be permitted.

We also request comment on whether any further modifications to HHS risk adjustment regulations under 45 CFR part 153 may be needed to align with any expected differences in rating practices and any resulting risk selection; whether we should use the same catastrophic HHS risk adjustment models regardless of whether the catastrophic plan is offered for a standard plan year or on a multi-year basis or whether we should have separate models or factors for these catastrophic plans (or enrollees in catastrophic plans) offered on a multi-year basis and, if so, what data, trending assumptions, and plan benefit design assumptions should be used for those models; whether we should calculate risk adjustment transfers for catastrophic plans offered for a standard plan year separately from risk adjustment transfers for catastrophic plans offered on a multi-year basis; and whether and how the State average premium term in the State payment transfer formula [147] should be modified to account for the influence of the length of the plan term in regards to the State average premium term of the formula, plan allowable rating factor, or for any other reason. We also request comment on whether and how plans with longer terms should be treated for MLR purposes, particularly whether the current MLR standard set forth in 45 CFR part 158 is appropriate for measuring revenue and claims experience of multi-year plans, and whether multi-year plans should be considered under the same book of business as plans with a traditional 1-year plan term for purposes of MLR. We also seek comment on what incentives or disincentives issuers would have to offer multi-year catastrophic plans, potential administrative barriers for issuers, and how long it would take issuers to develop and offer these plans. We seek comment on whether to require or permit, issuers to offer multi-year terms for individual market catastrophic and metal level plans, and if so, which ones and why. We request comment on potential interactions between this proposal and the health insurance market rules in 45 CFR parts 144 and 147, including rules for guaranteed availability and guaranteed renewability, fair health insurance premiums, specifically with respect to premium variations based on age and restrictions to the 3:1 age rating, and uniform modifications to coverage; and whether more regulatory changes would be needed to effectuate this policy. Finally, we request comment on how this proposal would exist and interact with other laws related to tax policy such as health savings accounts and individual coverage health reimbursement arrangements, and any changes, either to this proposal or such other laws, that would resolve any such conflict between this proposal and those laws.

[147] For resources explaining the State payment transfer formula, see Pope, G.C., *et al.* (2014). Risk Transfer Formula for Individual and Small Group Markets Under the Affordable Care Act. *Medicare and Medicaid Research Review, 4*(3). Available at: *https://www.cms.gov/mmrr/downloads/mmrr2014_004_03_a04.pdf.* See also the 2014 Payment Notice (78 FR 15410, 15428 through 15434).

7. Cost Sharing for Bronze and Catastrophic Plans (§§ 156.136 and 156.155)

To address an issue that has arisen in the implementation of section 1302(c) through (e) of the Affordable Care Act, we propose changes to the permissible cost-sharing parameters for individual market bronze plans through new proposed § 156.136 and to the required cost-sharing parameters for catastrophic plans through revisions to § 156.155(a)(3).

Section 1301(a)(1)(B) of the Affordable Care Act directs all issuers of QHPs to cover the EHB package described in section 1302(a) of the Affordable Care Act, which includes coverage of the benefits described in section 1302(b) of the Affordable Care Act, adherence to the cost-sharing limits described in section 1302(c) of the Affordable Care Act, and meeting the AV levels established in section 1302(d) of the Affordable Care Act.

Section 2707(a) of the PHS Act, which is effective for plan or policy years beginning on or after January 1, 2014, extends the requirement to cover the EHB package to non-grandfathered individual and small group health coverage, irrespective of whether such coverage is offered through an Exchange. In addition, section 2707(b) of the PHS Act directs non-grandfathered group health plans to ensure that cost sharing under the plan does not exceed the limitations described in section 1302(c)(1) of the Affordable Care Act.

Section 2707(a) of the PHS Act and section 1302 of the Affordable Care Act direct issuers of non-grandfathered individual and small group health insurance plans (including QHPs) to ensure that these plans adhere to the levels of coverage specified in section 1302(d)(1) of the Affordable Care Act (except for catastrophic plans described in section 1302(e) of the Affordable Care Act). Section 1302(c) of the Affordable Care Act limits the annual cost sharing incurred under a health plan to the maximum annual limitation on cost sharing. Section 1302(d)(2) of the Affordable Care Act provides that a level of coverage of a plan, or its AV, is determined based on its coverage of the EHB for a standard population. Section 1302(d)(1)(A) through (D) of the Affordable Care Act requires a bronze plan to have an AV of 60 percent, a silver plan to have an AV of 70 percent, a gold plan to have an AV of 80 percent, and a platinum plan to have an AV of 90 percent. Section 1302(d)(2) of the Affordable Care Act directs the Secretary to issue regulations on the calculation of AV and its application to the levels of coverage. Section 1302(d)(3) of the Affordable Care Act requires the Secretary to develop *de minimis* variations in AV calculations.

Section 1302(e) of the Affordable Care Act permits an individual market health plan not providing a bronze, silver, gold, or platinum level of coverage to be a catastrophic health plan that is treated as meeting the levels of coverage specified in section 1302(d)(1) of the Affordable Care Act for a plan year. A catastrophic plan may be offered only in the individual market and only to qualified individuals who have not attained age 30 before the beginning of the plan year, or to qualified individuals who are exempt from the requirement to maintain minimum essential coverage under section 5000A of the Internal Revenue Code by reason of a hardship exemption or an exemption described in section 5000A(e) of the Internal Revenue Code relating to the affordability of coverage. Catastrophic coverage must provide coverage for the EHB and must meet the statutory requirement to cover at least three primary care visits before the plan deductible is applied. In addition, catastrophic plans must comply with all other requirements applicable to QHPs except those specifically modified by section 1302(e) of the Affordable Care Act, and they must be offered through the Exchange in the same manner as other qualified health plans. We codified the requirements for catastrophic plans at § 156.155 in the Exchange Establishment Rule.

In the sections that follow, we provide an overview of how HHS has implemented the AV requirements of the Affordable Care Act, including a discussion of the major components of AV calculation. We go on to explain that we have discovered an inherent and unavoidable issue for implementation of the cost-sharing provisions of the EHB package in section 1302(c) through (e) of the Affordable Care Act that will eventually make issuer compliance with all these provisions mathematically

impossible. This issue has first become evident with respect to bronze and catastrophic plans, though without further changes, it will eventually impact silver plans and plans at higher metal tiers. To mitigate the worsening issue, we propose to create new optional cost-sharing parameters for bronze plans and to revise the cost-sharing requirements for catastrophic plans in the individual market only.

a. The Three Major Components of AV Calculation

AV is the anticipated covered medical spending for coverage of EHB [148] paid by a health plan (1) for a standard population, (2) computed in accordance with the plan's cost sharing (that is capped by the maximum annual limitation on cost sharing), and (3) divided by the total anticipated allowed charges for EHB coverage provided to the standard population. The denominator of this calculation is the average allowed cost of all services for the standard population in the year for a specified metal tier; the numerator is the share of average allowed cost covered by the health plan, using the cost-sharing parameters specified. These are the three major components of AV calculation, and year-over-year changes in each of them influence how AV calculation changes year-over-year.

AV Component #1: The Standard Population. In accordance with section 1302(d)(2)(A) of the Affordable Care Act, HHS develops and provides a standard population for the AV Calculator that resemble enrollees who are likely to be covered by individual and small group market health insurance in a particular year. The costs and utilization of this population are currently derived from the enrollee-level EDGE data. As the AV Calculator Methodology that HHS releases each year in connection with the AV Calculator describes in detail,[149] we apply adjustments to the claims and enrollment data of the standard population, including weighting to account for the expected demographic distribution across individual and small group plans, and use it to create a series of continuance tables that underlie the AV Calculator. Our annual updates to the AV Calculator's standard population ensure accordance with generally accepted actuarial principles and methodologies. Generally, the claims and enrollment data indicate that the standard population is costlier to cover each year, which leads to a corresponding rise in AV each year. If we did not update the AV Calculator to account for changes in the standard population, the AV Calculator would not accurately account for the enrollees who are likely to be covered by individual and small group market health insurance in a particular year, and would be increasingly nonrepresentative of the people who enroll in metal-tier plans.

AV Component #2: The Maximum Annual Limitation on Cost Sharing. Section 1302(c) of the Affordable Care Act sets the maximum annual limitation on cost sharing [150] which limits an enrollee's overall financial responsibility by restricting the maximum out-of-pocket (MOOP) limit for a plan. For PY 2014, section 1302(c)(1)(A) of the Affordable Care Act sets this limit at the maximum cost-sharing limit for high-deductible health plans (HDHPs) under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986—that is, $6,350 for a self-only plan. Section 1302(c)(1)(B) of the Affordable Care Act requires HHS to update the maximum annual limitation on cost sharing annually. For plan years after 2014, section 1302(c)(1)(B)(i) of the Affordable Care Act sets the limit for a self-only plan at the product of the 2014 value and the PAPI, the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance coverage for 2013.[151] Under section 1302(c)(1)(B)(ii) of the Affordable Care Act, the maximum annual limitation on cost sharing for other plans, like coverage other than self-only, is twice the limit of a self-only plan. In accordance with § 156.130(e), in years where HHS is not making methodological changes, HHS will release the PAPI in guidance that will include the maximum annual limitation on cost sharing amount for the applicable benefit year.[152] Using PAPI, the maximum annual limitation on cost sharing for self-only coverage has risen from $6,350 in PY 2014 to $12,000 in PY 2027 (see Table 8).

[148] As defined in 45 CFR 156.110(a).

[149] For an example of the methodology, see *https://www.cms.gov/files/document/updated-revised-final-2026-av-calculator-methodology-september-2025.pdf.*

[150] Cost sharing is defined at § 156.20 as any expenditure required by or on behalf of an enrollee with respect to EHB; the term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers that are not prohibited by the No Surprises Act, and spending for non-covered services.

[151] See section 1302(c)(4) of the Affordable Care Act.

[152] In the 2025 Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability final rule (90 FR 27074, 27166 through 27168 (June 25, 2025)), HHS finalized a change to the methodology for calculating the premium adjustment percentage such that the average per capita premium will be based on the National Health Expenditure Accounts (NHEA) estimates of private health insurance (PHI) premiums (excluding Medigap and the medical portion of property and casualty insurance) for the 2026 benefit year and beyond. As discussed in this proposed rule, for the 2027 benefit year, HHS is not proposing changes to the methodology to calculate the premium adjustment percentage or related parameters. As such, for the 2027 benefit year, we released these parameters in guidance entitled ''Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year.'' Available at: *https://www.cms.gov/files/document/2027-papi-parameters-guidance-2026-01-29.pdf.*

TABLE 8: Maximum Annual Limitations on Cost Sharing For Self-only Coverage By Year

Year	Maximum Annual Limitation on Cost Sharing, Self-Only	Percentage Increase from Previous Year
2014	$6,350	N/A
2015	$6,600	3.94%
2016	$6,850	3.79%
2017	$7,150	4.38%
2018	$7,350	2.80%
2019	$7,900	7.48%
2020	$8,150	3.16%
2021	$8,550	4.91%
2022	$8,700	1.75%
2023	$9,100	4.60%
2024	$9,450	3.85%
2025	$9,200	-2.65%
2026	$10,600	15.22%
2027	$12,000	13.21%

The maximum annual limitation on cost sharing impacts AV calculation since it changes the maximum amount that an enrollee may have to pay out-of-pocket each year. When the maximum annual limitation on cost sharing increases from year-to-year (which it typically does), it has the effect of decreasing year-over-year AVs. This is because plans can increase their MOOPs with a higher maximum annual limitation on cost sharing, which means enrollees typically need to pay more out-of-pocket for the EHB than they did in previous years, which would lower AV.

AV Component #3: EHB Costs. We also adjust the AV Calculator each year with an update to the cost of EHB that is provided to the AV Calculator's standard population, again to ensure accordance with generally accepted actuarial principles and methodologies and section 1302(d)(2)(A) of the Affordable Care Act. We project historical claims data for medical items and services and prescription drugs covered as EHB for the standard population for the next plan year. We often refer to this projection as the ''trend factor.'' For years that we used a trend factor in the AV Calculator, we have set it for an increase of between 3.25 percent and 6.50 percent for medical costs and between 6.50 percent and 11.50 percent for prescription drug costs.[153] Table 9 sets forth the AV Calculator trend factors from 2014 to 2026.

[153] For PYs 2014–2017, we applied a single trend factor for medical and prescription drug costs combined. We began applying different trend factors for medical and prescription drug costs in 2018.

TABLE 9: AV Calculator Trend Factors By Year, Percent

AV Calculator	Medical Claims Trend Factor	Prescription Drug Claims Trend Factor
2014	6.50	
2015	0.00	
2016	6.50	
2017	6.50	
2018	3.25	11.50
2019	5.40	11.50
2020	6.10	9.80
2021	5.40	8.70
2022	0.00	0.00
2023	5.80	8.70
2024	5.40	8.20
2025	6.40	9.90
2026	6.40	10.10

We review a variety of data sources on medical services and prescription drug claims costs, including rate data from the Unified Rate Review Templates (URRTs) and National Health Expenditure data from the HHS Office of the Actuary, to develop and select the proposed adjustment to health care costs. This health care cost update also impacts AV calculation; as health care becomes more expensive, the generosity of a plan's AV increases as an enrollee needs to receive less medical care than in previous years to reach the maximum annual limitation on cost-sharing. If we did not apply this trend factor, the AV Calculator would not account for changes in the cost of health care and would be less and less accurate each year, inconsistent with section 1302(d)(1)(A)'s instruction to calculate AV based on the ''actuarial value of the benefits provided under the plan.''

b. The Rates of Change for the Three Major AV Components

Together, these three major components of AV calculation affect AV differently each year, depending on how the health of the standard population, the maximum annual limitation on cost sharing, and EHB costs all change, and at different rates. Ideally, the effect of a higher statutory maximum annual limitation on cost sharing each year would allow plans to exactly offset the year-over-year increase on AV created by the more expensive standard population and increased EHB costs required by the statute. That would mean that the net impact of the three major factors on AV would be zero each year, and in turn any particular plan with the same cost-sharing structure would have the same AV year-over-year. We believe this is the actuarially preferred approach, because it would allow for relatively consistent cost sharing and benefits design year-over-year, which promotes consumer understanding. However, plans do not have the same AVs each year because the three factors change at different rates.

For nearly every year since 2014, the effect of updating the AV Calculator with the most recent data on the standard population and health care costs has led to a faster rise in AV with the same cost sharing structure than can be mitigated by the effect that a higher maximum annual limitation on cost sharing has on decreasing AV.[154] In other words, the effects of updating the standard population and health care costs every year to maintain the accuracy of AV calculations typically results in AVs increasing year-over-year, and the effects of an increased maximum annual limitation on cost sharing make AVs decrease year-over-year, but not enough to offset the standard population and health care costs. This is the outcome of the PAPI—calculated from the percentage difference between the average per capita premium for health coverage for the preceding calendar year and the average per capita premium for health coverage for 2013—being outpaced by the increasing costs of the health care for the population enrolling in metal-tier plans. This means that we expect that a particular plan with the same cost-sharing structure has a *higher* AV year-over-year, even if nothing about the plan changes. We discussed this previously as long ago as 2016 in the

[154] There is one year that is an exception. The maximum annual limitation on cost sharing decreased for PY 2025 due to updated NHEA data from the CMS Office of the Actuary. In the NHEA Projections 2021–2030 data set available at the time of calculation of the PY 2024 maximum annual limitation on cost sharing, the estimated 2023 per capita employer-sponsored insurance (ESI) premiums value used in the premium adjustment percentage index calculation was $7,292. In the NHEA Projections 2022–2031 data set available at the time of the calculation of the PY 2025 maximum annual limitation on cost sharing, the estimated 2024 per capita ESI premiums value used in the premium adjustment percentage index calculation was $7,110, which was lower than the previously projected 2023 per capita ESI premiums from the previous data set. *See* Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2025 Benefit Year (November 15, 2023) available at *https://www.cms.gov/files/document/2025-papi-parameters-guidance-2023-11-15.pdf. See also,* the Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2024 Benefit Year (December 12, 2022) available at: *https://www.cms.gov/files/document/2024-papi-parameters-guidance-2022-12-12.pdf.* The current NHEA projections are available at: *https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected.*

2018 Payment Notice proposed rule [155] and most recently in the Marketplace Integrity and Affordability final rule.[156]

This shift often forces issuers to change other parts of a plan's cost-sharing structure to (make the plan less generous to) conform to the relevant *de minimis* ranges that we permit for plans at § 156.140 in accordance with section 1302(d)(3) of the Affordable Care Act. Such changes are not actuarially sound, because the same plan, with the same cost-sharing structure, should have generally the same AV year-over-year. Over the years, as explained below, we have also modified the methodology by which issuers calculate AV, in an effort to mitigate some of these challenges. However, modifications made to ensure that plans at a certain metal tier can continue to exist do not carry the level of fidelity to AV calculation that may be justified by generally accepted actuarial principles and methodologies, and we believe we have reached a point which further modifications would undermine the integrity of AV calculation and threaten our ability to implement section 1302(d) of the Affordable Care Act in such a manner.

The discrepancy in the rates of change of the three components have a magnified effect on the ability of issuers to design plans that conform to the *de minimis* ranges or that offer what issuers consider desirable; thus, issuers have narrower options to adjust cost sharing in their plan offerings each year. If current trends persist, eventually the maximum annual limitation on cost sharing will be too low to allow for an AV calculation for the most basic bronze plan design, with a deductible set to the maximum annual limitation on cost sharing, that is within widened *de minimis* ranges, even with the use of an AV Calculator that caps claims. Thus, an actuarial issue exists in the implementation of the statutory text of section 1302(c) through (e) of the Affordable Care Act and the observed differences in the trend rates of the competing factors: PAPI (setting the maximum annual limitation on cost sharing and therefore plans' MOOP limit) and AV (which rises with increasing claims costs), discussed in greater detail in later lettered subsections.

Since we expanded the bronze *de minimis* range in 2018, we have seen a clear increase in the percentage of bronze plans at the upper end of the permissible *de minimis* range (+5 percent). In 2025, approximately 18 percent of FFE bronze plans were not in the expanded *de minimis* range, down from approximately 81 percent in 2018.

TABLE 10: Percentage of FFE Bronze Plans by AV Percentage, 2018-2025[157]

AV	2018	2019	2020	2021	2022	2023	2024	2025
56.00 to <57.00%	9*	9*	0*	0*	0*	N/A	N/A	N/A
57.00 to <58.00%	1*	0*	5*	0*	0*	N/A	N/A	N/A
58.00 to <59.00%	6	11	2*	0*	0*	0*	0*	0*
59.00 to <60.00%	4	6	10	0*	0*	15	0*	8
60.00 to <61.00%	27	7	7	0*	0*	6	9	2
61.00 to <62.00%	34	36	15	20	17	6	3	8
62.00 to <63.00%	9	8	25	2	5	3	5	11
63.00 to <64.00%	2	8	10	10	8	12	9	46
64.00 to ≤65.00%	8	14	24	68	70	59	73	26

Today, bronze plans appear increasingly more as silver plans than bronze plans. As previously noted, over the years we have changed the methodology underlying the AV Calculator (for example, by imposing a spending cap) and expanded the *de minimis* ranges (for example, by creating expanded bronze plans) in order to allow bronze plan viability. However, we believe that further changes to the AV Calculator methodology and *de minimis* ranges for the purpose of preserving bronze plans would near the outer boundary of our statutory authority to address this issue under section 1302(d)(3) of the Affordable Care Act. When bronze plans have an AV between 62 and 65 percent, they are closer to the bottom of the silver *de minimis* range (66 percent) than they are

[155] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Proposed Rule, 81 FR 61456, 61510 (September 6, 2016).

[156] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 FR 27075, 27175 (June 25, 2025).

[157] After the 2023 Payment Notice raised the lower bound of the permitted AV *de minimis* range from −4 percent to −2 percent, no bronze plans could be certified as a QHP with an AV below 58 percent. In Table 10, where bronze plans' AVs are not permitted, they are marked ''N/A''. The asterisks are used to indicate when that AV percentage is nearly impossible to reach for a bronze plan through its cost sharing design. The non-zero numbers marked with an asterisk represent actual bronze plans that had an even lower AV calculated than for a theoretical bronze plan that only provides non-preventative benefit coverage after an enrollee has reached their MOOP, with the MOOP set as equal to the given plan year's annual limitation on cost sharing. Bronze plans with AVs calculated as lower than this minimum-generosity design are no longer possible after an algorithm improvement in the 2021 AV Calculator, which ensured that plans using ''copay with deductible'' would no longer have an underestimated AV (due to previous AV Calculators overestimating enrollee spending during the plan's deductible phase).

to the bottom of the bronze *de minimis* range (56 percent or 58 percent, depending on the year). This clearly undermines the integrity of silver plan cost-sharing designs and makes it more difficult for consumers to distinguish between the two metal tiers.

However, the maximum annual limitation on cost sharing limits issuers' options in bronze plan design. We believe issuers may have designed competitive plans that would be attractive for bronze plan consumers but that are ineligible for sale because they need to have a higher MOOP than is permissible under the maximum annual limitation on cost sharing. Specifically, the existing permissible MOOP leads to issuers offering higher deductible bronze plans over time because costs have risen faster than the permissible MOOP, requiring plans to raise cost-sharing below the permissible MOOP to meet the AV range for bronze plans. By 2024, the average deductible for bronze plans exceeded $7,000. With a $9,450 maximum annual limitation on cost sharing that year, these plans look increasingly like catastrophic plans with a deductible that is almost set to the maximum annual limitation on cost sharing, and this includes expanded bronze plans that have an AV of up to 65 percent. The convergence of non-expanded bronze plans with catastrophic plan design is even more stark when viewing the median (or midpoint) of the deductibles and MOOPs of all the bronze plans offered on the FFEs alongside the maximum annual limitation on cost sharing over the last few years (Table 11).

TABLE 11: Median Deductible and Median MOOP of non-expanded FFE Bronze Plans, and the Maximum Annual Limitation on Cost Sharing, 2023-2026

	2023	2024	2025	2026
Median Deductible of Bronze (58%-62% AV) Plans	$9,100	$9,100	$9,200	$10,600
Median MOOP of Bronze (58%-62% AV) Plans	$9,100	$9,450	$9,200	$10,600
Maximum Annual Limitation on Cost Sharing	$9,100	$9,450	$9,200	$10,600

This convergence in the deductible and MOOP in these plan designs with the maximum annual limitation on cost sharing occurred at the same time the AV of bronze plans increased (Table 10). If issuers lowered deductibles in existing bronze plans but held their MOOP and average copayment rate between the deductible and MOOP constant, those plans would have higher AVs and risk appearing more like silver plans than bronze plans, or having to meet the requirements described at § 156.140(c) to be an expanded bronze plan. Issuers could feasibly lower the AV of their bronze plans by raising the deductible in those plans, but few offer such plans (Table 10).

Plans could increase their MOOP in order to offer plans with lower deductibles and copayment rates. Variation in MOOPs and deductibles across bronze plans in 2024 reveals that, for the median bronze plan a $1 higher MOOP is associated with a 58 cent lower deductible. There is less response to the MOOP in higher metal tiers, consistent with the idea that the MOOP affects deductibles more at lower AV levels. However, as claims continue to rise at a rate greater than the growth in the statutory maximum annual limitation on cost sharing (due to rising faster than the index calculated based on how much premiums have increased), a higher MOOP may eventually be warranted to tamp down deductibles for plans seeking to maintain their AV compliance with higher metal tiers than bronze, as well. However, the deductible and MOOP of most plan designs at the other metal tiers have not converged with the maximum annual limitation on cost sharing; in other words, silver plans and higher metal tier plans appear to still have appropriate flexibility in their cost sharing design, as observed by their wider ranges of deductibles, pre-deductible coverage, and MOOPs compared to non-expanded bronze plans (see Table 11).

Of the metal plans, bronze plans are most susceptible to increases in AV because they have the lowest AV (60 percent), and the highest allowable maximum annual limitation on cost sharing typically requires issuers to cover more than 60 percent of allowed claims. Issuers have fewer options to adjust the cost sharing for bronze plans compared to other metal level plans and, as noted previously, are increasingly designing them to have a deductible near or equal to the maximum annual limitation on cost sharing. To address this increase in AV for bronze plans in the short-term, we have already utilized the authority at section 1302(d)(3) of the Affordable Care Act to revise § 156.140(c) to expand the allowable de minimis range for bronze plans to a maximum of 65 percent AV, and refer to these plans as ''expanded bronze'' plans.[158]

[158] Expanded bronze plans are bronze plans currently referenced in § 156.140(c) that cover and pay for at least one major service, other than preventive services, before the deductible or meet the requirements to be a high deductible health plan within the meaning of section 223(c)(2) of the Code. (81 FR 94058).

We began to reduce the distortion created by outliers with very high spending in the AV Calculator's standard population beginning in 2021 by implementing a cap on enrollee spending at $1,000,000. In later years, we capped enrollee spending at the 99.50th percentile of annual allowed amounts for all enrollees in the claims data. Without this cap, many, if not all, bronze plan designs would already be non-viable. For example, utilizing the 2027 version of the AV Calculator without the enrollment cap, we estimate that all bronze plan AVs would be 5 to 6 percentage points higher than with it. Based on internal analysis, all existing non-expanded bronze plans offered in the FFEs in PY 2026 would have an average AV of 65.1 percent if calculated using an AV Calculator that did not apply the enrollment cap. The simulated AV results range from 64.5 percent to 68.0 percent, which is much higher than the currently permitted maximum of 62 percent. We further estimated the effect on the other metal levels without the cap and found standard silver AVs would be 4 to 5 percentage points higher; gold plan AVs would be 1 to 2 percentage points higher; and platinum plan AVs would be up to 1 percent higher.

As AVs increase year-over-year, absent some other administrable regulatory solution, we may need to consider continuously expanding the cap on enrollee spending beyond the 99.50th percentile in order to preserve plan design viability, particularly for bronze plans. We know expanding this

cap is not a permanent solution. The AV Calculator becomes less accurate, and less representative of the standard population as more and more enrollees are excluded from it. Moreover, continued cap expansion does not align with the statutory requirements for determining the AV. While the initial cap may have reasonably been set from the Secretary's discretion to define a standard population, the continued expansion of cap clearly serves a separate purpose. However, without it, bronze plans will eventually become entirely non-viable, which is not a result that Congress could have intended. Thus, an issue exists in the implementation of sections 1302(c) through (e) of the Affordable Care Act and, to date, we have chosen to address it by applying flexibility in the determination of the AV. However, if current trends persist (and we have no reason to believe they will not), eventually the maximum annual limitation on cost sharing will be too low to allow for an AV calculation for a bronze plan design with a deductible set to the maximum annual limitation on cost sharing that is within widened *de minimis* ranges, even with an AV Calculator that uses a spending cap.

We are not aware of any administrable, actuarially sound regulatory alternatives that we might propose that could address these issues to preserve the integrity of AV calculations and the comparability between the levels of coverage. As discussed above, we can continue to expand the cap on enrollee spending beyond the 99.50th percentile as a temporary solution, but we hesitate to do so in order to preserve the integrity of AV calculations, as section 1302(d)(1)(A) of the Affordable Care Act directs the calculation of AV based on the ''actuarial value of the benefits provided under the plan. We have also considered not trending the AV Calculator to account for changes in the standard population or for changes in EHB costs. This would make AV rise less quickly year-over-year. However, we believe doing so would render the AV Calculator wholly inaccurate actuarially. We have also considered proposing changes to EHB policy to reduce the scope of benefits that are covered as EHB to address this issue, but the calculation of AV does not so readily factor in the scope of covered benefits under the plan. We believe that changing the current EHB benchmark framework and potentially making significant changes to covered benefits is an extreme approach that would yield minor benefits, if any because AV is a measurement of the cost sharing imposed by an issuer on whatever benefits the plan covers as EHB, and not a measurement of the EHB themselves. Additionally, section 1302(b)(2)(A) of the Affordable Care Act requires HHS to define the EHB to cover items and services covered within 10 specific categories of benefits such that their scope is equal to the scope of benefits provided under a typical employer plan; the statute does not create ability to define the EHB in order to accommodate AV calculations. In addition, we believe there are no changes to the PAPI methodology that would raise the annual limitation on cost sharing enough to preserve the viability of AV calculations, even in the short-term, though we solicit comment on whether there are any regulatory changes we might make to the PAPI that would address this AV issue.

We seek comment on other administrable regulatory alternatives that we might consider that could address these issues to preserve the integrity of AV calculations and the comparability between the levels of coverage long-term. However, at this time, we believe no administrable alternatives exist because the issue is one of innate mathematical incongruence, not methodological decisions. In the end, we believe the differing rates of changes between the three major factors of AV calculation pose an insurmountable regulatory problem created by the cost-sharing provisions of section 1302 of the Affordable Care Act.

c. Statutory Adherence

Below, we propose to revise the cost-sharing parameters for bronze plans and to revise the cost-sharing requirements for catastrophic plans, respectively, in order to adhere to the cost-sharing provisions of section 1302 of the Affordable Care Act, given this regulatory issue.

Consistent with longstanding principles of statutory interpretation, we seek to give effect to all provisions of the Affordable Care Act so that they operate together in a coherent structure.[159] The Supreme Court has recognized that agencies should adopt statutory interpretations that harmonize related provisions wherever possible and should implement statutes in a manner that advances the overall statutory scheme.[160] However, where two statutory requirements cannot reasonably be satisfied simultaneously, an agency must act in a manner that best effectuates congressional intent and preserves the operability of the relevant statutory framework.[161]

We believe that maintaining the AV requirement for metal-level plans is the more specific and operational statutory instruction, and adherence to it best serves Congress' intent. The AV requirement applies only to a defined subset of plans offered in the individual and small group markets, and establish precise quantitative benchmarks that define the statutory coverage tiers themselves. By contrast, the maximum annual limitation on cost sharing applies broadly across all plan types and markets and functions as a general consumer protection ceiling rather than a plan-defining metric. In addition, compliance with the AV requirements necessitates detailed, plan-level calibration of cost-sharing parameters and is central to preserving Congress' deliberate creation of distinct metal-level coverage categories, whereas the maximum annual limitation on cost sharing operates as a uniform backstop that does not distinguish among plan types. Thus, we are prioritizing the highly specific statutory AV requirement over the generally applicable maximum annual limitation on cost-sharing.

Interpreting the AV requirement as the more specific statutory directive is consistent with how the Affordable Care Act, as originally passed, treated another conflict between cost-sharing limits and AV calculations. As originally passed, the Affordable Care Act included an annual limitation on deductibles for employer-sponsored plans under section 1302(c)(2) of the Affordable Care Act.[162] Recognizing that this limitation would conflict with the AV, the statute provided that the limitation ''shall be applied in such a manner so as to not affect the actuarial value of any health plan, including a plan in the bronze level.'' [163] Congress ultimately entirely abandoned any limitation on deductibles for employer-

[159] See *FDA* v. *Brown & Williamson Tobacco Corp.,* 529 U.S. 120, 133 (2000) (explaining that statutes should be interpreted as a ''symmetrical and coherent regulatory scheme''); *Gustafson* v. *Alloyd Co.,* 513 U.S. 561, 570 (1995) (statutory provisions should not be interpreted in a manner that renders any part ''superfluous'').

[160] See *King* v. *Burwell,* 576 U.S. 473, 492 (2015) (recognizing that reviewing courts will exercise independent judgment in evaluating whether the agency has acted within its statutory authority and noting that the Affordable Care Act's statutory language must be read in context and in light of the statute's structure and purpose).

[161] See *Loper Bright Enters.* v. *Raimondo,* 603 U.S. 369, 412 (2024).

[162] See Patient Protection and Affordable Care Act, Public Law 111–148 § 1302(c)(2), 124 Stat. 119, 166 (Mar. 23, 2010).

[163] *Id.* Section 1302(c)(2)(C) of the Affordable Care Act.

sponsored plans in 2014, while leaving in place the relevant AV requirements.[164] This statutory history suggests that Congress did not intend maximum annual cost-sharing requirements employer-sponsored plans to disrupt the AV calculation requirements.

For these reasons, we conclude that the proposals that follow represent a reasonable and legally permissible approach to implementing section 1302 that gives effect to Congress' core design of distinct coverage tiers while preserving the overall operability of the statutory framework. Accordingly, these proposals reflect our obligation to implement section 1302's interrelated provisions in a manner that is understandable and workable.

d. An Incremental Approach

Before turning to our proposals for bronze and catastrophic plans beginning with PY 2027, we note that any regulatory framework that permits plans to exceed the maximum annual limitation on cost sharing should be as limited as possible in order to still implement section 1302(c) through (e) of the Affordable Care Act so that these paragraphs operate together in as coherent a structure as Congress could have intended. Since the issue becomes more pronounced each year due to the growing disparity in the rates of change among the three major components of AV calculation, absent a statutory change, we believe we should implement regulatory solutions in a gradual, proportional manner.

To that end, we view the set of proposals that follow as only the beginning of necessary regulatory changes to the cost-sharing parameters for metal-tier and catastrophic plans. Catastrophic and bronze plans are the two plans most demonstrably and presently affected by this issue, and so we propose changes to the cost-sharing parameters for these plans first in the hopes of giving enrollees more PY 2027 options at lower premiums and with more attractive plan designs. Because we seek to minimize the extent that these plans may exceed the maximum annual limitation on cost sharing, we anticipate proposing future amendments to the applicable regulations through notice and comment rulemaking to address other metal tiers—at the point that the growing disparity in the rates of change among the three major components of AV begins to affect these higher tiers, and after sufficient research into how to prevent unintended effects on the calculation of premium tax credits.

As demonstrated above, standard silver plans would already be non-viable if we had not already adjusted the standard population by capping enrollee spending at the 99.50th percentile of annual allowed amounts for all enrollees in the claims data. We considered proposing changes to the permissible cost-sharing parameters for silver plans in this rule but chose not to at this time. Rather, our intent in the future would be to propose changes to the cost-sharing parameters for silver plans, when necessary, through future notice and comment rulemaking. Second-lowest cost silver plans are used as the benchmark to determine premium tax credit amounts. Seeking changes to the permissible cost-sharing parameters for silver plans could have an outsized impact on the overall affordability of plans for subsidized enrollees, and we seek to minimize any destabilizing effects of this proposed policy by assuming such an incremental regulatory approach. For now, we will monitor and consider future incremental action we may take to change the cost-sharing parameters for the other metal tiers, and we invite comments about how we might calculate an appropriate threshold for flagging that the cost sharing incongruence is severely limiting silver plan design. We also seek comment on other implications that may exist for silver plans that do not exist for bronze and catastrophic plans.

e. Bronze Plan Cost-Sharing Parameters

To ensure that plans designated at the bronze metal level can continue to exist in the future and to also preserve a meaningful difference between the AVs of bronze and silver plans, which we believe was part of the congressional intent of having metal tiers, we propose to add new § 156.136 that states, for plan years beginning on or after January 1, 2027, if an issuer offers a bronze plan (as defined at § 156.140(b)(1)) in the individual market that complies with the cost-sharing requirements at § 156.130 and the levels of coverage requirements at § 156.140, it may also offer, within the same service area, bronze plans that utilize a cost-sharing design that exceeds the maximum annual limitation on cost sharing at § 156.130 by amounts in increments of 50 dollars in order to achieve an AV within the standard bronze *de minimis* variation at § 156.140(c), calculated as described in § 156.135.

We further propose, that, in order for an issuer to avail itself of the ability to offer individual market bronze plans that utilize a cost-sharing design that exceeds the maximum annual limitation on cost sharing, the issuer must also offer at least one individual market bronze plan in the same service area that utilizes a cost-sharing design that does not exceed the maximum annual limitation on cost sharing at § 156.130 and complies with the levels of coverage requirements at § 156.140. This proposed flexibility is necessary to support the design and offering of bronze plans with AVs closer to the 60 percent intended by the Affordable Care Act. The MOOP for such individual market bronze plans must be in increments of 50 dollars. Under this proposal, we would not specify a strict dollar amount as the upper bound by which issuers could exceed the maximum annual limitation on cost sharing; rather, issuers would calculate this amount so that it fits within the narrower bronze *de minimis* range at § 156.140(c). We do not believe it is necessary set such an upper bound because plan MOOPs would still be restricted by the requirement that the plan's AV to comply with the levels of coverage requirements at § 156.140. However, we seek comment on whether we should set a strict dollar amount as the upper bound by which issuers could exceed the maximum annual limitation on cost sharing upon finalization of this rule, and if so, what the upper bound should be.

In addition, limiting this additional flexibility for bronze plans to issuers that also offer a bronze plan that complies with the existing cost-sharing requirements in the same service area ensures that, to the extent a bronze plan is available, there would be at least one in the service area that meets the maximum annual limitation on cost sharing. By allowing a wider range of possible cost-sharing designs at the bronze metal tier in the individual market, we create opportunities for issuers to offer plans that are appealing to more consumers with lower premiums and more pre-deductible coverage than would have been possible without this proposal.

We considered imposing no precondition that issuers offer a bronze plan within the same service area that utilizes a cost-sharing design that does not exceed the maximum annual limitation on cost sharing at § 156.130 in order to offer bronze plans that utilize a cost-sharing design that exceeds the statutory maximum annual limitation on cost sharing. However, we believe the precondition is necessary at this time because bronze plans are barely still viable in 2027 without the 99.50th

[164] See Protecting Access to Medicare Act of 2014, Public Law 113–93 § 213, 128 Stat. 1040, 1047 (April 1, 2014).

percentile cap (a bronze plan with a deductible equal to maximum annual limitation on cost sharing has an AV of 63.91 percent in 2027) and we believe consumers must retain access to bronze plans that do not exceed the maximum annual limitation on cost sharing so that we can best signal our good faith efforts to adhere to the statute.

If it is no longer possible to design a bronze plan with a MOOP set at or below the maximum annual limitation on cost sharing and a permissible bronze AV, then it would also no longer be possible to take advantage of this new proposed flexibility in bronze plans' allowed MOOP limit: as in, it would no longer be possible to additionally offer a non-expanded (standard) bronze plan with a higher MOOP limit. The proposed flexibility relies on the issuer already offering a bronze plan in the same service area which has a permissible bronze AV and complies with that plan year's maximum annual limitation on cost sharing as a prerequisite to setting a higher MOOP for additional bronze plans. If the market reaches this point, as we are warning in this rule—that a bronze plan with a MOOP set at the maximum annual limitation on cost sharing will be unable to fit within the bronze AV *de minimis* range according to that year's AV Calculator—we will need to propose a new approach to maintaining bronze plans' viability through future notice-and-comment rulemaking.

Thus, we intend to require such plans for as long as these bronze plan remain actuarially viable; however, pursuant to the overall incremental approach described earlier, we may revisit this precondition in future rulemaking as AVs continue to rise. Given these circumstances, we are considering and request comment on whether we should allow an adjustment to the result of the AV Calculator (which uses the 99.50th percentile cap) that approximates an AV calculation based on a standard population which includes those highest-cost enrollees (*i.e.,* approximates what the AV output would be from an AV Calculator which includes claims from the 0.50th highest percentile). We seek comment on how to better align with standard actuarial practice in our interpretation of the AV Calculator's outputs in light of the statutory incongruence described in this section, and how future AV Calculators might appropriately include more of these high-cost enrollees in its standard population without causing unnecessary disruption to existing plans that seek to remain in the same metal tier in the following plan year. Alternatively, we seek comment on whether an issuer should be permitted to offer bronze plans which exceed the maximum annual limitation on cost sharing in order to achieve an AV between 58 and 62 percent only after a default adjustment to the 2027 AV Calculator's output for that plan design which approximates what the plan's AV would be if measured by an AV Calculator without a spending cap, and on whether a future release of the AV Calculator, such as the PY 2028 AV Calculator, could reduce or remove the spending cap.

We further propose that this flexibility would apply only in the individual market. Specifically, we believe that individual market consumers in particular would be interested in more plan choices offering lower deductibles and lower premiums. We believe that prospective consumers who do not qualify for APTCs may be deterred from enrolling in individual market plans due to the benefit design of current bronze plans. Providing additional plan design flexibility may encourage individual market enrollment and in turn promote a healthier risk pool by capturing currently uninsured people.

As already is the case, States that are the primary enforcers of AV standards would be responsible for ensuring that issuers that design bronze plans that exceed the maximum annual limitation on cost sharing do so to achieve an AV within the standard (non-expanded) bronze *de minimis* ranges at § 156.140(c). Title XXVII of the PHS Act contemplates that States will exercise primary enforcement authority over health insurance issuers in the group and individual markets to ensure compliance with health insurance market reforms, which include the EHB requirements in 45 CFR subpart B. Under this proposal, States that enforce Affordable Care Act insurance market requirements would retain their primary enforcement authority over the EHB, and may determine that a particular bronze plan design unnecessarily exceeds the maximum annual limitation on cost sharing. HHS would conduct such reviews of bronze plans offered in States where HHS directly enforces Affordable Care Act insurance market reform requirements.[165] We invite comments about the enforcement of this proposed flexibility.

We seek comment on this proposal. Specifically, we seek comment on what, if any, additional requirements we should consider in order for issuers to avail themselves of the flexibility to exceed the maximum annual limitation on cost sharing. For example, we also considered whether to propose allowing bronze plans to exceed the maximum annual limitation on cost sharing only when bronze plans would otherwise be non-viable (that is, impossible to design). In addition, we are interested in comments discussing what additional consumer protections we can consider implementing to educate and notify consumers about individual market bronze plans that have a MOOP that does not exceed the maximum annual limitation on cost sharing. For example, we welcome comments on imposing disclosure requirements on any such bronze plan to explain the plan's higher MOOP in the Summary of Benefits and Coverage (SBC) and on an Exchange website, though we note that any such changes would be unlikely for PY 2027 due to time constraints preventing appropriate time to discuss and make a formal proposal in consultation with other Executive agencies including the Department of Treasury and Department of Labor. We seek comment on whether this policy should also apply to the small group market. We also seek comment on whether we should annually set a precise amount by which an issuer could utilize a plan design with cost sharing that exceeds the maximum annual limitation on cost sharing, or whether the proposed regulatory language is precise enough to limit the instances in which an issuer could offer such a plan. We seek comment on operational effects of this policy, such as whether these plans would be considered the same plan under § 157.106(e)(3)(iv), and what impact this would have on plan crosswalking. We seek comment on these additional requirements related to permitting a high MOOP for some bronze plans, or any others commenters may identify, that we might finalize in this rule.

As we contemplate how this policy could apply to plans at higher metal levels, we seek comment on what special considerations may exist for those plans, and particularly for silver plans in determining the second lowest cost silver plan. We also seek comment

[165] Pursuant to § 150.203, in the event that a State notifies HHS that it does not have statutory authority to enforce or that it is not otherwise enforcing one or more of the provisions of title XXVII of the PHS Act, or if HHS determines that the State is not substantially enforcing the requirements, HHS has the responsibility to enforce these provisions in the State. As of the date of this proposed rule, the following States have notified HHS that they do not have the authority to enforce or are not otherwise enforcing the Affordable Care Act market reform provisions, including the EHB: Missouri, Oklahoma, Tennessee, Texas, and Wyoming.

on whether this flexibility should also apply to cost-sharing variants. Finally, we seek comment on whether we should propose changes to the bronze de minimis range and expanded bronze policy at § 156.140(c)(1).

f. Catastrophic Plan Cost-Sharing Requirements

Lastly, to best preserve a meaningful difference between the AVs of bronze and catastrophic plans, we propose to amend § 156.155(a)(3) to require catastrophic plans to provide no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount equal to 130 percent of the maximum annual limitation on cost sharing, rounded down to the next lowest multiple of 50 dollars, is reached.

The issue regarding the implementation of the maximum annual limitation on cost sharing and AV also impacts catastrophic plans. Issuers do not have flexibility in varying the cost sharing for catastrophic plans; the Affordable Care Act requires catastrophic plans to have a deductible and MOOP set to the maximum annual limitation on cost sharing and provide few specific benefits pre-deductible at section 1302(e)(1)(B). Because of this rigidity, catastrophic plans do not have prescribed AV requirements. Nevertheless, the perceived value of catastrophic plans is still affected by the conflict. We estimate that the year-over-year AVs for catastrophic plans are gradually rising, just like metal-tier plans. However, they are rising at an even faster rate than bronze plans.

An eligible consumer might prefer to select a bronze plan over a catastrophic plan if the catastrophic plan has a similar premium to the bronze plan *and* has a comparable AV to a bronze plan, but the bronze plan is able to provide more pre-deductible benefits and lower deductibles and MOOPs. This obvious choice is evident in enrollment data; enrollment in catastrophic plans on the FFEs has decreased every year since 2016 while bronze *plan* enrollment has increased. In 2016, nearly 100,000 people enrolled in catastrophic plans, but only about 20,000 people enrolled in catastrophic plans in 2025. Since we expanded the bronze de minimis ranges in 2018, enrollment in bronze plans has more than doubled from about 2.5 million to about 5.4 million in 2025. We believe the continuous rise in AVs for bronze plans and the decrease in enrollment for catastrophic plans may be causally connected, though we seek comment on other potential reasons to explain this phenomenon.[166]

We believe that catastrophic plans only appeal to consumers when there is a clear difference in the perceived value between catastrophic and bronze plans. When there is such a clear difference, the healthier consumers that are generally eligible and best suited to enroll in catastrophic plans are more motivated to select a catastrophic plan in lieu of a bronze plan. This is plainly what Congress intended.

Accordingly, we propose a revision to § 156.155 that would more clearly distinguish expanded catastrophic plans from bronze plans. We propose to require catastrophic plans to provide no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount equal to 130 percent of the maximum annual limitation on cost sharing, rounded down to the next lowest multiple of 50 dollars, is reached, beginning in 2027. For PY 2027, this amount would be $12,000 \times 1.3$, or $15,400. We chose to propose multiplying the maximum annual limitation on cost sharing by a factor of 130 percent because we estimate this would lower the estimated AV for these catastrophic plans to 55 percent; by definition, increasing the cost sharing for which consumers are responsible in a plan design reduces some of the market pressure that drive increasing premiums. We believe this is a reasonable estimate for a theoretical AV of catastrophic plans, as it strikes a balance between comprehensiveness of coverage and premium affordability for healthier enrollees.

This higher cost-sharing limit for catastrophic plans would allow for a more meaningful difference between the cost sharing typically expected for catastrophic and bronze plans and would allow issuers to more aggressively price catastrophic rates lower so that cheaper catastrophic plans would appeal to the kinds of consumers that we believe should tend to be enrolled in catastrophic plans—especially the healthy, non-subsidized enrollees who may be disincentivized from enrolling in a QHP due to the rise in costs. However, we seek comment on whether we should strive for a theoretical AV for catastrophic plans that is higher or lower than 55 percent, including whether we should phase in this multiplication factor over a number of plan years to ease the impact on catastrophic plan cost sharing, and how the availability of catastrophic plans at 130 percent of the maximum annual limitation on cost sharing would affect the landscape of plans available to consumers. We reserve the ability to finalize a different factor than 130 percent in the final rule after reviewing public comments. In addition, we solicit comments that address whether, in potentially finalizing this proposal, we should not require catastrophic plans to provide no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount equal to 130 percent of the maximum annual limitation on cost sharing. Alternatively, we solicit comments that address whether we should, in potentially finalizing this proposal, require issuers to offer, in the same service area, at least one catastrophic plan that provides no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount equal to 100 percent of the maximum annual limitation on cost sharing, as a precondition to being able to offer catastrophic plans that provide no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount equal to 130 percent of the maximum annual limitation on cost sharing. We also solicit comment on whether we should, in potentially finalizing this proposal, alternatively allow catastrophic plans to provide no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount that could be less than 130 percent of the maximum annual limitation on cost sharing (but not less than 100 percent). This proposed approach for catastrophic plans harmonizes plan and market outcomes with section 1302(c) through (e) of the Affordable Care Act to the greatest extent possible to preserve meaningful catastrophic plan availability without jeopardizing the integrity of the metal-tier framework that Congress envisioned. And, while raising the maximum annual limitation for catastrophic plans beyond what Congress specified is not an action we take lightly, we believe that, due to the mathematical irreconcilability created by current section 1302(c) through (e) of the Affordable Care Act, this proposal is necessary and most narrowly-tailored to ensure the coherent implementation of the Affordable Care Act's overall statutory scheme with as minimal

[166] For example, section 1302(c)(1) of the Affordable Care Act requires HHS to trend the maximum annual limitation on cost sharing forward in accordance with the premium adjustment percentage, while the IRS may only trend the maximum allowable MOOP for HDHPs forward to account for inflation (see section 223(c)(2)(A)(ii)(I) of the Code). This creates a discrepancy between the Affordable Care Act's maximum annual limitation on cost sharing and the maximum allowable HDHP MOOP, which could also explain the recent shift in bronze plans at the upper end of the permissible +5 range.

disruption to consumers as possible. Per the previous section, we also propose to allow issuers to offer catastrophic plans with a multi-year term: if finalized, all catastrophic plans that an issuer wishes to offer for PY 2027 would be required to use the higher annual limitation on cost sharing.

We also seek comment on whether there would be impacts to HHS risk adjustment as a result of requiring catastrophic plans to provide no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount equal to 130 percent of the maximum annual limitation on cost sharing, rounded down to the next lowest multiple of 50 dollars, is reached. Finally, we considered whether the guidance document on the ''Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage'', or another regulatory vehicle, might be more appropriate for releasing this additional permitted MOOP limitation annually, and invite comment on where to release and seek comment on the updated MOOP limitations ahead of each plan year.

We seek comment on all aspects of these proposals, including revisions to § 156.130 to reflect the proposed exception to the annual limitation on cost sharing that we propose to add for bronze plans at § 156.136, the changes to cost-sharing requirements for catastrophic plans at § 156.155, and any proposed alternative requirements we might consider finalizing in this rule connected to these proposals. Additionally, we seek comment on whether the methodology for estimating the PAPI should be revised to further reflect per capita claims cost growth in the individual health insurance market,[167] so that the annual adjustment to the maximum out-of-pocket limit better tracks the claims experience of the population in the individual market to which that limit applies. Because the premium adjustment percentage is also used to determine other parameters under the Affordable Care Act and the Internal Revenue Code and the annual limitation on cost sharing also impacts the large group and self-insured markets, we are particularly interested in comments addressing the potential consequences of such a methodological change for other areas of policy in which the premium adjustment percentage is a factor.

8. Standardized Plan Options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv))

We propose to exercise our authority under sections 1311(c)(1) and 1321(a)(1)(B) of the Affordable Care Act to discontinue the full suite of standardized plan option policies effective beginning in PY 2027. Specifically, we propose to remove the following from our regulations: the definition of ''standardized option'' at § 155.20; all requirements pertaining to standardized plan options at § 156.201 (the requirements for FFE and SBE–FP QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one another at paragraph (c)); the differential display of standardized plan options on *HealthCare.gov* at § 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv). Finally, we propose to cease the annual design and publication of these plans in the applicable Payment Notice rulemaking for each plan year.

a. Regulatory History

Standardized options were first introduced in the 2017 Payment Notice at § 155.20 (81 FR 12289 through 12293). These standardized option plan designs were subsequently updated in the 2018 Payment Notice (81 FR 94107 through 94112). The 2018 Payment Notice (81 FR 94118) also introduced the authority for HHS to differentially display standardized options on *HealthCare.gov* at § 155.205(b)(1), which allowed consumers the ability to filter all available plan options to view only standardized options and receive an accompanying message explaining how standardized options differed from non-standardized options. The 2018 Payment Notice (81 FR 94118) also introduced standardized option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv).[168]

Standardized options were then discontinued in the 2019 Payment Notice (83 FR 16974 through 16975). However, the discontinuance was challenged in the United States District Court for the District of Maryland. On March 4, 2021, the court decided *City of Columbus, et al.* v. *Cochran*.[169] The court reviewed nine separate policies HHS had issued in the 2019 Payment Notice, vacating four of them. The court vacated the policy finalized in the 2019 Payment Notice that ceased HHS' practice of designating some plans in the FFEs and SBE–FPs as ''standardized options,'' a policy that the 2019 Payment Notice (83 FR 16974 through 16975) stated was intended to maximize innovation by issuers in designing and offering a wide range of plans to consumers.

As a result, in part 2 of the 2022 Payment Notice (86 FR 24264 through 24265), we announced our intent to engage in rulemaking under which we would propose to resume designation of standardized options and propose specific designs in more detail in PY 2023. Thus, in the 2023 Payment Notice (87 FR 27310 through 27322), we reintroduced standardized plan options to enhance the consumer experience, increase consumer understanding, simplify the plan selection process, and combat discriminatory benefit designs.[170] We required FFE and SBE–FP issuers offering QHPs in the individual market to offer these plans, but we exempted FFE and SBE–FP issuers offering QHPs in the small group market as well as issuers in State Exchanges from these requirements. We also exempted issuers of QHPs in FFEs and SBE–FPs that were already required to offer standardized plan options under State action taking place on or before January 1, 2020, such as issuers in the State of Oregon,[171] from the requirement

[167] In the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability (90 FR 27074), CMS finalized updates to the methodology for calculating the premium adjustment percentage to establish a premium growth measure that captures premium changes in both the individual and employer-sponsored insurance markets for the 2026 plan year and beyond.

[168] Under these requirements, when an internet website of a web-broker or issuer is used to complete the QHP selection, at a minimum the internet website must differentially display all standardized options prominently and in accordance with the requirements under § 155.205(b)(1) in a manner consistent with that adopted by HHS for display on the FFE website and with standards defined by HHS, unless HHS approves a deviation.

[169] *City of Columbus* v. *Cochran,* 523 F. Supp. 3d 731 (D. Md. 2021).

[170] Although the official nomenclature for these plans was ''standardized options'' in the 2017 through 2019 Payment Notices, when we resumed this policy in the 2023 Payment Notice and in all subsequent Payment Notices, the official nomenclature became ''standardized plan options.''

[171] *See* Or. Admin. R. 836–053–0009.

to offer the standardized plan options specified by HHS in rulemaking.

In the 2023 Payment Notice (87 FR 27312), we finalized standardized plan options at the following metal levels: one bronze plan, one bronze plan that meets the requirement to have an AV up to 5 points above the 60 percent standard, as specified in § 156.140(c) (known as an expanded bronze plan), one standard silver plan, one version of each of the three income-based silver CSR plan variations, one gold plan, and one platinum plan. We did not finalize standardized plan options for the AI/AN CSR plan variations as provided for at § 156.420(b) given that the cost sharing parameters for these plan variations are already largely specified.

In the 2023 Payment Notice (87 FR 27312), we finalized two sets of standardized plan options to accommodate different States' cost sharing laws. Specifically, the first set of standardized plan options applied to all FFE and SBE–FP issuers, except issuers in Delaware, Louisiana, and Oregon. The second set of standardized plan options applied only to issuers in Delaware and Louisiana to accommodate these two States' specialty prescription drug cost sharing laws.

We designed these standardized plan options to resemble the most popular QHP offerings that millions of consumers were already enrolled in by taking the following steps: selecting the most popular cost sharing type for each benefit category; selecting enrollee-weighted median cost sharing values for each of these benefit categories based on PY 2022 cost sharing and enrollment data; modifying these plans to ensure they were able to comply with applicable State cost sharing laws; and decreasing the AVs for these plan designs to be at the floor of each AV *de minimis* range, primarily by increasing deductibles.

In the 2023 Payment Notice (87 FR 27313), we also resumed the differential display of standardized plan options on *HealthCare.gov* under the authority at § 155.205(b)(1), including those standardized plan options required under State action taking place on or before January 1, 2020. In addition, we resumed enforcing the standardized plan option differential display requirements for approved web-brokers and QHP issuers using a DE pathway to facilitate enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv).

As such, web brokers and QHP issuers were once more required to differentially display standardized plan options in accordance with § 155.205(b)(1) in a manner consistent with how standardized plan options are displayed on *HealthCare.gov,* unless we approve a deviation. Any requests from web brokers and QHP issuers seeking approval of an alternate differentiation format are reviewed based on whether the same or a similar level of differentiation and clarity is provided under the requested deviation as is provided on *HealthCare.gov*.

In the 2024 Payment Notice (88 FR 25847 through 25855), we maintained a high degree of continuity with our approach to standardized plan options finalized in the 2023 Payment Notice. However, in contrast to the policy finalized in the 2023 Payment Notice, at § 156.201(b), we finalized for PY 2024 and subsequent plan years to no longer include a standardized plan option for the non-expanded bronze metal level—primarily due to AV constraints and the infeasibility of designing such a plan.

In the 2025 Payment Notice (89 FR 26357 through 26362) and in the 2026 Payment Notice (90 FR 4493 through 4500), we continued to maintain a high degree of continuity with the approach to standardized plan options finalized in the immediately preceding Payment Notices (that is, the 2024 and 2025 Payment Notices). In each rulemaking, we made only minor modifications to the plan designs to ensure they continued to have AVs within the permissible *de minimis* range for each metal level. Additionally, in the 2026 Payment Notice, we finalized a requirement for FFE and SBE–FP QHP issuers in the individual market offering multiple standardized plan options within the same product network type, metal level, and service area to meaningfully differentiate these plans from one another in terms of included benefits, provider networks, included prescription drugs, or a combination of some or all these factors at § 156.201(c).

We explained that this requirement was based in part on our experience with the meaningful difference standard, which was previously codified at § 156.298. The meaningful difference standard was introduced in the 2015 Payment Notice (79 FR 13813 through 13814), revised in the 2017 Payment Notice (81 FR 12312 and 12331), and subsequently discontinued and removed from our regulations in the 2019 Payment Notice (83 FR 17027). The meaningful difference standard was originally intended to enhance the consumer experience on *HealthCare.gov* by preventing duplicative plan offerings and limiting plan proliferation.

We refer readers to the preambles to the 2023, 2024, 2025, and 2026 Payment Notices discussing § 156.201 (87 FR 27310 through 27322, 88 FR 25847 through 25855, 89 FR 26357 through 26362, and 90 FR 4493 through 4500, respectively) for more detailed discussions regarding our approaches to standardized plan options in previous plan years. We also refer readers to the preambles to the 2015, 2017, and 2019 Payment Notices discussing § 156.298 (79 FR 13813 through 13814, 81 FR 12312 and 12331, and 83 FR 17027, respectively) for more detailed discussions regarding our approaches to the meaningful difference standard in previous plan years.

b. Current Proposal

We propose, effective beginning in PY 2027, that FFE and SBE–FP QHP issuers in the individual market would no longer be required to offer standardized plan options. Further, we would remove the following from our regulations: the definition of ''standardized options'' at § 155.20; all requirements pertaining to standardized plan options at § 156.201 (the requirements for FFE and SBE–FP QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one another at paragraph (c)); the authority to differentially display standardized plan options on *HealthCare.gov* at § 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv). Finally, we would cease the annual design and publication of these plans in the applicable Payment Notice for each plan year.

Nothing under this proposal would impact or preclude State-enacted standardized plan option requirements, including the requirement for issuers in the State of Oregon to offer such plans.[172] Thus, under this proposal, Oregon issuers would continue to be subject to State requirements. However, standardized plan options offered under those requirements would no longer be differentially displayed on *HealthCare.gov,* and approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP would no longer be required to differentially display those standardized plan options. We also note that nothing under this proposal would preclude State Exchanges from requiring their respective issuers to offer standardized plan options or from differentially

[172] *See* Or. Admin. R. 836–053–0009.

displaying such plans on their respective enrollment platforms.

We also clarify that while we propose to discontinue the requirement for issuers to offer standardized plan options, the annual design and publication of these plans in the applicable Payment Notice each plan year, and the differential display of these plans on *HealthCare.gov* and the DE pathways, we are not proposing to require issuers to discontinue their existing standardized plan option offerings altogether. Instead, under this proposal, issuers would be permitted to choose whether to discontinue their existing standardized plan option offerings altogether or continue offering them with either the same or modified cost sharing, while we simultaneously discontinue the differential display of these plans and designation of these plans as standardized plan options.

Under this proposed approach, if issuers wished to discontinue their existing standardized plan option offerings altogether, they would be permitted to do so, and enrollees in these plans would be crosswalked to a different plan in accordance with the crosswalk hierarchy at § 155.335(j). Additionally, if issuers wished to continue offering these existing standardized plan options with the same cost sharing, they would also be permitted to do so, and enrollees in these plans would continue to be auto-reenrolled in these plans from one plan year to the next, absent selecting a different plan or discontinuing coverage. However, these plans would no longer be visually distinguished as standardized plan options on *HealthCare.gov* or the DE pathways. Finally, if issuers wished to continue offering these existing standardized plan options but also wished to modify these plans' cost sharing structures, they would be permitted to do so, but these issuers would continue to be subject to the requirements under the definition of ''plan'' at § 144.103 and to the uniform modification requirements at § 147.106.

c. Rationale for Proposal

We propose this approach for several reasons. To begin, when we reintroduced standardized plan options in the 2023 Payment Notice (87 FR 27316 through 27317), we noted that *City of Columbus* vacated the discontinuation of standardized plan options in the 2019 Payment Notice.[173] We then stated that several commenters explained that HHS was not legally obligated to resume standardized plan options under this ruling. These commenters explained that the previous Administration simply provided insufficient justification for discontinuing standardized plan options, but that discontinuing them was not unlawful. These commenters suggested that instead of resuming standardized plan options, HHS should issue a new rule with a more thorough explanation than what was provided in the 2019 Payment Notice explaining why standardized plan options should remain discontinued.

In response to these comments, in the 2023 Payment Notice (87 FR 27316 through 27317), we acknowledged and agreed that *City of Columbus* did not require HHS to resume standardized plan options. However, we explained that this ruling caused us to reevaluate our previous decision to discontinue standardized plan options in the 2019 Payment Notice. We also explained that we believed it was appropriate to resume standardized plan options at that time since the contemporary market conditions differed significantly from the market conditions present when standardized plan options were discontinued in the 2019 Payment Notice—namely, the individual market was no longer considered to be at risk of destabilization.

In the 2023 Payment Notice (87 FR 27316 through 27317), we further explained that the stabilization of the individual market was demonstrated by the proliferation of plan offerings, increased issuer participation in the Exchanges, and record enrollment. We thus explained that resuming standardized plan options at that time could play a constructive role in enhancing the consumer experience, increasing consumer understanding, and simplifying the decision-making process for consumers on the Exchanges, despite the fact that *City of Columbus* did not legally obligate HHS to do so.

In the 2023 Payment Notice (87 FR 27316), we further explained that we believed standardized plan options could play an important role in that simplification by allowing consumers to compare offerings based on other meaningful features outside of cost sharing structures, such as premiums, networks, formularies, and quality ratings. We then explained that employing standardized plan option requirements at that time would allow consumers to more easily and more meaningfully differentiate between choices and select a plan that meets their unique health care needs.

Thus, issuers that offer QHPs through the FFEs and SBE–FPs have been required to offer standardized plan options at every product network type, at every metal level (with the exception of the non-expanded bronze metal level since PY 2024), and throughout every service area they offer non-standardized plan options since PY 2023. As such, we have accumulated 4 plan years of experience (PY 2023 through PY 2026) administering these standardized plan option policies. This cumulative experience provides us with a comprehensive and nuanced perspective regarding weighing both the advantages and disadvantages of requiring FFE and SBE–FP QHP issuers to offer standardized plan options, whether this strategy aligns with our originally articulated objectives with standardized plan option policies, and whether this strategy has yielded the intended results.

Based on this experience, we have concluded that requiring FFE and SBE–FP QHP issuers to offer standardized plan options is an ineffective strategy in enhancing the consumer experience, increasing consumer understanding, and simplifying the plan selection process—the originally articulated objectives of employing our standardized plan option policies. This is primarily because requiring issuers to offer standardized plan options at every product network type, at every metal level, and throughout every service area that they offer non-standardized plan options led to an increase in the total number of QHPs that issuers offer through the FFEs and SBE–FPs in PY 2023 (the first year in which the requirement to offer these plans was introduced), which exacerbated plan proliferation—directly counteracting our originally articulated objectives.

In fact, the resumption of standardized plan options and the introduction of the requirement for FFE and SBE–FP QHP issuers to offer standardized plan options coincided with an increase in the weighted average number of total plans available per enrollee from 108 in PY 2022, the year before the introduction of the requirement to offer standardized plan options, to 114 in PY 2023, the year in which this requirement was introduced, with most of this increase in plans being comprised of standardized plan options. Furthermore, plan proliferation as measured by the weighted average number of total plans offered per issuer (which is derived by dividing the weighted average number of total plans available per enrollee by the weighted average number of total issuers per enrollee) increased from 16.9 in PY 2022 to 17.3 in PY 2023—meaning each issuer on average tended to offer a

[173] *City of Columbus* v. *Cochran,* 523 F. Supp. 3d 731 (D. Md. 2021).

higher number of plans after the imposition of the requirement to offer standardized plan options than the year before this requirement was made effective.[174]

Furthermore, even with the introduction of the non-standardized plan option limit of four in PY 2024 and its reduction to two as well as the introduction of the exceptions process in PY 2025, the net impact of both the requirement to offer standardized plan options as well as the subsequent imposition of non-standardized plan option limits and exceptions on the weighted average number of total plans available per enrollee and the weighted average number of total plans offered per issuer (including both standardized and non-standardized plan options) was marginal—despite the substantially increased regulatory complexity and the associated burden of creating and submitting certification applications for new plans (standardized plan options) and correspondingly adjusting existing portfolios of plan offerings (non-standardized plan options).

Specifically, the weighted average number of total plans available per enrollee decreased from 114 in PY 2023 to 100 in PY 2024 and remained consistent at 100 in PY 2025. The weighted average number of total plans offered per issuer decreased from 17.3 in PY 2023 to 14.7 in PY 2024 and 13.7 in PY 2025. Thus, from PY 2022, before this suite of standardized plan option policies was introduced, there was a weighted average number of 108 total plans available per enrollee and a weighted average number of 16.9 total plans offered per issuer, whereas in PY 2025 (after several consecutive years imposing novel layers of requirements), these same measures were 100 and 13.7, respectively.

We do not believe that the marginal net reductions in the weighted average number of total plans available per enrollee and the weighted average number of total plans offered per issuer achieved by introducing this suite of standardized plan option and non-standardized plan option limit requirements warrant imposing additional burden on issuers or impeding issuer innovation in plan design choice—especially given that these marginal net reductions have likely been largely indiscernible to consumers during the plan selection process. This is especially true given that these metrics continue to remain significantly elevated compared to only several plan years ago. For example, in PY 2020, the weighted average number of total plans available per enrollee was 39, and the weighted average number of total plans offered per issuer was 11.1. The impact of our non-standardized plan option limits and exceptions process policies on these metrics and plan proliferation are discussed in greater detail in section III.E.9 of this proposed rule.

The increase in the weighted average number of total plans available per enrollee from PY 2022 to PY 2023 (which arose primarily from the introduction of the requirement for issuers to offer standardized plan options), even taken altogether with the subsequent marginal net reductions in PY 2024 and PY 2025 (which arose primarily from the introduction of the non-standardized plan option limit of four in PY 2024 and the reduction of this limit to two as well as the introduction of the exceptions process in PY 2025), is particularly important.

We have utilized this metric, the weighted average number of total plans per enrollee, as opposed to the unweighted average number of total plans per enrollee, as the primary metric by which to evaluate plan choice overload because utilizing weighted averages takes into consideration the number of enrollees in a particular service area when calculating the average number of plans available to enrollees. As a result of weighting averages by enrollment, service areas with a higher number of enrollees have a greater impact on the overall average than service areas with a lower number of enrollees. Thus, weighting averages by enrollment allows a more representative metric to be calculated that more closely resembles the actual experience of enrollees.

Therefore, as measured by this metric, the weighted average number of total plans per enrollee, the plan proliferation that occurred subsequent to the introduction of the requirement for FFE and SBE–FP QHP issuers to offer standardized plan options in PY 2023 is inconsistent with our originally articulated objectives of enhancing the consumer experience, increasing consumer understanding, and simplifying the plan selection process for consumers on *HealthCare.gov*—even with the marginal net reductions that occurred subsequent to the introduction of non-standardized plan option limits and its reduction from four to two in PY 2024 and PY 2025, respectively. As we explained in the comment solicitation on choice architecture and preventing plan choice overload in the 2023 Payment Notice (87 FR 27345 through 27347), this is because increasing the total number of plans that consumers must compare and evaluate increases the risk of plan choice overload, suboptimal plan selection, and unexpected financial harm.

Based on our 4 plan years of experience (PY 2023 through PY 2026) administering this suite of standardized plan option and non-standardized plan option limits and exceptions policies, we have concluded that a marginal net reduction in the number of plan choices in the FFEs and SBE–FPs created by the approach of imposing requirements to offer standardized plan option and imposing non-standardized plan option limits and exceptions has significant disadvantages—namely, imposing additional burden and constraining issuer innovation and consumer choice.

We further note that the FFEs operate under constraints that differ substantially from other contexts in which standardized plan options have been implemented, such as in States with a State Exchange model type. In particular, there is a significant degree of heterogeneity on the FFEs (for example, in terms of consumer demographics, health care needs, and preferences) given that there are currently 28 States with an FFE model type, and it is impractical to design a standardized plan option offering that issuers must conform to regardless of the market dynamics in a given location. We further do not believe that it is feasible for HHS to more precisely tailor specific plan designs and requirements to the unique circumstances and market conditions in each State and update these plan designs on an annual basis. Finally, we do not believe that such an approach would be warranted in the first place given the limited efficacy that these policies have demonstrated in the last several years.

Relatedly, the strategy of requiring issuers to offer standardized plan options as well as differentially displaying these plans on *HealthCare.gov* and the DE pathways (which is discussed in greater detail later in this section) was intended to enhance plan comparability for consumers navigating the plan selection process. Theoretically, requiring issuers to offer plans with standardized cost sharing parameters would facilitate the plan selection process by reducing the number of factors that consumers must consider when evaluating all available plan options—since a certain subset of plans would have the same cost sharing parameters. As a result of having access to plans with standardized cost sharing parameters, consumers would

[174] ''Plan Year 2025 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces.'' October 25, 2024. *https://www.cms.gov/files/document/2025-qhp-premiums-choice-report.pdf.*

theoretically have the ability to shift their focus to other important plan attributes, such as premiums, benefit coverage, provider networks, formularies, and quality ratings, during the plan selection process.

However, based on our 4 plan years of experience (PY 2023 through PY 2026) administering these standardized and non-standardized plan option policies, we have found that in practice, given that standardized plan options continue to be offered alongside non-standardized plan options, whether a particular plan offering was a standardized or non-standardized plan option served as yet another variable that consumers must consider during the plan selection process, adding an additional layer of complication. Furthermore, in our experience, we have found when consumers are faced with a large number of heterogeneous plan options, they continue to rely primarily on premiums, networks, and issuer brand—meaning that standardizing cost sharing parameters by itself (especially when doing so only for a subset of all available plan options) fails to meaningfully reduce decision complexity for consumers.

We also considered more recent literature examining the effects of offering standardized plan options alongside non-standardized plan options. We highlight a 2024 study demonstrating that the introduction of ''Simple Choice'' plans in PY 2017 and PY 2018 was associated with a reduction in gross premiums.[175] Although we acknowledge that these findings contribute to a broader understanding of how plan standardization may influence issuer pricing behavior under certain market conditions, we emphasize that the authors caution against extrapolating these effects beyond the specific context in which they arose. In particular, the study period coincided with a period of pronounced market instability, characterized by significant issuer exits, rapidly increasing market concentration, and the defunding of cost-sharing reduction payments. The authors concluded that observed premium effects were likely attributable, in part, to issuer uncertainty during this volatile period and state that similar policies implemented in more stable environments would have likely yielded smaller effects.

The study further documented that premium impacts dissipated following the discontinuation of the policy after PY 2018, with no evidence of persistent effects in subsequent years—suggesting that plan standardization, absent continued market disruption or policy-induced uncertainty, did not result in durable structural changes to issuer pricing behavior. We consider this lack of persistence particularly relevant when evaluating the continued necessity of standardized plan option requirements and associated non-standardized plan option limits within the current market context—especially with the increased burden, inhibition of issuer innovation, and constrained consumer choice associated with these policies.

Beyond this more recent literature, we note that for each plan year since these requirements were introduced in PY 2023, there has consistently been a comparatively low uptake of standardized plan options relative to corresponding non-standardized plan options. In fact, only 20 percent of total enrollment in the FFEs and SBE–FPs was in standardized plan options in PY 2023, 33 percent in PY 2024, and 33 percent in PY 2025, even with the reduction in non-standardized plan option offerings due to the introduction of the non-standardized plan option limit of four in PY 2024 and its reduction to two in PY 2025.[176]

Relatedly, 25 percent of total plan offerings were standardized plan options in PY 2023, 28 percent in PY 2024, and 31 percent in PY 2025.[177] Thus, total enrollment in standardized plan options was lower compared to what would be expected based on the total proportion of plans that are standardized plan options in PY 2023 and only increased to be approximately equal with what would be expected as the non-standardized plan option limit was introduced in PY 2024 and reduced in PY 2025. The consistently low proportion of consumers enrolled in standardized plan options over the years suggests that these plans fail to appeal to consumers compared to corresponding non-standardized plan options—or at the very least that consumers are unable to perceive a meaningful difference between standardized and non-standardized plan options.

Moreover, even among active plan selections (which includes both consumers currently enrolled in a QHP that are making a new plan selection as well as consumers who are enrolling in any QHP offered through an FFE or SBE–FP for the first time, but excludes consumers who are auto-reenrolled in their current QHP from one year to the next), only 18 percent of consumers in the FFEs and SBE–FPs actively selected standardized plan options in PY 2023, 26 percent in PY 2024, and 18 percent in PY 2025.[178] This comparatively lower than expected rate of active plan selections for standardized plan options further suggests that these plans have consistently failed to appeal to consumers—or at the very least that it is difficult for consumers to meaningfully distinguish standardized from non-standardized plan options or ascertain the benefits of enrolling in such plans.

We note that this consistently low uptake of standardized plan options by FFE and SBE–FP consumers for the last several plan years, as measured by both the proportion of total enrollment in as well as active selections of these plans, has occurred despite the fact that a full suite of differential display features visually distinguishes these plans from corresponding non-standardized plan options on both *HealthCare.gov* and the DE pathways, in accordance with the differential display requirements at §§ 155.205(b)(1), 155.220(c)(3)(i)(H), and 156.265(b)(3)(iv).

Under the present form of differential display on *HealthCare.gov* (and the corresponding forms of differential display on the DE pathways), standardized plan options are labelled ''easy pricing'' plans, and an accompanying icon visually distinguishes these plans from non-standardized plan options. Accompanying hover text also explains both the benefits and distinctive features of these plans and how these plans differ from non-standardized plan options. An additional ''quick tip'' feature provides greater detail regarding the benefits of standardized plan options—including that these plans contain pre-deductible coverage and that they are easier to compare because they have the same MOOP values, deductibles, and cost sharing within their respective health plan categories. Finally, consumers have the option to select a filter to view only standardized plan options among all available plan options—which excludes non-standardized plan options from the list of search results.

[175] Hopkins, B., and Lyons, S. (2024, December 13). ''The Effect of Offering 'Simple Choice' Plans on Premiums in the Federally Facilitated ACA Marketplaces.'' *https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5084737.*

[176] ''Marketplace Open Enrollment Period Public Use Files.'' *https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products.*

[177] ''Plan Year 2025 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces.'' October 25, 2024. *https://www.cms.gov/files/document/2025-qhp-premiums-choice-report.pdf.*

[178] ''Marketplace Open Enrollment Period Public Use Files.'' *https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products.*

Even with this full suite of differential display features that visually distinguishes standardized plan options from non-standardized plan options on *HealthCare.gov* and the DE pathways, non-standardized plan options are consistently the more popular option for consumers, with a greater proportion of total enrollment in and active plan selections of non-standardized plan options each plan year since these requirements were introduced in PY 2023. Without this full suite of differential display features that visually distinguishes standardized plan options from non-standardized plan options, standardized plan options would likely constitute an even lower proportion of both total enrollment and active plan selections, further suggesting that these plans have consistently failed to appeal to consumers compared to non-standardized plan options.

Furthermore, total enrollment in and active selections of standardized plan options would be conceivably lower without the progressively more stringent non-standardized plan option limits (since there would have been a greater number of non-standardized plan options for consumers to select from). Given the consistently low proportion of total enrollment in and active selections of standardized plan options each plan year since these requirements were introduced in PY 2023, we no longer believe that the benefits of requiring issuers to offer these plans outweighs the burden of requiring them doing so—especially since employing this strategy has failed to achieve our originally articulated objectives.

Specifically, the burden of requiring issuers to offer these plans includes creating new plans that have cost sharing parameters that conform with the designs specified by HHS in annual rulemaking, the burden for both issuers and HHS in certifying a greater number of plans during QHP certification each year (standardized plan options as well as non-standardized plan option limit exceptions process plans), and the burden on issuers correspondingly adjusting portfolios of plan offerings (non-standardized plan options).

In addition to enhancing the consumer experience, increasing consumer understanding, and simplifying the decision-making process for consumers purchasing coverage through the Exchanges, as we stated in the 2023 Payment Notice (87 FR 27311), another original objective of requiring FFE and SBE–FP QHP issuers to offer these standardized plan options was combatting discriminatory benefit designs. We attempted to achieve this objective in our approach to the design of these plans.

In particular, each plan year since we introduced standardized plan options in PY 2023, in our design of these plans, we exempted the following frequently utilized benefit categories from the deductible at every metal level: primary care visits, specialist visits, mental health and substance use outpatient office visits, speech therapy, physical and occupational therapy, and generic drugs—with an increasing number of benefit categories being exempted from the deductible at higher metal levels. We adopted this approach since exempting benefits from the deductible reduces barriers to access for these services and makes it easier (that is, less expensive) for consumers to obtain these health care services. We also attempted to combat discriminatory designs by requiring flat copayments as the form of cost sharing instead of coinsurance rates for a greater number of benefit categories. We incorporated this plan design feature to enhance consumer certainty and reduce the risk of unexpected financial costs when obtaining health care.

We continue to recognize that subjecting additional benefit categories to the deductible and including coinsurance rates as the form of cost sharing instead of flat copayments may make it more difficult for consumers to obtain the corresponding health care services. However, we acknowledge that these design features (specifically, pre-deductible benefit coverage and flat copayments for the aforementioned benefit categories) are routinely included for the corresponding benefit categories in many non-standardized plan option offerings, and with similar cost sharing amounts. This is because, as we explained in the 2023 Payment Notice (87 FR 27319), we design these standardized plan options to mirror the most popular plan design features of QHPs offered through the FFEs and SBE–FPs in previous plan years.

More specifically, regarding the methodology we employ to design these plans, in the 2024 Payment Notice (88 FR 25848), we explained that we design these standardized plan options by selecting the most popular cost sharing type for each benefit category (which is a copayment or coinsurance rate that is either subject to or exempt from the deductible); selecting enrollee-weighted median cost sharing values for each of these benefit categories (as well as for the annual limitation on cost sharing and deductible values) based on refreshed cost sharing and enrollment data; modifying these plans to be able to accommodate State cost sharing laws; and decreasing the AVs for these plan designs to be at the floor of each AV *de minimis* range, primarily by increasing deductibles.

Employing this methodology in the annual design of these standardized plan options has resulted in these plans being comparable in many respects to corresponding non-standardized plan options that millions of consumers are already enrolled in. This further means that pre-deductible benefit coverage and flat copayments as the form of cost sharing instead of coinsurance rates are design features that are not exclusive to standardized plan options. Instead, these plan design features largely reflect market consensus and do not substantially deviate from this consensus. The fact that these plan design features are already routinely included in many non-standardized plan options means that we could combat discriminatory plan designs (another originally articulated objective for reintroducing the requirement for issuers to offer standardized plan options) without subjecting both issuers and HHS to the increased burden of requiring issuers to offer and submit certification applications for these plans that largely reflect market consensus and existing offerings.

Furthermore, we believe that incorporating coinsurance rates as the form of cost sharing for particular benefits instead of flat copayments can serve an important role in plan design—by promoting greater engagement on behalf of consumers in evaluating health care options and by providing issuers additional levers to control costs, thereby helping to manage rising premiums. We believe incorporating coinsurance rates as the form of cost sharing promotes greater engagement on behalf of consumers by encouraging consumers to more comprehensively research the full costs for particular services from different providers. We thus believe that employing coinsurance rates instead of flat copayments as the form of cost sharing for particular benefits is not in itself necessarily discriminatory in nature and is an important factor in controlling costs and by extension counteracting increasing premiums.

Additionally, the combination of standardized plan option requirements as well as non-standardized plan option limits has increasingly constrained issuers' ability to offer a sufficiently broad range of plans for several plan years. This includes plans with tiered provider networks, plans with separate medical and drug deductibles (as opposed to integrated medical and drug deductibles), plans with separate

medical and drug MOOPs (as opposed to integrated medical and drug MOOPs), HSA-eligible high-deductible health plans (HDHPs), and plans with more than four tiers of prescription drug coverage. Issuers have not been able to offer plans with these design features as standardized plan options since doing so would deviate from the required cost sharing parameters specified by HHS in rulemaking. Thus, removing this suite of requirements would grant issuers additional flexibility to once more vary plans along these parameters, which would enhance both issuer innovation in plan design as well as the degree of consumer choice.

d. Plan Discontinuations

However, we recognize that some issuers and consumers may still find certain features of these plan designs valuable. This is why we are not proposing to require issuers to discontinue their standardized plan option offerings altogether. Instead, under this proposed approach, FFE and SBE–FP QHP issuers would be permitted to choose whether to discontinue these offerings altogether or to continue offering them with either the same or modified cost sharing, while we simultaneously discontinue the differential display of these plans on *HealthCare.gov* and the DE pathways.

Under our proposed approach, if issuers wished to discontinue their standardized plan option offerings altogether, they would be permitted to do so, and enrollees in these plans would be crosswalked to a different plan in accordance with the crosswalk hierarchy at § 155.335(j). Additionally, if issuers wished to continue offering these standardized plan options with the same cost sharing, they would also be permitted to do so, and enrollees in these plans would continue to be auto-reenrolled in these plans from one plan year to the next. However, these plans would no longer be visually distinguished as standardized plan options on *HealthCare.gov* or the DE pathways. Finally, if issuers wished to continue offering these standardized plan options but also wished to modify these plans' cost sharing structures, they would be permitted to do so, but these issuers would continue to be subject to the requirements under the definition of ''plan'' at § 144.103 and to the uniform modification requirements at § 147.106.

In most scenarios where an issuer modifies the cost sharing structure of one of its standardized plan option offerings, the newly modified plan that was formerly the standardized plan option would be considered a new plan and would therefore require a new plan ID. In this scenario, enrollees would be crosswalked from the discontinued plan to another plan in accordance with the crosswalk hierarchy at § 155.335(j). These enrollees could be crosswalked into the newly modified plan that was formerly the standardized plan option, or an entirely different plan altogether, depending on the unique circumstances in each county.

However, under the definition of ''plan'' at § 144.103, a State may permit issuers to make greater changes to a plan's cost sharing while still permitting that plan to be considered the same plan—thus maintaining the same plan ID. Furthermore, under § 147.106(e)(3)(iv), as long as the variation in cost sharing is solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level (and other applicable requirements under § 147.106(e) are met), the modifications could be considered uniform (thus, a viable exception to guaranteed renewability).

In the scenario where an issuer modifies what was formerly a standardized plan option's cost sharing structure while maintaining the same plan ID, enrollees in the plan would be auto-reenrolled from one plan year to the next. In either case, whether the modification of a former standardized plan option's cost sharing results in that plan being considered the same or a different plan, enrollees would be crosswalked in accordance with the crosswalk hierarchy at § 155.335(j), and that plan would no longer be differentially displayed as a standardized plan option on *HealthCare.gov* or the DE pathways. Adopting this approach would effectively remove the standardization component of this suite of policies while minimizing the risk of disruption for consumers enrolled in and issuers of these plans.

Altogether, we believe that employing this suite of policies for the last several plan years has failed to achieve the originally articulated objectives of enhancing the consumer experience, increasing consumer understanding, and combatting discriminatory benefit designs. This failure is demonstrated by exacerbated plan proliferation in PY 2023 and the comparatively low uptake of these standardized plan options despite the full suite of differential display features that visually distinguishes these plans from corresponding non-standardized plan options. Finally, these standardized plan options reflect market consensus and incorporate the most popular plan design features of many existing non-standardized plan option offerings, meaning these plan design features are not exclusive to standardized plan options.

Given that imposing these requirements has increased burden for both issuers and HHS (for example, by requiring issuers to create and submit certification applications for additional plans) and unnecessarily constrained issuers in plan design while failing to achieve our originally articulated objectives, we no longer believe that the advantages of employing this strategy outweigh the disadvantages of doing so. We therefore believe that discontinuing the full suite of standardized plan options policies (in conjunction with discontinuing non-standardized plan option limits and exceptions, discussed in section III.E.9 of this proposed rule) would reduce issuer and HHS burden and provide more flexibility for issuers to innovate in plan design.

Accordingly, this proposal would remove the following from our regulations effective beginning PY 2027: the definition of ''standardized option'' at § 155.20; all requirements pertaining to standardized plan options at § 156.201 (the requirements for FFE and SBE–FP QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one another at paragraph (c)); the differential display of standardized plan options on *HealthCare.gov* at § 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv). This proposal would also entail the cessation of the annual design and publication of these plans in the applicable Payment Notice rulemaking for each plan year.

We seek comment on this proposal. We also seek comment on potential regulatory alternatives that would allow us to achieve the same goals of simplifying the plan selection process and reducing burden without discontinuing this suite of policies in its entirety. In particular, we seek comment on continuing to require issuers to offer standardized plan options only at particular metal levels, such as the bronze and silver metal levels (instead of at every metal level at which they offer non-standardized plan options). We also seek comment on requiring issuers to offer standardized plan options only in certain service areas in which they offer a certain number of non-standardized plan options. We also seek comment on transitioning from

requiring issuers to offer these standardized plan options to once more allowing issuers to voluntarily offer them—as was the approach with the previous iteration of the policy—while we continue to maintain the differential display of these plans on *HealthCare.gov* and the DE pathways.

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

We propose to exercise our authority under sections 1311(c)(1) and 1321(a)(1)(B) of the Affordable Care Act to discontinue non-standardized plan option limits and exceptions at § 156.202 effective beginning in PY 2027. Section 1311(c)(1) of the Affordable Care Act directs the Secretary to establish criteria for the certification of health plans as QHPs. Section 1321(a)(1)(B) of the Affordable Care Act directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the Affordable Care Act, which includes section 1311, for, among other matters, the offering of QHPs through such Exchanges.

In the 2023 Payment Notice proposed rule (87 FR 27345 through 27347), we solicited comment on choice architecture and preventing plan choice overload. In this comment solicitation, we noted that although we continued to prioritize competition and choice on the FFEs and SBE–FPs, we were concerned about plan choice overload, which can result when consumers have too many choices in plan options. We referred to a 2016 report by the RAND Corporation reviewing over 100 studies which concluded that having too many health plan choices can lead to poor enrollment decisions due to the difficulty consumers face in processing complex health insurance coverage information.[179] We also referred to a study of consumer behavior in Medicare Part D, Medicare Advantage, and Medigap that demonstrated that a choice of 15 or fewer plans was associated with higher enrollment rates, while a choice of 30 or more plans led to a decline in enrollment rates.[180]

With this concern in mind, in the 2023 Payment Notice proposed rule (87 FR 27345 through 27347), we explained that we were interested in exploring possible methods of improving choice architecture and preventing plan choice overload. We expressed interest in exploring the feasibility and utility of limiting the number of non-standardized plan options that QHP issuers could offer through the FFEs and SBE–FPs as one option to reduce the risk of plan choice overload and to further streamline and optimize the plan selection process for consumers on the FFEs and SBE–FPs.

Accordingly, we sought comment on the impact of limiting the number of non-standardized plan options that issuers can offer through the FFEs and SBE–FPs, on effective methods to achieve the goal of reducing the risk of plan choice overload and to further streamline and optimize the plan selection process for consumers on the FFEs and SBE–FPs, the advantages and disadvantages of these methods, and if there were alternative methods not considered. We also sought comment on evidence-based approaches to enhancing choice architecture within the FFEs and SBE–FPs.

In response to this comment solicitation, in the 2023 Payment Notice (87 FR 27345 through 27347), we highlighted many commenters' specific recommendations regarding modifying choice architecture to enhance the consumer shopping experience. We also noted that several commenters supported limiting the number of QHPs that could be offered through the FFEs and SBE–FPs, explaining that adopting such an approach could lower costs for consumers, set standards for plan quality, and foster robust competition among issuers seeking entry into the FFEs and SBE–FPs. Conversely, we noted that several commenters opposed limiting the number of QHPs that could be offered through the FFEs and SBE–FPs, explaining that doing so would limit issuer flexibility to design plans based on consumer preferences and needs. We also noted that several commenters supported resuming an updated version of the meaningful difference standard, which was previously codified at § 156.298.

In the 2024 Payment Notice (88 FR 25855 through 25865), at § 156.202, we introduced limits on the number of non-standardized plan options that issuers of QHPs can offer through Exchanges on the Federal platform (including SBE–FPs) to four non-standardized plan options per product network type (as described in the definition of ''product'' at § 144.103), metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage, in any service area for PY 2024, and two for PY 2025 and subsequent plan years.

In the 2024 Payment Notice (88 FR 25856 through 25857), we explained that we introduced non-standardized plan option limits for several reasons. We explained that there had been a sizeable increase in the weighted average number of total QHPs on the FFEs and SBE–FPs available per enrollee and plans offered per issuer in recent years. We stated that with this continued plan proliferation, we believed that limiting the number of non-standardized plan options that FFE and SBE–FP issuers of QHPs could offer through the FFEs and SBE–FPs would greatly enhance the consumer experience on *HealthCare.gov*. We further explained that we made several enhancements to the consumer experience and choice architecture on *HealthCare.gov* in conjunction with introducing non-standardized plan option limits.

We explained that we believed that adopting both of these measures (in conjunction with requiring issuers to offer standardized plan options) would be the most effective method to streamline the plan selection process and to reduce the risk of plan choice overload for consumers on *HealthCare.gov*. We also explained that we believed that directly limiting the number of non-standardized plan options that issuers could offer through the FFEs and SBE–FPs was a more effective approach in reducing the risk of choice overload than reinstituting a revised version of the meaningful difference standard, which had previously demonstrated limited efficacy.

In the 2025 Payment Notice (89 FR 26362 through 26375), we introduced an exceptions process allowing issuers to offer additional non-standardized plan options exceeding the limit of two per product network type, metal level, inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage, and service area for PY 2025 and subsequent plan years, if issuers demonstrate that these additional non-standardized plans have specific design features that would substantially benefit consumers with chronic and high-cost conditions. As part of this exceptions process, each issuer must demonstrate how cost sharing pertaining to the treatment of the chronic and high-cost condition would be reduced by 25 percent or more relative to that issuer's other non-standardized plan option offerings in the same product network type, metal level, inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage, and service area.

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

[180] Chao Zhou and Yuting Zhang, ''The Vast Majority of Medicare Part D Beneficiaries Still Don't Choose the Cheapest Plans That Meet Their Medication Needs.'' Health Affairs, 31, no. 10 (2012): 2259–2265.

In the 2025 Payment Notice (89 FR 26366), we explained that we introduced this exceptions process for several reasons. Specifically, we noted that several commenters explained that reducing the non-standardized plan option limit from four in PY 2024 to two in PY 2025 would cause FFE and SBE–FP issuers to discontinue non-standardized plans with lower enrollment, which would likely be plans with designs that are attractive to a smaller number of enrollees who have relatively less common and high-cost health care needs. Commenters further explained that many of the plans that would likely be discontinued would be those that benefit consumers with chronic and high-cost conditions. Commenters explained that permitting issuers to offer additional non-standardized plan options that would provide targeted coverage specifically for medically complex populations with chronic and high-cost conditions would allow for more targeted innovation by issuers while still achieving the reduction in plan proliferation HHS has sought.

Under our proposed approach in this rulemaking, issuers would no longer be subject to the non-standardized plan option limit of two per product network type, metal level, inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage, in any service area at § 156.202(a) through (c), for PY 2027 and subsequent years. Issuers would similarly no longer be required to utilize the non-standardized plan option limit exceptions process at § 156.202(d) through (e) to offer additional non-standardized plan options given that they would no longer be limited in the number of non-standardized plan options they may offer. We would correspondingly remove § 156.202 from our regulations.

Similar to our proposal to discontinue the requirement for issuers to offer standardized plan options (as well as the differential display of these plans) but not to require issuers to discontinue these existing offerings altogether, we propose to discontinue the non-standardized plan option limits and exceptions process but not require issuers to discontinue these existing offerings altogether. Instead, under this proposal, issuers would be permitted to choose whether to discontinue the chronic and high-cost condition plans originally offered through the non-standardized plan option limit exceptions process altogether or continue offering them with either the same or modified cost sharing.

Under this proposed approach, if issuers wished to discontinue the chronic and high-cost condition plans originally offered through the non-standardized plan option limit exceptions process altogether, they would be permitted to do so, and enrollees in these plans would be crosswalked to a different plan in accordance with the crosswalk hierarchy at § 155.335(j).

Additionally, if issuers wished to continue offering the chronic and high-cost condition plans originally offered through the exceptions process with the same cost sharing structures, they would also be permitted to do so, and enrollees in these plans would continue to be auto-reenrolled in these plans from one plan year to the next. Finally, if issuers wished to continue offering the chronic and high-cost condition plans originally offered through the exceptions process but also wished to modify these plans' cost sharing structures, they would be permitted to do so, but these issuers would continue to be subject to the requirements under the definition of ''plan'' at § 144.103 and to the uniform modification requirements at § 147.106.

In most scenarios where an issuer modifies the cost sharing structure of one of its chronic and high-cost condition plans originally offered through the exceptions process (or other non-standardized plan options not associated with the non-standardized plan option limit exceptions process that they currently offer subject to the existing non-standardized plan option limit), the newly modified plan that was formerly the exceptions process plan would be considered a new plan and would therefore require a new plan ID. In this scenario, enrollees would be crosswalked from the discontinued plan to another plan in accordance with the crosswalk hierarchy at § 155.335(j). These enrollees could be crosswalked into the newly modified plan that was formerly the exceptions process plan, or an entirely different plan altogether, depending on the unique circumstances in each county.

However, under the definition of ''plan'' at § 144.103, a State may permit issuers to make greater changes to a plan's cost sharing while still permitting that plan to be considered the same plan—thus maintaining the same plan ID. Furthermore, under § 147.106(e)(3)(iv), as long as the variation in cost sharing is solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level (and other applicable requirements under § 147.106(e) are met), the modifications could be considered uniform (thus, a viable exception to guaranteed renewability).

In the scenario where an issuer modifies what was formerly an exceptions process plan's cost sharing structure while maintaining the same plan ID, enrollees in the plan would be auto-reenrolled from one plan year to the next. In either case, whether the modification of a former exceptions process plan's cost sharing results in that plan being considered the same or a different plan, enrollees would be crosswalked in accordance with the crosswalk hierarchy at § 155.335(j), including reenrollment, if applicable.

We propose this approach for several reasons. As discussed earlier in this section and in the section of this proposed rule addressing proposed updates to § 156.201, for the last several plan years, we have employed a multi-faceted strategy in an attempt to streamline the consumer experience. This strategy entailed requiring issuers to offer standardized plan options, requiring these plans to meaningfully differ from one another, differentially displaying these plans, making additional enhancements to choice architecture on *HealthCare.gov,* limiting the number of non-standardized plan options that issuers can offer through the FFEs and SBE–FPs, and permitting issuers to offer additional non-standardized plan options beyond this limit if issuers demonstrate that these plans would substantially benefit consumers with chronic and high-cost conditions.

As we noted in the preamble section of this proposed rule addressing the proposed removal of § 156.201, we have accumulated 4 plan years of experience (PY 2023 through PY 2026) administering this strategy. This cumulative experience provides us with a comprehensive and nuanced perspective regarding weighing both the advantages and disadvantages of employing this strategy, whether this strategy has aligned with our originally articulated objectives, and whether this strategy has yielded the intended results.

Similar to our view on the ineffectiveness of employing standardized plan option requirements, based on this experience, we have concluded that imposing non-standardized plan option limits and permitting exceptions to this limit for chronic and high-cost condition plans is an ineffective strategy in counteracting plan proliferation and enhancing the consumer experience on *HealthCare.gov,* the originally articulated objectives of employing our

non-standardized plan option limits and related exceptions process policies.

This is because requiring issuers to offer additional plans in the form of standardized plan options increased the weighted average number of total plans available per enrollee from 108 in PY 2022, the year before the introduction of the requirement to offer standardized plan options, to 114 in PY 2023, the year in which this requirement was introduced, with most of this increase in plans being comprised of standardized plan options. Furthermore, plan proliferation as measured by the weighted average number of total plans offered per issuer (which is derived by dividing the weighted average number of total plans available per enrollee by the weighted average number of total issuers per enrollee) increased from 16.9 in PY 2022 to 17.3 in PY 2023—meaning each issuer on average tended to offer a higher number of plans after the imposition of the requirement to offer standardized plan options than the year before this requirement was made effective.[181]

Furthermore, even with the introduction of the non-standardized plan option limit of four in PY 2024 and its reduction to two as well as the introduction of the exceptions process in PY 2025, the net impact of both the requirement to offer standardized plan options as well as the subsequent imposition of non-standardized plan option limits and exceptions on the weighted average number of total plans available per enrollee and the weighted average number of total plans offered per issuer (including both standardized and non-standardized plan options) was marginal—despite the substantially increased regulatory complexity and the associated burden of creating and submitting certification applications for new plans (standardized plan options) and correspondingly adjusting existing portfolios of plan offerings (non-standardized plan options).

Specifically, the weighted average number of total plans available per enrollee was reduced from 114 in PY 2023 to 100 in PY 2024 (when the non-standardized plan option limit of four was introduced) and remained constant at 100 in PY 2025 (when the limit was reduced to two and the non-standardized plan option limit exceptions process was introduced). Relatedly, the weighted average number of total plans offered per issuer decreased from 17.3 in PY 2023 to 14.7 in PY 2024 and 13.7 in PY 2025. Thus, in PY 2022, the year before this suite of policies was introduced, there was a weighted average number of 108 total plans available per enrollee and a weighted average number of 16.9 total plans offered per issuer, whereas in PY 2025 (after several consecutive years of imposing new layers of requirement), these same measures were 100 and 13.7, respectively.

We do not believe that the marginal net reductions in the weighted average number of total plans available per enrollee and the weighted average number of total plans offered per issuer achieved by introducing this suite of standardized plan option and non-standardized plan option limit and exceptions requirements warrant imposing additional burden, impeding issuer innovation in plan design, and constraining consumer choice—especially given that these reductions are largely indiscernible to consumers during the plan selection process. This is especially true given that these metrics continue to remain significantly elevated compared to only several plan years ago. Specifically, in PY 2020, the weighted average number of total plans available per enrollee was 39, and the weighted average number of total plans offered per issuer was 11.1.

Thus, the primary metric by which we have evaluated plan proliferation (the weighted average number of total QHPs available per enrollee in the FFEs and SBE–FPs) has remained relatively constant despite the imposition of multiple layers of requirements from PY 2023 to PY 2025 (specifically, the requirement to offer standardized plan options in PY 2023, non-standardized plan option limits in PY 2024, and the reduction of this limit and the introduction of the exceptions process in PY 2025). Further, the imposition of these requirements substantially increased burden for both issuers and HHS (that is, the burden associated with issuers creating and submitting certification applications for additional plans that would otherwise not be created and offered and HHS reviewing and certifying these additional plans). This suite of policies creates additional fixed costs for issuers, introducing market inefficiencies. Finally, the imposition of these requirements caused a significant degree of market disruption—as reflected by the substantial number of plan discontinuations and the high number of enrollees impacted by these discontinuations, as is discussed in greater detail later in this section.

We refer readers to the section III.E.8 of this proposed rule addressing the proposal to discontinue standardized plan options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv)) for a detailed discussion of relevant literature we also considered in our approach to the proposal to discontinue non-standardized plan option limits and exceptions.

Relatedly, the strategy of requiring issuers to offer standardized plan options, differentially displaying these plans on *HealthCare.gov* and the DE pathways, and limiting the number of non-standardized plan options that issuers can offer was intended to enhance plan comparability for consumers navigating the plan selection process. Theoretically, requiring issuers to offer plans with standardized cost sharing parameters would facilitate the plan selection process by reducing the number of factors that consumers must consider when evaluating all available plan options—since a certain subset of plans would have the same cost sharing parameters. As a result of having access to plans with standardized cost sharing parameters, consumers would theoretically have the ability to shift their focus to other important plan attributes, such as premiums, benefit coverage, provider networks, formularies, and quality ratings, during the plan selection process.

However, in practice, given that standardized plan options continue to be offered alongside non-standardized plan options, whether a particular plan option was a standardized or non-standardized plan option served as yet another variable that consumers must consider during the plan selection process. Furthermore, in our experience, we have found when consumers are faced with a large number of heterogeneous plan options, they continue to rely primarily on premiums, networks, and issuer brand—meaning that standardizing cost sharing parameters alone (especially when doing so only for a subset of all available plan options) fails to meaningfully reduce decision complexity for consumers.

In addition, we believe the fact that the consistently high proportion of total FFE and SBE–FP enrollment in as well as active selections (which includes both consumers currently enrolled in a QHP who are making a new plan selection as well as consumers who are enrolling in any QHP offered through the FFEs and SBE–FPs for the first time, but excludes consumers who are auto-reenrolled in their current QHP from one year to the next) of non-standardized plan options reflects the

[181] ''Plan Year 2025 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces.'' October 25, 2024. *https://www.cms.gov/files/document/2025-qhp-premiums-choice-report.pdf.*

fact that consumers value the full range of choice within these plan offerings.

Specifically, 80 percent of all consumers in the FFEs and SBE–FPs were enrolled in non-standardized plan options in PY 2023, 67 percent in PY 2024, and 67 percent in PY 2025. Furthermore, non-standardized plan options constituted 82 percent of FFE and SBE–FP active selections in PY 2023, 74 percent in PY 2024, and 82 percent in PY 2025.[182] Relatedly, 75 percent of total plan offerings were non-standardized plan options in PY 2023, 72 percent in PY 2024, and 69 percent in PY 2025.[183] Thus, total enrollment in non-standardized plan options was higher compared to what would be expected based on the total proportion of plans that were non-standardized plan options in PY 2023 and within the expected range of deviation for PY 2024 and PY 2025. Furthermore, active plan selections for non-standardized plan options were higher compared to what would be expected based on the total proportion of plans that were non-standardized plan options in PY 2023, PY 2024, and PY 2025.

The consistently low proportion of consumers enrolled in standardized plan options over the years suggests that these plans fail to appeal to consumers compared to corresponding non-standardized plan options—or at the very least that consumers are unable to perceive a significant difference between standardized and non-standardized plan options. This is despite the full suite of differential display features for standardized plan options on *HealthCare.gov* and the DE pathways that visually distinguish standardized plan options from non-standardized plan options and effectively steer consumers into standardized plan options and away from corresponding non-standardized plan options in accordance with §§ 155.205(b)(1), 155.220(c)(3)(i)(H), and 156.265(b)(3)(iv).

Without this full suite of differential display features that visually distinguishes standardized plan options from non-standardized plan options, the proportion of FFE and SBE–FP total enrollment in and active selections of non-standardized plan options would likely be considerably higher. We believe consumers' demonstrated preference for non-standardized plan options (as measured by both total enrollment and active plan selections) is in large part due to the fact that there is a greater degree of choice and variety in these plan offerings compared to standardized plan options.

Indeed, as we stated in the 2024 Payment Notice (88 FR 25860), many commenters who opposed imposing non-standardized plan option limits emphasized the importance of permitting issuers to maintain a diverse range of plan offerings as a mechanism to maximize the degree of consumer choice. These commenters specifically explained that imposing non-standardized plan option limits would force issuers to drastically reduce the unique plan designs they have thoughtfully developed to best serve their members' health care needs, which would in turn force consumers into a ''one-size fits all'' benefit offering.

Relatedly, the combination of standardized plan option requirements as well as non-standardized plan option limits has increasingly constrained issuers' ability to offer a sufficiently broad range of plans for several plan years. This includes plans with tiered provider networks, plans with separate medical and drug deductibles (as opposed to integrated medical and drug deductibles), plans with separate medical and drug MOOPs (as opposed to integrated medical and drug MOOPs), HSA-eligible high-deductible health plans (HDHPs), and plans with more than four tiers of prescription drug coverage.

Issuers have been constrained by these requirements since they have been forced to discontinue offerings to comply with the non-standardized plan option limit. The plans that issuers have discontinued have generally been those with lower enrollment—which has often been plans with the aforementioned design features. Thus, removing this suite of requirements would grant issuers additional flexibility to once more vary plans along these parameters, which would enhance consumer choice. Removing this suite of requirements would also simultaneously reduce the issuer burden associated with creating and submitting additional QHP certification applications as well as HHS burden in reviewing and approving these applications.

Regarding market disruption that arose from issuers discontinuing plans to conform to the non-standardized plan option limit, we acknowledge that there is a baseline rate of routine plan discontinuations on the FFEs and SBE–FPs that occur for a range of reasons unrelated to the imposition of new requirements. For example, in the FFEs and SBE–FPs from PY 2020 to PY 2021, 17 percent of plan-county combinations were discontinued, affecting 10 percent of enrollees.[184] Additionally, in the FFEs and SBE–FPs from PY 2021 to PY 2022, 22 percent of plan-county combinations were discontinued, affecting 13 percent of enrollees. Thus, based on measures from the 2 plan years immediately preceding the introduction of the standardized plan option requirements in PY 2023, the baseline rate of routine plan-county discontinuations in the FFEs and SBE–FPs ranged from 17 to 22 percent, while the corresponding baseline rate of enrollees impacted by these discontinuations ranged from 10 to 13 percent.

However, from PY 2022 to PY 2023, when the requirement for FFE and SBE–FP QHP issuers to offer standardized plan options was introduced, 35 percent of plan-county combinations in the FFEs and SBE–FPs were discontinued, affecting 19 percent of enrollees. From PY 2023 to PY 2024, when the non-standardized plan option limit of four was introduced, 24 percent of plan-county combinations in the FFEs and SBE–FPs were discontinued, affecting 17 percent of enrollees. Finally, from PY 2024 to PY 2025, when the non-standardized plan option limit was reduced from four to two, 24 percent of plan-county combinations in the FFEs and SBE–FPs were discontinued, affecting 15 percent of enrollees on the FFEs and SBE–FPs.

Thus, employing these standardized plan option, non-standardized plan option limit, and non-standardized plan option limit exceptions process policies coincided with an increase in plan-county discontinuations of 18 percent and an increase in enrollees affected by these discontinuations of 9 percent compared to the years immediately preceding the introduction of these requirements (specifically between PY 2020 and 2021 and when the requirement to offer standardized plan options was introduced from PY 2022 to PY 2023). Ultimately, requiring issuers to discontinue other existing plans (to comply with the new non-standardized plan option limits) increased plan-county discontinuations and the number of enrollees affected by these discontinuations.

[182] ''Marketplace Open Enrollment Period Public Use Files.'' *https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products.*

[183] ''Plan Year 2025 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces.'' October 25, 2024. *https://www.cms.gov/files/document/2025-qhp-premiums-choice-report.pdf.*

[184] Plan-county combinations are the count of unique plan ID and FIPS code combinations. This measure was used because a single plan may be available in multiple counties, and specific limits on non-standardized plan options may have different impacts on one county where there are four plans of the same product network type and metal level versus another county where there are only two plans of the same product network type and metal level, for example.

We acknowledge that some portion of these plan discontinuations and the subsequent number of enrollees affected by these discontinuations is attributable to the narrowing of the AV *de minimis* ranges per §§ 156.140, 156.200, and 156.400 in PY 2023 (such as the narrowing the AV *de minimis* range for on-Exchange silver offerings from 66 percent through 72 percent to 70 percent through 72 percent—which required issuers to either discontinue or modify offerings within the 66 percent through 70 percent range to have an AV within the 70 through 72 percent range). However, the rates of plan-county discontinuations and the subsequent number of enrollees impacted by these discontinuations continued to remain elevated in PY 2024 and PY 2025 (as the non-standardized plan option limit was introduced and subsequently reduced) compared to baseline rates of plan-county discontinuations and the number of enrollees affected by these discontinuations in PY 2020 through PY 2022—implying that a substantial portion of these discontinuations was also attributable to the imposition of the requirement to offer standardized plan options as well as the introduction of the non-standardized plan option limit.

Given this accumulation of data, we no longer believe that the advantages of imposing non-standardized plan option limits and exceptions (namely, a marginal net reduction in plan proliferation) outweigh the disadvantages of imposing these requirements (namely, increased burden, increased regulatory complexity, market disruption, inhibition of issuer innovation in plan design, and constrained consumer choice).

Altogether, we propose to discontinue non-standardized plan option limits under § 156.202(a) through (c) and the corresponding exceptions process under § 156.202(d) through (e), since we have concluded that adopting these measures (in conjunction with requiring issuers to offer standardized plan options) is an ineffective method of achieving our originally articulated objectives of employing this suite of policies to streamline the plan selection process, counteract plan proliferation, and reduce the risk of plan choice overload for consumers on *HealthCare.gov.* Furthermore, discontinuing these policies would decrease regulatory complexity, issuer burden, and the market disruption caused by plan discontinuations arising from the non-standardized plan option limit. Finally, discontinuing these policies would enhance consumer choice by supporting issuers' ability to innovate in plan designs.

We seek comment on this proposal.

10. Deferral of Network Adequacy Reviews to States With an Effective Provider Access Review Program (§§ 156.230 and 155.1050)

We propose to exercise our authority under sections 1311(c)(1)(B) and 1321(a)(1)(B) of the Affordable Care Act to defer reviews of network adequacy to FFE States, including States performing plan management, provided the State elects to conduct such reviews, and demonstrates sufficient authority and the technical capacity to conduct network adequacy reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program under proposed § 155.1050(d)(2) through (d)(4). We propose to revise § 156.230 to clarify that HHS would continue to conduct network adequacy reviews using standards described at § 156.230(a)(2) through (a)(4) for QHP issuers that use a provider network in FFE States that do not elect to conduct their own provider access reviews, or that HHS has determined do not satisfy applicable criteria to be considered to have an Effective Provider Access Review Program, as described at proposed § 155.1050(d).

Section 1311(c)(1)(B) of the Affordable Care Act requires the Secretary to establish minimum criteria for provider network adequacy that a health plan must meet to be certified as a QHP. Section 1321(a)(1)(B) of the Affordable Care Act directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the Affordable Care Act, which includes section 1311, for, among other matters, the offering of QHPs through such Exchanges.

In the Exchange Establishment Rule (77 FR 18418), we set forth minimum network adequacy standards that plans must satisfy to be certified as QHPs at § 156.230. The Exchange Establishment Rule (77 FR 18409 through 18420) provided that an issuer of a QHP that uses a provider network must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible to enrollees without unreasonable delay. In the 2016 Payment Notice (80 FR 10830 through 10833), we revised § 156.230(a) to clarify that network adequacy requirements only apply to QHPs that use a provider network, defining such networks as networks comprised only of providers that are contracted as in-network. For PYs 2015 through 2017, the FFEs conducted network adequacy reviews of proposed QHPs for compliance with network adequacy time and distance standards.

The 2017 Market Stabilization final rule (82 FR 18346) initially deferred reviews of network adequacy for QHPs to States that HHS determined to have a sufficient network adequacy review process, an approach that was reiterated in the 2019 Payment Notice (83 FR 16930). Specifically, we deferred these reviews to States that possessed sufficient authority to enforce network adequacy standards that were at least equal to the reasonable access standard defined in § 156.230 and that had the means to assess the adequacy of plans' provider networks. In States without the authority or means to conduct network adequacy reviews, we relied on an issuer's accreditation (commercial, Medicaid, or Exchange) from an HHS-recognized accrediting entity—specifically, either The National Committee for Quality Assurance (NCQA), URAC, or Accreditation Association for Ambulatory Health Care (AAAHC). Any unaccredited issuers were required to submit an access plan to demonstrate that the proposed QHP's provider network met the requirement in § 156.230(a)(2) to demonstrate that an issuer had standards and procedures in place to maintain an adequate provider network consistent with the National Association of Insurance Commissioners' (NAIC's) Health Benefit Plan Network Access and Adequacy Model Act. To provide additional support to States, we further coordinated with States to monitor network adequacy through consumer complaint tracking and resolution.

On March 4, 2021, the United States District Court for the District of Maryland issued its decision in *City of Columbus* v. *Cochran*, which addressed a challenge to the policy of outsourcing network adequacy reviews.[185] The court specifically vacated the portion of the 2019 Payment Notice's deferral of network adequacy reviews of QHPs offered through the FFEs to States with the authority and means to conduct sufficient network adequacy reviews, first finalized in rulemaking in the Market Stabilization final rule (83 FR 17024 through 17026). While the decision held that our policy of deferring network adequacy reviews to the States was not contrary to law, the court vacated the policy as an arbitrary and capricious agency action, holding

[185] *City of Columbus* v. *Cochran,* 523 F. Supp. 3d 731 (D. Md. 2021).

that HHS did not meaningfully respond to comments and evidence in the record.

Comments and evidence in question centered around assessment of States' ability to meaningfully conduct network adequacy reviews, and the use of accreditation as a basis for determining QHP issuers' satisfaction of provider network adequacy standards. Commenters stated that States' and accrediting entities' review processes do not do enough to ensure enrollees have adequate access to necessary care. In particular, the decision raised concerns about HHS' position that States' network adequacy review procedures are adequate simply because States have State-specific regulations without explaining what these entail or why they are comparable to review under Federal standards. The court also raised concerns about comments stating that State review procedures are often not adequate, have no quantitative standards for network adequacy in place, and, in many States, are complaint driven rather than preemptive, as well as comments that in some States, requirements only apply to certain types of plan designs. Comments expressing concern about relying on accreditation as a determination of network adequacy standard satisfaction stated that accreditation standards are not public, accreditors do not have regulatory authority over plans, and accreditors are not in a position to monitor network adequacy via consumer complaints or other means.

In the 2023 Payment Notice (87 FR 27322), we finalized that we would evaluate the adequacy of QHP provider networks offered through the FFEs, or of plans seeking certification as FFE QHPs, except for FFEs in States performing plan management (that is, Michigan, New Hampshire, South Dakota, and West Virginia) beginning with the 2023 QHP certification cycle. Additionally, in the 2023 Payment Notice (87 FR 27322), we adopted time and distance standards at § 156.230(a)(2) to assess whether plans seeking to be certified as QHPs in all FFE States meet network adequacy time and distance requirements.

In the 2024 Payment Notice (88 FR 25740), we revised network adequacy standards at § 156.230(a)(2) to establish appointment wait time standards starting in PY 2025. We also required all individual market QHPs, including individual market SADPs, and all SHOP QHPs, including SHOP SADPs, across all Exchanges to use a network of providers that complies with the network adequacy standards, and removed the exception that these requirements do not apply to plans that do not use a provider network. A limited exception was finalized at § 156.230(a)(4) for certain SADP issuers that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers.

In the 2025 Payment Notice (89 FR 26218), we finalized § 155.1050(a)(2)(i)(A) to require that State Exchanges and SBE–FPs establish and impose quantitative time and distance network adequacy standards for QHPs that are at least as stringent as standards for QHPs participating on the FFEs under § 156.230. We also finalized § 155.1050(a)(2)(i)(B) which required that, for plan years beginning on or after January 1, 2026, State Exchanges and SBE–FPs conduct quantitative network adequacy reviews to evaluate a plan's compliance with network adequacy standards under § 156.230(a)(1)(ii), (a)(1)(iii), and (a)(2)(i)(A) prior to certifying any plan as a QHP, while providing QHP certification applicants the flexibilities described under § 156.230(a)(2)(ii) and (a)(3) and (4).

To implement the requirements for FFEs that were in place from PY 2023 and beyond as outlined above, we published in the 2023 Final Letter to Issuers in the Federally-facilitated Exchanges [186] a list of provider types and facility types, developed consistent with industry standards, alongside the time and distance standard for each provider or facility specialty type for each county type designation which are based on population size and density parameters (Large Metro, Metro, Micro, Rural, and Counties with Extreme Access Considerations). All FFE issuers were required to submit a Network Adequacy (NA) template during the QHP Certification period which is populated with their in-network provider and facility information (for example, NPI, specialty type, address(s) of their practice(s)). We used that information to conduct geocoding analyses for compliance with network adequacy standards.[187] This is an iterative process during QHP certification, with issuers informed of their review results and encouraged to contract with more providers to meet the standards if appropriate. Though there was no requirement for issuers to contract with a third-party vendor to assist with populating network adequacy templates, we are aware of some issuers that opt to outsource this work to vendors that have access to their claims data to assist in populating the template with providers with which the issuer is actively contracted.

Additionally, beginning January 1, 2025, QHP issuers in the FFEs were required to meet appointment wait time standards established in the 2023 Letter to Issuers.[188] The 2025 Final Letter to Issuers on the Federally-facilitated Exchanges established the requirement for QHP issuers to contract with a third-party entity to administer secret shopper surveys on a sample of in-network providers to determine their level of compliance with appointment wait time standards for two provider types; [189] specifically, the requirement that enrollees would be able to schedule an appointment at least 90% of the time within 15 business days for routine primary care, within 10 business days for behavioral health providers, and within 30 business days for routine specialty providers. We use the final Network Adequacy templates submitted by FFE issuers during QHP certification to generate the Provider Population Files for QHP issuers and their third-party entity to develop the Appointment Wait Time Secret Shopper Survey Samples as outlined in the Appointment Wait Time Secret Shopper Survey Technical Guidance.

The preceding years of conducting reviews of QHP issuer provider network adequacy, including analyzing issuer submitted data and through discussions with States, issuers, and other various interested parties around diverse market conditions, have demonstrated that a one-size-fits all approach to provider network adequacy review is not satisfactory. For example, issuers have highlighted to us persistent challenges in locating and contracting with enough providers of various specialties (for example, allergy and immunology, behavioral health, gastroenterology) in remote or difficult to access areas of a State. States have brought to our attention various geographic constraints that impact QHP issuers' ability to satisfy time and distance requirements and have made suggestions to assess a QHP issuer's ability to meet a time or a distance standard individually, rather

[186] ''2023 Final Letter to Issuers in the Federally-facilitated Exchanges'', April 28, 2022. Available at *https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf.*

[187] Geocoding is the process of converting provider street addresses, into geographic coordinates (latitude and longitude), enabling them to be used in the calculation of time and distance analysis.

[188] ''2023 Final Letter to Issuers in the Federally-facilitated Exchanges'', April 28, 2022. Available at *https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf.*

[189] ''2025 Final Letter to Issuers in the Federally-facilitated Exchanges'', April 10, 2024. Available at *https://www.cms.gov/files/document/2025-letter-issuers.pdf.*

than requiring it to meet a standard that assesses time and distance together, which may be insurmountable due to a topographical constraint such as a body of water or navigating roads in mountainous terrain.[190]

Partnerships with States performing plan management, who have elected to conduct their own network adequacy reviews, have also highlighted for us how States may innovate in their approach to conducting network adequacy reviews that are sensitive to conditions and capacity in the State. For example, we are aware of States performing plan management that assess network adequacy based on access to services rather than provider types. Deferring network adequacy reviews to FFE States that demonstrate sufficient authority and the technical capacity by satisfying the criteria to demonstrate they have an Effective Provider Access Review Program would empower these States to similarly innovate and mold their network adequacy standards to the needs of consumers in their individual States. For example, a State may find it is in the interest of their consumers to assess network adequacy using a time or a distance standard individually rather than assessing whether a QHP issuer meets a time and distance standard, make adjustments to time and distance standards that account for more remote areas or more urban areas, assess network adequacy in different ways such as through provider-enrollee ratios, expand or change the provider types they assess, and implement other innovative, State-specific approaches to identify and address the systemic issues that result in many issuers being unable to meet the network adequacy standards described at § 156.230(a)(2). A State, with its more intimate knowledge of its own demographics, topography, quantity, and density of providers, is often best positioned to evaluate local provider networks and market conditions and tailor network adequacy standards in a more nuanced way than Federal requirements.

[190] CMS currently uses a calculation for network adequacy that factors in both time and distance. Time and distance is especially critical in large metro areas where there is a standard of 15 miles/30 minutes as an example. There may be many providers available within 15 miles, but the time to travel would far exceed 30 minutes due to slower travel speeds in urban areas. The ''and'' condition makes it necessary for a provider location to be available within both the mileage and the time criteria. We are aware of State Exchanges and SBE–FP States that have implemented an ''or'' condition, particularly in rural areas where topographical limitations may make it feasible to meet a time requirement or a distance requirement without a need to meet both to ensure reasonable access to all services by enrollees without unreasonable delay.

Thus, in recognition of the crucial role States have in developing and enforcing network adequacy standards and because we believe that States are often best positioned to evaluate local provider networks and market conditions, we propose at § 155.1050(d), for PY 2027 and beyond, to allow FFE States, including States that perform plan management, that elect to do so, to conduct reviews for provider access for issuers' plans that use and do not use a provider network, provided that we determine the State has sufficient authority and the technical capacity to conduct the reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program as described at proposed § 155.1050(d)(2) through (d)(4). Concurrently, we propose, for plan years beginning on or after January 1, 2027, to amend § 156.230, including (1) revising the section heading to state, ''Provider access standards for network plans''; (2) revising § 156.230(a)(1) to remove the requirement that a QHP must use a provider network and clarify that the standards described in § 156.230(a)(1)(i), (ii), and (iii) apply to a QHP that uses a network of providers; (3) revising § 156.230(a)(2)(i) and (ii) to clarify that requirements for issuers of QHPs to meet time and distance standards and appointment wait time standards at § 156.230(a)(2) only apply to States that do not elect to conduct their own provider access reviews or States that we have determined do not do not satisfy the criteria to be considered to have an Effective Provider Access Review Program as described at proposed § 155.1050(d) and explained further in this section; (4) revising the exception at § 156.230(a)(3) to clarify that it applies only when HHS is conducting network adequacy reviews; and (5) revising § 156.230(a)(4) to conform with proposed revisions to § 156.230(a)(1).

Additionally, in recognition of the traditional role that all State Exchanges and SBE–FPs have in developing and enforcing network adequacy standards and to align with proposed changes for FFE States detailed in section III.D.18 of this proposed rule, we propose to remove the requirements under § 155.1050(a)(2)(i) and (ii) for State Exchanges and SBE–FPs to establish and impose quantitative time and distance network adequacy standards for QHPs that are at least as stringent as standards for QHPs participating on the FFEs under § 156.230 and to no longer require State Exchanges and SBE–FPs to conduct quantitative network adequacy reviews to evaluate a plan's compliance with network adequacy standards under § 156.230(a)(1)(ii), (a)(1)(iii), and (a)(2)(i)(A) prior to certifying any plan as a QHP. Instead, we propose to restore § 155.1050(a)(2) to a pre-PY 2025 policy and require that State Exchanges and SBE–FPs must ensure that each QHP provides sufficient access to providers in a manner that meets applicable standards specified in § 156.230(a)(1)(ii) and (iii) for network plans, or proposed § 156.236(a) for non-network plans, as applicable. This proposal is discussed in more detail in section III.D.18 of this proposed rule.

In addition, we also now believe that there are alternative administrable regulatory standards that can ensure satisfaction of provider sufficiency requirements by QHPs that do not use traditional contracted networks of providers and that, especially in light of efforts to improve health care price transparency, an expanded definition of how to achieve sufficient access to providers would allow for innovations in plan design. Our proposal to allow for QHP certification of plans without a provider network is described in detail in section III.E.12 of this proposed rule.

Our proposed revisions to §§ 156.230(a)(2)(i) and (ii) and (a)(3) reflect our proposed change in policy at § 155.1050(d) to defer network adequacy reviews to FFE States that elect to perform such reviews, and that demonstrate they have sufficient authority and the technical capacity to conduct these reviews by satisfying the criteria to be considered to have an Effective Provider Access Review Program as described at § 155.1050(d)(2) through (d)(4), while also retaining Federal standards for HHS to utilize in conducting network adequacy reviews, including time and distance and appointment wait time standards, in States that do not elect to conduct such reviews or do not demonstrate they have sufficient authority and the technical capacity to conduct these reviews by satisfying the criteria to be considered to have an Effective Provider Access Review Program.

Network adequacy analyses are often highly data-intensive. Because the FFE has economies of scale in the collection and analysis of various forms of network adequacy data, including time and distance data and appointment wait time data, under our proposal, we would continue collecting this data from all FFE issuers, either to use to conduct Federal network adequacy reviews in FFE States that do not elect to do so or do not demonstrate they have sufficient authority and the technical capacity to conduct these reviews by satisfying the criteria to be

considered to have an Effective Provider Access Review Program as described at § 155.1050(d)(2) through (d)(4), or with a view to make it available in a standardized format to States that are determined to have an Effective Provider Access Review Program, to assist them in their network adequacy analysis. We have extensive tools to standardize data, including a network adequacy template, other supporting document templates, manual data validation resources, and FAQs. The continuation of the aforementioned activities would support consumer protection as HHS would maintain an ability to utilize the collected data to research and address consumer or other complaints, provide continuity for States that may need time to expand their technical capacity and seek to rely on our infrastructure, and prevent any gaps in awareness as FFE States expand and fortify their own reviews. This aspect of our proposal primarily seeks to support States that do not presently have sufficient authority or the technical capacity to conduct reviews and States that demonstrate sufficient authority and the technical capacity but seek to capitalize on HHS' data collection and analysis to supplement their provider access review programs. We believe this approach appropriately balances State and Federal responsibilities as it seeks to empower States that elect to conduct network adequacy reviews but also utilizes Federal systems to provide support to States, maximizing consumer protection and taking advantage of State expertise in developing and enforcing provider network adequacy requirements.

We would consider a State to have sufficient authority and the technical capacity to conduct network adequacy reviews if the State meets criteria set forth at proposed § 155.1050(d)(2) through (4)(discussed at section III.D.18. of this proposed rule). The proposal also clarifies that if States are not determined to have an Effective Provider Access Review Program, then HHS would continue to perform provider access certification reviews consistent with § 156.230(a)(1) through (a)(4) for network plans and proposed § 156.236 for non-network plans.

As proposed at § 155.1050(d)(2), an FFE State with an Effective Provider Access Review Program would be required to ensure that a QHP issuer that uses a network of providers ensures that its network of providers, as available to all enrollees, includes ECPs in accordance with § 156.235, and maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay, and is consistent with the rules for network plans of section 2702(c) of the PHS Act. We propose at § 155.1050(d)(3) that an FFE State with an Effective Provider Access Review Program must ensure that a QHP issuer that does not use a network of providers (a non-network plan) provides access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full, including ECPs and providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay.

Under our proposal at § 155.1050(d)(4), a State operating an FFE that elects to conduct its own provider access reviews would be considered to have an Effective Provider Access Review Program by satisfying the following requirements:

(1) The FFE State has established provider access standards that are set forth in State statute or regulation which are consistent with provider access standards as set forth in § 156.230(a)(1)(ii) and (iii), and reports to HHS whether the State has delegated authority to some entity other than the State Department of Insurance to perform any or all provider access review activities;

(2) The FFE State's provider access review process includes reporting systems for State-required provider access metrics and documentation of methodology and the State provides descriptions of all data collection systems, resources, templates, and methodologies used by the State or the State's delegated entity to collect and review provider access data; and the State receives from issuers data and documentation in connection with provider access standards that are sufficient to conduct the examination;

(3) The FFE State's provider access review process includes procedures to ensure full and ongoing compliance with State provider access standards and enforcement frameworks applicable to issuers that fail to meet provider access standards so that those issuers come into compliance with State provider access standards, including standardized processes to assess efforts the issuer is pursuing to come into compliance with State provider access standards, and implementing any justification and exception processes for issuers that have not yet or cannot meet provider access requirements;

(4) The FFE State establishes and maintains clear procedures and timeline requirements for regular provider access reviews, including processes that ensure reviews occur prior to each plan year's QHP certification cycle;

(5) The FFE State has a process for monitoring and addressing consumer-related provider access complaints to ensure sufficient access to providers consistent with section 1311(c)(1)(B) of the Affordable Care Act and as set forth in State statute; and

(6) The FFE State has a process to collect and review information sufficient to show that non-network plans provide access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full.

We propose at § 155.1050(d)(5) that we would determine whether a State has an Effective Provider Access Review Program based on information available to us that demonstrates whether the program meets the criteria described at proposed § 155.1050(d)(4). We propose at § 155.1050(d)(6) that we may also grant an exception to these criteria if we determine that making such an exception is in the interests of qualified individuals in the State or States in which such Exchange operates. We also propose at § 155.1050(d)(7) that we would notify the FFE State electing to conduct provider access certification reviews of our decision in writing regarding whether the State is determined to have an Effective Provider Access Review Program and can therefore conduct its own provider access certification reviews. We propose that we would also reserve the right at any time to evaluate whether, and to what extent, a State's circumstances have changed such that it has established, or no longer has, an Effective Provider Access Review Program under § 155.1050(d). We propose that these evaluations may result in HHS assuming provider access review responsibilities or transitioning such responsibilities back to the State.

We also propose that a State would need to demonstrate that it meets applicable criteria for both network plans and non-network plans under § 155.1050(d), if they decide to certify such plans, in order to receive the designation to have an Effective Provider Access Review Program. This would mean that a State would not be permitted to elect to conduct provider access certification reviews for only network plans and not non-network plans, if they certify such plans, or vice versa. We believe this is important, as some QHP issuers may choose to offer both network and non-network plans and centralizing reviews to a single entity, whether the FFE State or HHS,

for the same issuer, would reduce administrative inefficiencies that may result if the FFE State and HHS have to coordinate provider access certification review results across a range of network and non-network plans. We also believe that review authority being limited to a single entity, either the FFE State or HHS, would allow both network and non-network plans to undergo consistent, standardized reviews conducted by the same reviewing entity. We believe this would ensure similar requirements and methodologies would be applied fairly across network and non-network plans and reduce potential differences in provider access review results. Overall, just as with network plans, non-network plans would be required to ensure sufficient access to a range of providers in a manner consistent with section 1311(c)(1)(B) of the Affordable Care Act.

Rather than specifying the detailed methodology and standards States would be expected to use to determine sufficient access to providers, the proposed factors focus on processes to ensure a State has sufficient authority and the technical capacity to conduct network adequacy reviews. The approach, as set forth at proposed § 155.1050(d), would provide for more than a perfunctory review of authority, but rather would thoroughly investigate States' ability to ensure provider access sufficiency in line with § 156.230(a)(1)(ii) and (iii). This proposed approach would allow States more flexibility in defining network adequacy standards that reflect their local markets, provider availability, geographic considerations, and demographics. We would evaluate if the network adequacy review program in the State has established network adequacy standards that are set forth in State statute and regulation that are consistent with those set forth in § 156.230(a)(1)(ii) and (iii).

The first proposed criterion for evaluation requires that the State has established provider access standards that are set forth in State statute or regulation, which are consistent with provider access standards as set forth in § 156.230(a)(1)(ii) and (iii) and reports to HHS whether the State has delegated authority to some entity other than the State Department of Insurance to perform any or all provider access review activities. This criterion would be crucial as it addresses whether or not the State has sufficient authority to conduct provider access reviews. It would also be important for a State to report to us whether the State has delegated authority to some other entity to perform provider access review activities so we understand how the State is handling provider access review data and to whom it entrusts such data.

The second proposed criterion states that the State's provider access review process includes reporting systems for State required provider access metrics and documentation of methodology and the State provides descriptions of all data collection systems, resources, templates, and methodologies used by the State, or the State's delegated entity, to collect and review provider access data; and the State receives from issuers data and documentation in connection with provider access standards that are sufficient to conduct the examination. This information would be important for us to understand processes a State has in place to appropriately assess provider access. Under our proposal, we would evaluate whether the State's provider access data, documentation, and analysis practices are sufficient to ensure it can conduct provider access reviews.

The third proposed criterion provides that the State's provider access review process includes procedures to ensure full and ongoing compliance with State provider access standards and enforcement frameworks applicable to issuers that fail to meet provider access standards so that those issuers come into compliance with State provider access standards, including standardized processes to assess efforts the issuer is pursuing to come into compliance with State provider access standards, and implementing any justification and exception processes for issuers that have not yet or cannot meet provider access requirements. This information would be important for reasons similar to the previously discussed proposed factor. Ensuring that adequate compliance processes exist would bolster the robustness of any network adequacy review to ensure sufficient provider access.

The fourth proposed criterion requires that the State establish and maintain clear procedures and timeline requirements for regular provider access reviews, including processes that ensure reviews occur prior to each plan year's QHP certification cycle. We believe that it would be important for States to have clearly established procedures for network adequacy review that are not reactive but are preemptive to ensure that plans being offered on an Exchange provide sufficient access to providers and so that consumers shopping for a plan have that guarantee.

The fifth proposed criterion requires the State to have a process for monitoring and addressing consumer-related provider access complaints to ensure sufficient access to providers consistent with section 1311(c)(1)(B) of the Affordable Care Act and as set forth in State statute. This criterion would be important because provider access can change often during the year. For plans using a provider network, contracts may be executed or terminated throughout a plan year for various reasons. Also, any inaccuracies or out-of-date information contained in provider directories can create confusion or be misleading to consumers. Additionally, consumers may have trouble actually making appointments with network providers due to lack of availability of appointments. For plans without a provider network, we anticipate that providers that accept a benefit amount as payment in full may also change frequently depending on market conditions, negotiations, and competition.

The sixth proposed criterion requires the State to have a process to collect and review information capable of demonstrating whether non-network plans provide access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full. This criterion would be important to ensure that, should a State offer non-network plans, these plans also ensure sufficient access to providers.

While these proposed criteria for assessing whether a State has an Effective Provider Access Review Program are comprehensive, we believe this approach would provide ample flexibility to States to determine the best methodology to assess network adequacy within the State. We anticipate each State's approach would be dependent on available resources (for example, technical infrastructure, budget, staffing), topographical considerations, and population needs unique to each State, and we propose to empower States to utilize these factors to evaluate overall State processes that ensure sufficient consumer protection. This proposed approach would not simply 'rubber stamp' approval for a State to conduct provider access reviews upon a perfunctory review of authority but would thoroughly investigate States' processes to ensure provider access sufficiency in line with § 156.230(a)(1) as proposed in this rule. Our proposal also does not dictate the precise network adequacy review methodology which may reasonably differ from State to State.

Under our proposed approach, we would seek to work in partnership with States and would provide numerous resources to States to utilize as they see fit to further develop and enhance their

network adequacy review capabilities. For example, we would offer extensive resources originally developed for Federal network adequacy review during the annual QHP certification cycle as States may work to further develop network adequacy standards and review methods that best suit the conditions of their distinct consumer populations and needs. These tools, including a network adequacy template, other supporting document templates, manual data validation resources, and FAQs, could provide support to interested States as States continue to develop and implement processes to standardize any issuer-submitted data during their reviews, leveraging HHS' extensive experience in identifying efficient data formats and validation processes. This comprehensive support system would be available to States as States continue to develop and implement individualized network adequacy standards and review processes that are most appropriate and protective for their own consumers.

In summary, we propose, for plan years beginning on or after January 1, 2027, to amend § 156.230, including (1) revising the section heading to state, ''Provider access standards for network plans''; (2) revising § 156.230(a)(1) to remove the requirement that a QHP must use a provider network and clarify that the standards described in § 156.230(a)(1)(i), (ii), and (iii) apply to a QHP that uses a network of providers; (3) revising § 156.230(a)(2)(i) and (ii) to clarify that requirements to meet time and distance standards and appointment wait time standards at § 156.230(a)(2) only apply to States that we have determined do not satisfy the criteria to be considered to have an Effective Provider Access Review Program or that do not elect to conduct their own provider access reviews of issuers as described at proposed new § 155.1050(d); (4) revising exceptions to the aforementioned requirements at § 156.230(a)(3), to apply only when HHS is conducting network adequacy reviews; and (5) revising § 156.230(a)(4) to conform with revisions to § 156.230(a)(1). Through these proposed changes, we would defer provider access reviews, for network and non-network plans, to FFE States, including States performing plan management, provided the State elects to conduct such reviews, and demonstrates it has sufficient authority and the technical capacity to conduct network adequacy reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program, as detailed at proposed § 155.1050(d)(2) through (4).

We seek comment on these proposals.

11. Essential Community Provider Standards for Network Plans (§ 156.235) and Implementation of the Effective Essential Community Provider Review Program (§ 155.1051)

For PY 2027 and subsequent plan years, we propose changes to QHP certification requirements with respect to essential community providers (ECPs) included within a network plan issuer's provider network. First, we propose to reduce the minimum percentage requirement (also referred to as the ''ECP thresholds'' or ''ECP threshold requirements'') from 35 to 20 percent. (The minimum percentage requirement specifies a minimum percentage of participating ECPs that must be included within a network plan issuer's provider network based on the total available ECPs within the issuer's service area). Second, we propose to change the narrative justification regulation text at § 156.235(a)(3) and (b)(3) to be consistent with systems changes and existing issuer ECP data submission requirements as part of ECP certification reviews. Third, as further discussed in this section, we propose at new § 155.1051 to allow FFE States, including States performing plan management, to elect to conduct their own ECP certification reviews of QHP issuers' plans provided that the State has sufficient authority and the technical capacity to conduct these reviews by satisfying applicable criteria established by HHS to be considered an Effective Essential Community Provider (ECP) Review Program.

Section 1311(c)(1)(C) of the Affordable Care Act directs the Secretary to establish by regulation certification criteria for QHPs, including criteria that require QHP issuers to include ECPs within health insurance plan networks. ECPs include providers that serve predominantly low-income and medically underserved individuals, such as health care providers described in section 340B(a)(4) of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Act. We first implemented the above statutory provisions of the Affordable Care Act and codified ECP standards at § 156.235 in the Exchange Establishment Rule (77 FR 18310). These standards help ensure medical QHPs and SADP issuers include in their provider networks a sufficient number and geographic distribution of ECPs, where available, as a requirement to receive certification as a QHP.

a. Reduction of the Minimum Percentage (or Threshold) Requirement From 35 to 20 Percent

Sections 156.235(a)(2)(i) and (b)(2)(i) stipulate that a plan applying for QHP certification to be offered through an FFE has a sufficient number and geographic distribution of ECPs if it demonstrates, among other criteria, that its provider network includes as participating providers at least a minimum percentage, as specified by HHS, of available ECPs in each plan's service area collectively across all ECP categories defined under § 156.235(a)(2)(ii)(B). As stated in § 156.235(a)(2)(i) and (b)(2)(i), for purposes of satisfying this minimum percentage requirement, also known as the ECP threshold requirement, multiple providers at a single location count as a single ECP toward both the available ECPs in the plan's service area and the contracted ECPs included in the issuer's network for calculating the threshold.

The minimum percentage requirements have been modified over the years (for example, 20 percent, 30 percent, 35 percent) to accomplish different policy and operational priorities, such as to reduce regulatory burden (82 FR 18373, 83 FR 17025), to align with market conditions (82 FR 18373, 83 FR 17025), to expand access to care for consumers (87 FR 27336, 88 FR 25882), and to promote broader networks (87 FR 27336, 88 FR 25882). For example, for QHP certification for PY 2018, we reduced the minimum percentage requirement from 30 to 20 percent to substantially reduce the regulatory burden on issuers (due to issuers needing to submit less data on provider contracts with ECPs to demonstrate satisfaction of the ECP Standard under § 156.235), while still requiring issuers to include a sufficient number and geographic distribution of ECPs in their networks (82 FR 18373). These minimum percentage requirements have been set at 35 percent since PY 2023 (87 FR 27336). In the 2024 Payment Notice (88 FR 25882), we also began to apply these minimum percentage requirements separately to two existing types of ECP categories that comprise more than 60 percent of all facilities on the HHS ECP List, Federally Qualified Health Centers (FQHCs) and family planning providers, in accordance with revisions to § 156.235(a)(2)(i) and (b)(2)(i).[191]

[191] Revisions made to § 156.235(a)(2)(i) and (b)(2)(i) implemented separate minimum percentage requirements for the FQHC and family planning provider categories by specifying that a plan applying for QHP certification to be offered through

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At a high level, to meet the ECP threshold requirements under § 156.235, issuers have been required to contract with at least 35 percent of available ECPs in each plan's service area to participate in the plan's network (that is, the overall ECP threshold requirement), and separately, at least 35 percent of available FQHCs that qualify as ECPs in the plan's service area (that is, the FQHC threshold requirement), and at least 35 percent of available family planning providers that qualify as ECPs in the service area (that is, the family planning provider threshold requirement).

To reduce administrative burden for QHP issuers, we propose to reduce the overall threshold, FQHC threshold, and family planning provider threshold requirements from 35 to 20 percent for both medical QHP and SADP issuers in FFE States, including States performing plan management, for the upcoming PY 2027 and thereafter. We would consider medical QHP and SADP issuers to have satisfied the overall threshold requirement if these issuers contract with at least 20 percent of available ECPs in each plan's service area collectively across all ECP categories defined under § 156.235(a)(2)(ii)(B) to participate in the plan's provider network. Additionally, medical QHP issuers would be considered to have satisfied the separate FQHC and family planning provider threshold requirements by contracting with at least 20 percent of available FQHCs that qualify as ECPs in the plan's service area and at least 20 percent of available family planning providers that qualify as ECPs in the plan's service area, respectively. SADP issuers would be considered to have satisfied the separate FQHC threshold requirement by contracting with at least 20 percent of FQHCs offering dental services in the plan's service area. The calculation methodology for determining if an issuer meets the threshold requirements would be consistent with previous years.[192] We note that while we propose to lower the threshold requirements for each of these three thresholds, we recognize that issuers have the flexibility to continue to choose to exceed the proposed minimum percentage requirement within their provider networks. Each plan year, ECP certification data consistently indicate that the majority of issuers on the FFE, including States performing plan management, exceed each of the minimum percentage requirements,[193] and in prior years when the minimum percentage requirement was reduced (for example, from 30 to 20 percent during PY 2018), many FFE issuers continued to choose to exceed minimum percentage requirements.

We believe that reducing the overall threshold, FQHC threshold, and family planning provider threshold requirements from 35 to 20 percent would provide additional flexibility for QHP issuers to build provider networks that comply with the ECP Standard under § 156.235. We believe that reverting to the previous 20 percent minimum percentage that issuers were accustomed to at the establishment of the FFE in PY 2014 and during PYs 2018 through 2022 would minimize disruptions for issuers in adjusting to meet the threshold requirements. In the past, several commenters on the Market Stabilization final rule (82 FR 18373) had supported our proposals to decrease ECP threshold requirements, stating that the lower threshold requirement would reduce the administrative burden on issuers, especially for those issuers in rural areas or States with few ECPs. We welcome comments on if the proposed threshold percentage would still enable enrollees to access ECPs in rural areas and would not impose barriers to entry for issuers in rural areas by discouraging issuers from expanding into such areas. Similarly, we expect these proposed changes would continue to reduce the regulatory and administrative burden on QHP issuers, such as by reducing the amount of resources expended to secure and negotiate additional provider contracts and potential compliance related costs associated with submitting additional ECP data on provider contracts to meet the ECP standard under § 156.235. This may provide issuers with more resources and flexibilities while still ensuring that a meaningful number of ECPs are included within an issuer's provider network consistent with the requirements of section 1311(c)(1)(C) of the Affordable Care Act. Though, we solicit comment on whether there is an alternative threshold percentage that is more effective and appropriate, including threshold percentages that may be targeted to specific geographic areas where issuers may require additional flexibilities to meet threshold requirements, and a percentage that strikes the appropriate balance between issuer flexibility and enrollee access. Furthermore, we understand that network participation negotiations are an important tool that issuers use to manage costs; therefore, fewer provider contracts needed to comply with threshold requirements may free up financial resources that issuers may leverage for other activities, such as innovating plan offerings to meet the diverse needs of consumers or passing on savings to consumers through lower premium rates that may especially benefit low-income and underserved populations.

Lastly, we continue to recognize concerns shared previously by commenters related to potential access to care barriers when reducing ECP threshold requirements in the past (82 FR 18373). When ECP threshold requirements were set at or reduced to 20 percent in previous years (PY 2014, PYs 2018 through 2022), we expanded efforts to ensure continued access to care to ECPs within an issuer's provider network. We continuously monitored potential issues raised by consumers and escalated any ECP access concerns identified through monitoring efforts by performing direct outreach to QHP issuers, as appropriate, including as part of post-certification monitoring and compliance efforts. Similarly, we would continue to monitor potential issues and undertake efforts to ensure consumers maintain adequate access to ECPs, and we would address any concerns through future guidance and/or possible rulemaking, as appropriate.

b. Modifications to Narrative Justification Requirements at §§ 156.235(a)(3) and 156.235(b)(3)

Additionally, we propose to change the narrative justification regulation text at § 156.235(a)(3) and (b)(3) to be consistent with system changes, current HHS operational processes, and existing issuer ECP data submission requirements as part of ECP certification

an FFE must include as participating providers within their provider network at least a minimum percentage of available ECPs in each plan's service area *within certain ECP categories,* as specified by HHS. HHS applied this requirement to the FQHC and family planning provider categories.

[192] For calculating an issuer's satisfaction of the threshold requirements, we consider the number of in-network ECPs with which an issuer designates a contract is executed within their QHP certification application. The number of in-network contracted ECPs includes any qualified ECPs located within the plan's service area. The number of in-network contracted ECPs is the numerator in the threshold requirement calculation, and this number is divided by all available and qualified ECPs located within the plan's network service area in the denominator to create a threshold percentage. For the family planning provider and FQHC threshold requirements, we only count family planning providers and FQHCs in the calculation methodology within the numerator and denominator and not other ECP categories.

[193] For PY 2026, the average threshold percentage for all FFE QHP issuers, including issuers in States performing plan management, for the overall ECP threshold requirement was 71 percent, 85 percent for the family planning provider threshold requirement, and 79 percent for the FQHC threshold requirement.

reviews.[194] The regulations at § 156.235(a)(3) and (b)(3) currently state that if a plan applying for QHP certification to be offered through an FFE does not satisfy the ECP standard (under § 156.235(a)(2) for the General ECP Standard and § 156.235(b)(2) for the Alternate ECP Standard), the issuer must include as part of its QHP application a narrative justification describing how the plan's provider network provides an adequate level of service for low-income enrollees or individuals residing in Health Professional Shortage Areas within the plan's service area and how the plan's provider network will be strengthened toward satisfaction of the ECP standard prior to the start of the benefit year.

However, since beginning to collect this narrative justification information in PY 2014, we have instituted multiple refinements and modernizations to this process in recent years, including through innovations and standardizations to ECP data collection by implementing the ECP User Interface (UI) [195] in the Marketplace Plan Management System (MPMS). MPMS allows us to collect the same type of information previously obtained from the narrative justification without having to actually require issuers to fill out the narrative justification. We have integrated the ECP data collection into MPMS such that issuers can easily submit their ECP data, including justification related information previously collected through written narratives and pre-populated Excel templates, without having to again explain or describe how the plan's provider network provides an adequate level of ECPs prior to the start of the benefit year.

Due to these technical enhancements, along with other process efficiencies and resources provided to issuers (for example, Final Plan Year ECP Lists, outreach activities, and change reports), we have been able to efficiently obtain relevant quality data to adequately perform ECP certification reviews while reducing the time and resources required by issuers to submit supporting information, including the narrative justifications required by § 156.235(a)(3) and (b)(3). The ECP data obtained by issuers during the QHP certification process details which qualified ECPs have contracts executed with the issuer within each of the issuer's provider networks and service areas, which allows us to calculate an issuer's satisfaction of the ECP standard. This ECP data also identifies opportunities to alleviate gaps in an issuer's network and service area to ensure reasonable and timely access to ECPs by identifying additional ECPs an issuer may contract with to meet the ECP standard, while also highlighting different contract negotiation statuses that may explain why an issuer has not yet executed a contract with a specific provider.

Therefore, we propose to modify and simplify this regulatory language at § 156.235(a)(3) and (b)(3) to remove the narrative justification and description requirement so that the regulatory language simply requires that an issuer include as part of its QHP application the status of contract offers to qualified ECPs available in the network plan's service area. As stated above, we believe that continuing to collect contract negotiation status data from issuers is essential for performing ECP certification reviews. Not only does this data allow us to monitor an issuer's progress toward contracting with a specific ECP and learn the rationale for why an issuer has yet to offer a contract with a specific ECP, the type of contract negotiation status an issuer selects for an ECP also determines whether the issuer will receive credit for that ECP toward satisfaction of the threshold, category per county, and Indian health care requirements under the ECP Standard. For example, if an issuer designates that an ECP rejected their contract offer in MPMS as part of their QHP application, the issuer will receive credit towards their efforts to offer a contract despite it being rejected as part of the calculations for the category per county and Indian health care requirements under § 156.235(a)(2)(ii), but will not receive credit as part of the calculations for the threshold requirements under § 156.235(a)(2)(i) and (b)(2)(i), which require that contract offers be fully executed with an ECP in order to receive credit. Overall, collecting these contract statuses within the ECP UI in MPMS has allowed us to conduct ECP certification reviews that are as fulsome as certification reviews informed by narrative justifications, since the same information previously collected through narrative justifications is still received within MPMS but submitted by issuers in a simplified format through pre-populated contract status options that reduces issuer burden without written narratives required.

Moreover, this data had previously been collected through ECP narrative justifications, but the ECP UI enhancement now allows us to gather this information from issuers in a simplified and standardized format through various pre-populated fields, which eliminates the need for issuers to provide open-ended written descriptions that may be more time consuming for issuers that are continuing to work toward satisfaction of the ECP standard. In the ECP UI, this data is mainly collected from the status of contract negotiations. For example, the issuer could designate in its QHP application the contract negotiation status with an ECP for its networks by selecting if a contract was executed, a contract offer was made and awaiting a response, or a contract was not offered due to no response following issuer outreach, as some of the available standardized options.[196] To reflect collecting this type of information as part of ECP certification reviews, we propose to revise the regulations at § 156.235(a)(3) and (b)(3) to state that a network plan applying for QHP certification to be offered through a FFE must include as part of its QHP application the status of contract offers to qualified ECPs available in the network plan's service area. We note that since issuers have already been including this information as part of their QHP applications since PY 2025, there would be no substantive operational changes as a result of this proposal to the ECP data submission process as part of QHP certification.

Additionally, we note that issuers are not required to designate the contract negotiation status for all available ECPs within their service area in their QHP application. We understand that the total number of ECPs for which a

[194] QHP certification and ECP Data Collection to Support QHP Certification are already assessed and encompassed by the currently approved information collections (*Continuation of Data Collection to Support QHP Certification and other Financial Management and Exchange Operations* (OMB Control Number 0938–1187 (CMS–10433)/ Expiration date: June 30, 2025) and *Essential Community Provider/Network Adequacy (ECP/NA) Data Collection to Support QHP Certification* (OMB Control Number. 0938–1415 (CMS–10803)/ Expiration date: December 31, 2027)).

[195] The ECP UI is the web-based interface of the ECP section of the Marketplace Plan Management System (MPMS) Module, which is a sub-system of the Health Insurance and Oversight System, where QHP issuers demonstrate that they have a sufficient number and geographic distribution of ECPs. Medical QHP and SADP issuers submit provider data in each network associated with a QHP and/ or SADP into the ECP UI.

[196] Options for contract negotiation statuses are as follows: Contract Executed; Contract Offer Made-Awaiting Response; Pre-Contract Negotiations in Progress (Contract Offer Not Made Yet); Offer Rejected; Contract Not Offered Due to No Response Following Issuer Outreach; Facility Closed; Facility Does Not Contract And Has No Interest To Contract With Commercial Insurance; Facility Does Not Provide Medical Services; Facility Does Not Provide Dental Services; Provider is in an Exclusivity Contract That Prohibits Us From Contracting With Them; Provider is Not Licensed, Accredited, or Certified by the State; Provider Has Relocated Outside Service Area Preventing Us From Contracting With Them.

contract negotiation status is selected within each network and service area is variable among issuers for multiple factors, including the size of the issuer's service area, the number of qualified ECPs available in the service area, the number of ECPs the issuer has contacted and/or engaged in contract discussions with, resources required by the issuer to initiate contract discussions with all qualified ECPs in their service area, if an issuer finds evidence that an ECP may no longer be eligible to qualify as an ECP, and the number of ECPs an issuer must contract with to achieve each of the requirements of the ECP Standard. For these reasons, we propose to additionally clarify at § 156.235(a)(3) and (b)(3) that a network plan does not need to report on the status of contract negotiations for all available ECPs in their service area, but must at least report on the status of contract offers for all ECPs which the issuer has either included in its network plan or offered a contract to be included in its network plan within each service area.

c. Implementation of an Effective Essential Community Provider (ECP) Review Program (§ 155.1051)

To align with proposals in sections III.D.18 and III.E.10. of this proposed rule that would provide FFE States with additional flexibilities to conduct their own network adequacy reviews of QHP issuers operating in their States as long as they have sufficient authority and the technical capacity to conduct these reviews by satisfying applicable criteria established by HHS to be considered an Effective Provider Access Review Program, we propose to adopt new flexibilities for FFE States to conduct ECP certification reviews of QHP issuers' plans in their States provided that the State is determined by HHS to have an Effective ECP Review Program, as discussed later in this section. In proposing flexibilities for FFE States to conduct ECP certification reviews, we propose to exercise our authority under section 1311(c)(1)(C) of the Affordable Care Act, which provides the Secretary authority to establish QHP certification criteria related to ECPs, and our authority under section 1321(a)(1)(B) of the Affordable Care Act, which grants HHS general rulemaking authority to promulgate regulations related to offering QHPs through the Exchanges.

Thus, beginning with PY 2027, we propose to provide the opportunity for FFE States, including States performing plan management, to elect to conduct their own ECP certification reviews of QHP issuers' plans provided that the State demonstrates it has sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria established by HHS to have an Effective ECP Review Program in order to ensure reasonable and timely access to ECPs for low-income, medically underserved individuals. This proposal is set forth at new § 155.1051.

Over the years, we have deferred network adequacy reviews of QHPs to FFE States that were determined to have a sufficient network adequacy review process (82 FR 18346, 83 FR 16930). In determining whether it was appropriate to defer network adequacy reviews to FFE States, we considered a States' legal authority to enforce network adequacy standards and conduct network adequacy reviews, the means to conduct assessments on the adequacy of plans' provider networks, and the ability of States to enforce minimum access standards established by HHS (for example, reasonable access standards defined under § 156.230). In contrast, we have not historically deferred ECP certification reviews wholly to FFE States, in part due to the complexity of conducting ECP certification reviews, which require sufficient technical capacity and resources that may not be readily available to States. However, given the prior experience of many FFE States in reviewing issuer submitted network adequacy data and some FFE States in reviewing ECP data (for example, States performing plan management), we believe it is appropriate to reconsider a FFE State's desire, legal authority, and technical capability to effectively conduct ECP certification reviews. We note that some States performing plan management have experience conducting ECP certification reviews prior to PY 2026 due to previous data integration and system limitations that prevented HHS from being able to conduct these reviews before we implemented the ECP UI in MPMS, which eventually allowed us to effectively conduct these reviews for issuers operating in States performing plan management.

We recognize that States possess unique knowledge on local factors related to ECP reviews, such as on market conditions, geographic constraints, areas in the State with limited economic resources, provider shortages, workforce issues, and population demographics. The States' unique knowledge of these various local factors, in particular, could strengthen ECP certification reviews, which often involve identifying low-income areas and geographic areas with health professional shortages. A State's local knowledge of low-income areas and geographic areas with health professional shortages within the State could effectively help locate facilities in these areas that may qualify as ECPs to both measure access to ECPs across the State and for possible inclusion of these ECPs within an issuer's network towards satisfaction of the ECP standard under § 156.235. Lastly, a State's unique knowledge of local factors may allow States to innovate their approach to conduct ECP certification reviews that are more sensitive and tailored to local conditions and provider capacity in the State. For example, a State may choose to implement additional or alternative access standards for mental health facilities, a type of ECP, and consider these standards during ECP certification reviews if the State is experiencing many Mental Health Professional Shortage Areas that necessitate tailored approaches to ensure consumers have increased access to mental health facilities within their networks.

Additionally, we believe that several States already have robust ECP requirements in place, including quantitative measures to oversee the number or percentage of ECPs included in an issuer's network operating in their State. For example, a Government Accountability Office (GAO) report in 2022 found evidence that approximately 19 States reported having a quantitative standard for ECPs when reviewing individual and group plans.[197] The example given in the report of a quantitative standard is that multiple States require that 35 percent of ECPs in a service area must be included in the plan's network, which is consistent with the current federal ECP threshold requirement. Furthermore, we have developed and expanded resources over the years that have familiarized some States with our ECP certification review process and methodologies, including various ECP review tools and templates, the Final Plan Year ECP List which captures qualified ECPs in each State, sub-regulatory guidance published on the QHP certification website (for example, Frequently Asked Questions, QHP Application Materials for the ECP section), and webinars and office hours with States. We discovered through stakeholder engagement and communications throughout the years that some States utilize the aforementioned ECP certification resources as a foundation for their State ECP List and/or State ECP requirements.

Lastly, we note that States have expressed interest in the past for us to

[197] GAO. (2022, December). Private Health Insurance: State and Federal Oversight of Provider Networks Varies. Available at *https://www.gao.gov/assets/gao-23-105642.pdf*.

grant them with additional flexibility to conduct reviews of ECP data. For example, in response to our proposal in the 2026 Payment Notice proposed rule (90 FR 4506) to allow HHS to conduct ECP certification reviews of QHP issuers in States performing plan management, one State that operates a State Exchange expressed that each State's market demands tailored approaches to meet their unique needs, which may be more effectively addressed through State-level decision making and reviews of issuer-submitted ECP data.

For all these reasons, we believe that FFE States may have the legal authority, technical capacity, expertise, and interest to conduct their own ECP certification reviews. Thus, beginning PY 2027 and thereafter, we propose to allow FFE States, including States performing plan management, to elect to perform their own State reviews of issuer-submitted ECP data provided the State demonstrates sufficient authority and technical capacity by meeting the applicable criteria, as determined by HHS, to have an Effective ECP Review Program. An FFE State would be granted an Effective ECP Review Program designation if we determine it meets all applicable requirements described for this program under proposed § 155.1051. We believe that establishing applicable requirements under proposed § 155.1051 for FFE States to demonstrate they have an Effective ECP Review Program is necessary to ensure States have the authority and technical capacity to conduct these ECP certification reviews in a way that continues to ensure consumers have adequate access to ECPs through their plans. If we determine that an FFE State does not have an Effective ECP Review Program, then we would continue to perform ECP certification reviews consistent with § 156.235 for network plans.

We continue to believe that HHS should continue to primarily conduct ECP certification reviews as the default approach for issuers' plans applying for certification to be offered as QHPs through an FFE, including States performing plan management, except if an FFE State elects to conduct ECP certification reviews and is determined to have sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective ECP Review Program. We believe that Federal ECP certification reviews are highly valuable for several reasons.

First, ECPs serve predominately low-income, medically underserved individuals, and these populations often experience higher rates of illness and are less equipped to field high out-of-pocket costs; additionally, the services furnished by ECP facilities are often more highly specialized with greater levels of acuity and expense,[198] such as cancer care at Free-Standing Cancer Centers, Black Lung Disease treatment at Black Lung Clinics, tuberculosis treatment at Tuberculosis Clinics, hemophilia treatment at Hemophilia Treatment Centers, HIV/AIDs treatment with Ryan White Providers, and more. Altogether, centralized Federal ECP certification reviews are continuously valuable to perform complex analyses that aim to protect these more vulnerable populations and decrease potential disparities in access across States.

Second, while we are aware of many States that have qualitative and/or quantitative network adequacy regulatory standards that are comparable to standards under § 156.230 (including on time and distance and appointment wait time requirements) and experience conducting such reviews, less is known about to what extent States may have different and separate requirements for ECPs, integrate ECP and network adequacy requirements together under one standard, or do not have standalone ECP requirements at all. For this reason, we believe HHS retaining primary responsibility over conducting ECP certification reviews as the default approach is appropriate, at least until we learn additional information from FFE States on their ECP requirements as part of the Effective ECP Review Program determination process. To broaden knowledge on this issue, we solicit comments on different ways that FFE States, including States performing plan management, currently implement State-specific requirements for ECP standards and how these requirements may be comparable to or different from ECP requirements implemented at § 156.235.

Third, through stakeholder engagement throughout the years, we are also aware that some State Departments of Insurance may have limited resources and bandwidth to conduct ECP certification reviews, which are highly complex and data intensive. In the past, these State Departments of Insurance have expressed support of HHS conducting ECP certification reviews due to State resource limitations. We have expanded our data collection capabilities and means to efficiently and adequately conduct ECP certification reviews over the years, such as through the development of the ECP List[199] and ECP data collection in MPMS. The ECP List has helped us identify the exact geographic location and distribution of ECPs to highlight specific ECPs that may be available within an issuer's service area and available for contracting with the issuer to satisfy ECP requirements under § 156.235. And, it simultaneously ensures that the full range of different ECP categories defined in section 340B(a)(4) of the PHS Act and, for network plans, providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act are adequately represented and available to consumers in an issuer's network. This ECP List has been embedded within the ECP UI in MPMS, so that QHP issuers can select specific ECPs from this list that are contracted with the issuer and included in their network within a particular service area, which allows us to calculate an issuer's satisfaction toward the ECP threshold, ECP category per county, and ECP Indian health care requirements. Based on our experience conducting ECP certification reviews, we maintain that having adequate and accurate data on available ECPs in a geographic area, sufficient tools to collect and calculate issuer submitted ECP data, and sound methodologies to quantitatively assess this data to determine reasonable and timely access to ECPs in accordance with section 1311(c)(1)(C) of the Affordable Care Act is crucial for any FFE State to demonstrate the technical capacity to conduct their own ECP certification reviews. Outside of a couple of State Exchanges that have reached out annually to inquire about our ECP List and a couple of States that have shared that they keep their own State-specific list of available ECPs, it is unknown how many States can develop

[198] Edward J, Wiggins A, Young MH, Rayens MK. Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform. Health Lit Res Pract. 2019 Nov 5;3(4):e250–e258. doi: 10.3928/24748307–20190923–01. Available at *https://pmc.ncbi.nlm.nih.gov/articles/PMC6831506/*. Karen Pollitz, Kaye Pestaina, Alex Montero, Lunna Lopes, Isabelle Valdes, Ashley Kirzinger, and Mollyann Brodie. KFF. (2023, June 15). KFF Survey of Consumer Experiences with Health Insurance. Available at *https://www.kff.org/mental-health/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/*. OASH, Health People 2023, Literature Review. Available at *https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty#:~:text=Unmet%20social%20needs%2C%20environmental%20factors,for%20people%20with%20lower%20incomes.&text=For%20example%2C%20people%20with%20limit.*

[199] HHS has developed and regularly maintained an ECP List since 2015, which provides a large national snapshot of the universe of qualified ECPs across all States and by various category types.

and maintain a similar State-specific list of qualified ECPs or utilize HHS' ECP List that can be applied to conduct their own ECP certification reviews of issuer-submitted ECP data. It is also unknown what tools States may currently utilize to collect issuer submitted ECP data and methodologies States apply to assess this data to demonstrate reasonable and timely access to ECPs. For these reasons, too, we believe it is appropriate that HHS retain primary responsibility over conducting ECP certification reviews as the default approach, at least until we learn additional information from FFE States as part of the Effective ECP Review Program determination process. This additional information would include whether FFE States have a process to identify qualified ECPs ''where available'' that may be included within a network plan's provider network, tools to collect issuer-submitted ECP data, and methodologies to assess the adequacy of an issuer's network of ECPs. Additionally, to broaden our knowledge in this area, we seek comment to learn which States have their own ECP List or other related process to identify qualified ECPs that may be utilized for certification purposes.

Accordingly, we propose to set forth the criteria for an Effective ECP Review Program by adding § 155.1051 to part 155, subpart K. Under § 155.1051(a), we propose that FFE States may elect to conduct their own ECP certification reviews of issuers' plans applying for certification to be offered as QHPs through an FFE, including States performing plan management, provided that the State demonstrates sufficient authority and technical capacity to conduct these reviews by satisfying the applicable criteria in proposed § 155.1051. If FFE States do not satisfy the criteria established in proposed § 155.1051, then we would continue to perform ECP certification reviews consistent with § 156.235 for network plans.

In alignment with the proposal in section III.E.12 of this proposed rule to allow plans that do not use a network (non-network plans) to receive QHP certification, including by demonstrating that these plans ensure a sufficient choice of ECPs consistent with section 1311(c)(1)(B) of the Affordable Care Act, we would also provide additional flexibilities to FFE States to conduct ECP certification reviews of non-network plans if they are determined to have an Effective ECP Review Program. Similar to the approach for network plans, we would perform ECP certification reviews for non-network plans under proposed § 156.236 if FFE States do not satisfy criteria for having an Effective ECP Review Program. An FFE State would need to demonstrate that it meets applicable criteria for both network plans and non-network plans (under proposed § 155.1051(b) through (c)), and the sufficient authority and technical capacity to conduct reviews of such plans (as assessed under proposed § 155.1051(e)), if they decide to certify non-network plans, in order to receive a designation as having an Effective ECP Review Program. This would mean an FFE State would not be permitted to elect to conduct ECP certification reviews for only network plans and not non-network plans, if they certify non-network plans, or vice versa. However, if an FFE State notifies us that they do not intend to certify non-network plans within their State and consequently do not offer these plans to consumers on the FFEs operating in their State altogether (regardless of if the State or HHS would conduct ECP certification reviews), then we would continue to review whether an FFE State meets all applicable criteria for only network plans during the Effective ECP Review Program determination process. For additional details regarding the criteria for the Effective ECP Review Program under proposed § 155.1051 and how these criteria would pertain to reviews of non-network plans in FFE States electing to conduct ECP certification reviews, please see the discussion under sections III.D.19 and III.E.12.e of this proposed rule.

Furthermore, to ensure that issuers in FFE States continue to meet ECP requirements promulgated under section 1311(c)(1)(C) of the Affordable Care Act, and consistent with § 156.235 for network plans, we propose in § 155.1051(b) that FFE States with an Effective ECP Review Program must ensure that a QHP issuer with a provider network includes in its provider network a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the Exchange's network adequacy standards. Furthermore, we continue to believe that to protect low-income, medically underserved populations, and to ensure that enrollees in all FFEs have a minimum standard for consumer protections on reasonable access to providers and that disparities in access are minimized across FFE States, issuers in FFE States with an Effective ECP Review Programs must continue to demonstrate that they meet State requirements to ensure reasonable and timely access to ECPs that are consistent with requirements of the ECP Standard under § 156.235. Thus, we propose in § 155.1051(c) that FFE States with an Effective ECP Review Program must have established ECP requirements that are set forth in State statute or regulation. FFE States must demonstrate that these established ECP requirements ensure that issuers with a provider network in their State meet all of the following requirements that promote a sufficient number and geographic distribution of ECPs: the minimum percentage requirements under § 156.235(a)(2)(i), the Indian health care provider requirement under § 156.235(a)(2)(ii)(A), and the category per county requirements for each of the eight ECP category types described under § 156.235(a)(2)(ii)(B). In this manner, we believe that FFE States having ECP requirements consistent with the three aforementioned requirements would help maintain access to ECPs.

However, we recognize that FFE States may have alternative, distinct ECP requirements to ensure a sufficient number and geographic distribution of ECPs are included within an issuer's network to address various local conditions unique to each State. For example, some FFE States may have time and distance requirements that issuers must satisfy for enrollees to access certain types of ECPs; some FFE States may have different minimum percentage requirements than those described under § 156.235(a)(2)(i),[200] such as minimum percentages for rural health providers, mental health facilities, or other types of ECP facilities; some FFE States may have ECP facility to enrollee ratio requirements, which may require an issuer to contract with a certain number or categories of ECPs based on the number of enrollees enrolled in their plan (for example, 1 FQHC per 1,000 enrollees). We acknowledge that there could be numerous quantitative and qualitative methods beyond these aforementioned examples that States may use to analyze access to ECPs, which may especially be influenced by factors unique to each State. For these reasons, FFE States with alternative ECP requirements would be required to demonstrate how these requirements would promote a

[200] Current ECP minimum percentage requirements include an Overall ECP Threshold, FQHC Threshold, and Family Planning Provider Threshold.

sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to ECPs, and an adequate level of service for low-income enrollees or individuals residing in Health Professional Shortage Areas under § 155.1051(d). To assess an FFE State's satisfaction of the requirements in proposed § 155.1051(d), we would require FFE States to submit a written description of their alternative ECP requirements, an explanation of how the State collects ECP data from issuers to measure compliance with the alternative ECP requirement, and a detailed explanation of how the State uses this ECP data to analyze access to ECPs within an issuer's network.

In addition, for an FFE State to conduct ECP certification reviews, under our proposal, the FFE State would need to first express its interest to HHS and submit an attestation for having an Effective ECP Review Program. An FFE State would have the choice to submit an attestation for an Effective ECP Review Program, Effective Provider Access Review Program (described in section III.E.10 of this proposed rule), or both. This means that an FFE State can elect to conduct their own ECP certification reviews, provider access certification reviews, or both reviews provided the State demonstrates that it has sufficient authority and the technical capacity by satisfying the applicable criteria for the applicable review program depending on which review(s) it wishes to conduct. We propose that if an FFE State does not directly communicate to HHS its interest in conducting its own ECP certification reviews, then we will assume the FFE State prefers that we continue conducting these reviews. FFE States with an interest in conducting their own ECP certification reviews would need to submit their attestation that the State has an Effective ECP Review Program prior to the start of the QHP certification cycle for the first plan year it wishes to assume responsibility to conduct ECP certification reviews. We would review information submitted by the FFE State to ensure the State has the authority and technical capacity to conduct effective, timely reviews of ECP data submitted by an issuer prior to each plan year's QHP certification cycle. In our review, we would consider whether the FFE State receives adequate issuer data and documentation sufficient to conduct an examination of ECP requirements described in § 156.235 for network plans. For additional details regarding the proposed criteria for the Effective ECP Review Program under proposed § 155.1051 and how these criteria would pertain to reviews of non-network plans in FFE States electing to conduct ECP certification reviews, we refer readers to the discussion under sections III.D.19 and III.E.12.e of this proposed rule. We propose in § 155.1051(e)(1) through (10) that we would consider the following factors in our review to determine if a FFE State has an Effective ECP Review Program: [201]

(1) The State's legal authority to review whether plans applying for QHP certification meet ECP requirements, including relevant State regulations and statutes;

(2) Evidence that the State's requirements are consistent with ECP requirements under proposed § 155.1051(c)(1) through (c)(3) that promote a sufficient number and geographic distribution of ECPs, or the State's explanation of how its alternative ECP requirements promote a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to ECPs;

(3) A description of the State's definition of an ECP, if different from the definition under § 156.235(c), including relevant categories and eligibility criteria that the State uses to determine whether a facility qualifies as an ECP;

(4) Whether the State utilizes the Federal ECP List or has a process it uses to identify qualified ECPs that may be included within a network plan's provider network;

(5) Whether the State utilizes the Federal ECP List or has a process it uses to identify qualified ECPs that may accept a non-network plan's benefit amount as payment in full;

(6) A description of data collection systems, resources, templates, or methodologies used by the State to collect and review ECP data;

(7) Whether the State generally collects information from QHP issuers regarding the status of contract offers for network plans or offers of benefit amounts as payment in full to an ECP for non-network plans;

(8) Whether the State has delegated authority to some other entity other than the State Department of Insurance to perform ECP any or all review activities;

(9) Whether the State has compliance reviews, follow-up procedures, and enforcement frameworks applicable to issuers that demonstrate inadequate networks of ECPs so that those issuers come into compliance with State ECP requirements, including standardized processes to assess efforts the issuer is pursuing to come into compliance with State ECP requirements and any justification and exception processes for issuers that have not yet or cannot meet ECP requirements;

(10) Whether the State has a process for monitoring and addressing consumer-related complaints regarding access to ECPs to ensure sufficient access to ECPs consistent with section 1311(c)(1)(C) of the Affordable Care Act and set forth in State statute; and

The first proposed factor under § 155.1051(e)(1) requires that the FFE State has established ECP requirements that are set forth in State statute or regulation. This factor is crucial since it identifies whether the FFE State has sufficient legal authority to promulgate regulations to establish ECP requirements, and that it has the authority to conduct ECP certification reviews to ensure QHP issuers meet such requirements.

The second proposed factor under § 155.1051(e)(2) requires evidence that the FFE State's ECP requirements are consistent with ECP requirements under proposed § 155.1051(c)(1) through (c)(3) that promote a sufficient number and geographic distribution of ECPs, or the FFE State provides a rationale to describe how its alternative State ECP requirements promote a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to ECPs. This factor is important to ensure that an FFE State's requirements are consistent with those under § 156.235 for network plans and under proposed § 156.236 for non-network plans, so that these requirements continue to maintain access to ECPs especially if they differ from those ECP requirements under § 156.235 and proposed § 156.236.

The third factor under § 155.1051(e)(3) considers the FFE State's definition of an ECP, if different from the definition under § 156.235(c), and relevant categories and eligibility criteria that the FFE State uses to determine whether a facility qualifies as an ECP. This factor acknowledges that FFE States may have different categories of ECPs compared to those described under § 156.235(c), including that some FFE States may have chosen to expand the categories of facilities that may qualify to be an ECP in the State. An understanding of the FFE State's definition of an ECP is necessary to ensure the State satisfies statutory requirements under section 1311(c)(1)(C) of the Affordable Care Act which requires the Secretary to promulgate regulations to ensure QHPs include within their networks certain

[201] Please see the discussion regarding factors (5), (7), and (11) in section III.E.12.e of this proposed rule.

categories of ECPs, such as those specified in section 340B(a)(4) of the PHS Act and entities described in section 1927(c)(1)(D)(i)(IV) of the Act.

The fourth and fifth factors under § 155.1051(e)(4) and (e)(5) evaluate a FFE State's process to identify qualified ECPs that may be included within a network plan's provider network, or qualified ECPs that accept a non-network plan's benefit amount as payment in full, respectively; or whether it utilizes the Federal ECP List to identify qualified ECPs. As stated in the discussions above, we believe it is critical for the FFE State to have a process to identify qualified ECPs, ''where available.'' Understanding whether the FFE State utilizes the Federal ECP List or has its own process to identify qualified ECPs is crucial to evaluate the FFE State's satisfaction of the requirements under section 1311(c)(1)(C) of the Affordable Care Act which requires the Secretary to promulgate regulations to ensure QHP issuers include within health insurance plan networks those ECPs, ''where available'' that serve predominately low-income, medically underserved individuals. An FFE State implementing a process to identify qualified ECPs, or even the FFE State's utilization of the Federal ECP list, would allow the State to identify the exact geographic location and distribution of ECPs to highlight specific ECPs that may be available within an issuer's service area and available for contracting with the issuer to satisfy ECP requirements. And, if the FFE State identifies the category of services an ECP provides when identifying the qualified ECP, it can simultaneously ensure that the full range of different ECP categories defined in section 340B(a)(4) of the PHS Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act are adequately represented and available to consumers in an issuer's network.

The sixth factor under § 155.1051(e)(6) considers if the FFE State has data collection systems, resources, templates, or methodologies to collect and review ECP data. This information would be important for HHS to understand processes a FFE State has in place to efficiently collect large, complex amounts of an issuer's ECP data and their ability to meaningfully leverage that data to apply assessment methodologies to measure access to ECPs across the State. This information would offer additional evidence to demonstrate an FFE State's technical capacity by indicating the different documentation, resources, and expertise it has developed to have the means to conduct an effective, timely examination of ECP data.

The seventh factor under § 155.1051(e)(7) considers if the FFE State collects information from QHP issuers regarding the status of contract offers for network plans or offers of benefit amounts as payment in full to an ECP for non-network plans. We believe this type of ECP data is important for an FFE State to collect from QHP issuers during its assessment of the adequacy of an issuer's network of ECPs or during its assessment to ensure access to a sufficient choice of ECPs that would accept a non-network plan's benefit amount in full. An FFE State collecting this type of data would demonstrate that it has the technical capacity to validate a QHP issuer's progress towards contracting with ECPs, which allows the FFE State to track an issuer's effort in pursuing to build a sufficient network of ECPs so that consumers in network plans have reasonable and timely access to a broad range of ECPs. Similarly, an FFE State collecting data from QHP issuers with non-network plans regarding the status of offering benefit amounts as payment in full to ECPs would allow the State to assess the issuer's commitment to facilitating access to a sufficient number of ECPs that an enrollee can access in their service area without needing to pay charges in excess of the benefit amount for an array of services. These contract statuses would serve as important metrics during an FFE State's assessment of ensuring access to ECPs, where available, including by allowing States to measure an issuer's compliance with the minimum threshold percentage, category per county, and Indian health care requirements under proposed § 156.236(b)(1) through (b)(3), which would be evaluated based on measurements of contracts offered or executed, and benefit amounts as payment in full that were offered to or accepted by an ECP.

The eighth factor under § 155.1051(e)(8) considers whether the FFE State has delegated authority to some other entity other than the State Department of Insurance to perform any or all ECP review activities. It would be important for a FFE State to report to us any delegated authority to other entities to perform ECP review activities, so we understand how the FFE State is handling ECP review data and to whom it entrusts such data. In addition, it is important to review whether entities conducting such reviews have sufficient expertise to competently handle ECP reviews and that these entities would be able to conduct ECP reviews in such a way that would allow the FFE State to still satisfy all applicable criteria in proposed § 155.1051 as part of having an Effective ECP Review Program.

The ninth factor under § 155.1051(e)(9) considers whether the FFE State has compliance reviews, follow-up procedures, and enforcement frameworks applicable to issuers that demonstrate inadequate networks of ECPs or inadequate access to ECPs that accept benefit amounts as payment in full, so that those issuers come into compliance with State ECP requirements. This factor would also consider whether the FFE State has standardized processes to assess efforts the issuer is pursuing to come into compliance with State ECP requirements and any justification and exception processes for issuers that have not yet or cannot meet ECP requirements. We believe that the existence of these processes is critical for an FFE State to demonstrate sufficient enforcement authority, while maintaining the ability to evaluate the integrity and outcome of ECP certification reviews, which aims to ensure that low-income, medically underserved populations traditionally served by ECPs have sufficient access to these ECPs through their plans, where available. Overall, these processes would ensure an FFE State has the ability to require that QHP issuers continue to meet state ECP requirements and comply with ECP statutory requirements under section 1311(c)(1)(C) of the Affordable Care Act.

The tenth factor under § 155.1051(e)(10) considers whether the FFE State has a process for monitoring and addressing consumer-related complaints regarding access to ECPs to ensure sufficient access to ECPs consistent with section 1311(c)(1)(C) of the Affordable Care Act and as set forth in State statute. This factor is important since it would indicate the FFE State has a process to continuously monitor access to ECPs and ensure that State ECP requirements aimed to promote access to ECPs have their intended effect among consumers. Access to ECPs can change during the year for a multitude of factors, including due to facility closures, network terminations, changes in services offered by ECPs, financial stability and funding reductions, staffing shortages, etc. For plans using a provider network, contracts may be executed or terminated throughout a plan year for various reasons. Also, any inaccuracies or out-of-date information contained in provider directories can create confusion or be misleading to consumers. Additionally, consumers

may have trouble making appointments with network providers due to lack of availability of appointments. For plans without a provider network, we anticipate that ECPs that accept a benefit amount as payment in full could change depending on market conditions, negotiations, and competition, or that consumers may require additional assistance in understanding how to utilize plan benefit amounts to meet their health care needs in such a way that does not increase out-of-pocket costs beyond the plan's benefit amount.

Lastly, in § 155.1051(f), we propose that we would notify the FFE State electing to conduct ECP certification reviews of our decision in writing prior to the start of the QHP certification cycle whether the FFE State is determined to have an Effective ECP Review Program and can therefore conduct its own ECP certification reviews for the plan year. In subsequent years and prior to the start of the QHP certification cycle each year, we would reach out to FFE States with an Effective ECP Review Program designation to confirm if the FFE States wish to continue conducting their own ECP certification reviews for the upcoming plan year and to verify if any circumstances have changed that may affect an FFE State's authority and technical capacity to continue conducting effective, timely reviews of ECP data. We propose that we would reserve the right to evaluate the FFE State at any time whether, and to what extent, the FFE State's circumstances has changed such that it has begun to or has ceased to satisfy the criteria established by HHS under proposed § 155.1051, and consequently no longer has an Effective ECP Review Program. We often complete an annual environmental scan of State authorities to maintain situational awareness of changing authorities across FFE States, and the same would apply to this proposal to ensure FFE States with an Effective ECP Review Program continue to satisfy all applicable Federal requirements.

Additionally, we clarify that we would be available to provide technical assistance to FFE States on any issues related to the Effective ECP Review Program. We remain open to assisting FFE States at any point of the process, from electing to conduct their own ECP certification reviews to performing ECP certification reviews as an Effective ECP Review Program State, to ensure an FFE State's ECP requirements and certification review process continue to protect access to ECPs for low-income, medically underserved populations. We would also continue to make ECP resources publicly available, including for those FFE States that are determined to have an Effective ECP Review Program and wish to utilize these resources as part of their ECP certification reviews. These resources include the Final Plan Year ECP List and Rolling Draft ECP List, medical QHP and SADP ECP tools, the Available ECP Write-in List, the Plan Validation workspace in MPMS, and guidance on the QHP certification website.[202] We believe these supporting documents and tools are widely used across many States and among many issuers, serving as important resources for both identifying ECPs nationally to potentially include in a plan's network and assisting issuers in meeting ECP requirements.

In addition to the aforementioned resources and technical assistance that we would provide to FFE States, we would continue collecting ECP data from FFE issuers in FFE States with an Effective ECP Review Program, similar to the proposed approach for network adequacy in section III.E.10 of this proposed rule. We believe this data would provide additional insight to assess how QHP issuers are performing across the FFE, including in FFE States with an Effective ECP Review Program, to consistently compare issuer performance. Collecting this data would also provide us with the ability to continue to monitor consumer access to ECPs across the FFE. The data would also be available in a standardized format to FFE States with an Effective ECP Review Program, which could be utilized to inform their ECP certification reviews and to perform additional analyses to analyze access to ECPs across the State. We believe this proposed approach would support FFE States in their capacity to conduct these complex ECP reviews.

We seek comment on these proposals.

12. QHP Certification of Non-Network Plans (§§ 155.1050, 155.1051, 156.230, 156.235, 156.236, 156.275, and 156.810)

In this proposed rule, we propose a number of revisions to parts 155 and 156 to allow plans that do not use a network (non-network plans) to receive QHP certification beginning with PY 2027 by demonstrating that they ensure a sufficient choice of providers in a manner consistent with section 1311(c)(1)(B) and (C) of the Affordable Care Act. In addition, to ensure that non-network plans are subject to similar requirements as network plans, we propose that (1) FFE States that elect to conduct provider access certification reviews and are determined by HHS to have an Effective Provider Access Review Program under proposed § 155.1050(d) would be permitted to perform provider access reviews of non-network plans if the State satisfies all applicable criteria under § 155.1050(d); and (2) FFE States that elect to conduct ECP certification reviews and are determined by HHS to have an Effective ECP Review Program under proposed § 155.1051 would be permitted to perform ECP certification reviews of non-network plans if the State satisfies all applicable criteria under § 155.1051. For additional detail on how the Effective Provider Access Review Program and Effective ECP Review Program proposals would apply to FFE States conducting reviews of non-network plans, please reference these discussions in section III.E.12.d and section III.E.12.e of this proposed rule.

a. Previous Rulemaking Related to Non-Network Plans

Together, section 1311(c)(1), 1311(c)(1)(B), and 1311(c)(1)(C) of the Affordable Care Act directs HHS to establish by regulation certification criteria for QHPs, which include (but are not limited to) criteria that require QHPs to ensure a sufficient choice of providers, provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers, and include within health insurance plan networks those ECPs, where available, that serve predominantly low-income, medically-underserved individuals. We have historically implemented these provisions through our network adequacy and ECP requirements for network plans at § 156.230 and § 156.235, respectively.[203]

In the Exchange Establishment Rule (77 FR 18310), we finalized the minimum network adequacy criteria that plans, including medical plans and SADPs, must meet to be certified as QHPs at § 156.230. In the 2016 Payment Notice (80 FR 10749), we revised § 156.230(a) to specify that network adequacy requirements apply only to QHPs that use a provider network (network plans) to deliver services to enrollees and that a provider network includes only providers that are contracted as in-network. We also revised § 156.235(a) to state that the ECP criteria apply only to QHPs that use a provider network. In part 1 of the 2022

[202] These resources may be found at *https://www.qhpcertification.cms.gov/QHP/applicationmaterials/Essential-Community-Providers.*

[203] See 45 CFR 156.230 and 156.235.

Payment Notice (86 FR 6138), we added section (f) to § 156.230 to clarify that a plan for which an issuer seeks QHP certification or any certified QHP that does not use a provider network (or non-network plan) is not required to comply with the network adequacy standards at paragraphs (a) through (e) of § 156.230 to qualify for certification as a QHP. Unlike network-based plans, non-network health plans do not rely on a contracted set of providers that agree in advance to specific terms and negotiated payment rates, nor do they condition or differentiate benefits to enrollees based on whether the issuer has a network participating agreement with a provider that furnishes covered services. Instead, these plans set specific benefit amounts for covered services and communicate those benefit amounts to enrollees who may then seek covered services from any provider. The plan may determine the benefit amount based on an established methodology such as a percentage of a publicly available benchmark, a reference-based pricing structure, or another reimbursement standard (that is, Medicare or private payor rates, etc.).

In the 2024 Payment Notice (88 FR 25872 through 25879), we exercised the authority delegated to us by section 1311(c)(1) of the Affordable Care Act to establish criteria for the certification of health plans as QHPs in order to revise §§ 156.230 and 156.235 to require all individual market QHPs and SADPs and all SHOP QHPs across all Exchanges to utilize a network of providers that complies with the standards described in §§ 156.230 and 156.235. In doing so, we acknowledged that we had previously stated that ''nothing in [the Affordable Care Act] requires a QHP issuer to use a provider network'' because there is no explicit standalone network requirement (88 FR 25872 (quoting 84 FR 6154)). But we still expressed concerns over whether a plan without a network would be able to comply with Affordable Care Act section 1311(c)(1)(C)'s requirement that plans ''shall, at minimum . . . include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals,'' which we read to imply that access to ECPs would be provided ''within health insurance networks'' (88 FR at 25873). We also solicited comment on alternative administrable regulatory standards under which non-network plans could ''ensure a sufficient choice of providers'' consistent with section 1311(c)(1)(B) of the Affordable Care Act. At the time, neither commenters to the 2024 Payment Notice nor HHS had enough information to devise such an administrable regulatory standard to enable non-network plans to demonstrate a sufficient choice of providers to receive QHP certification. On these bases, in the 2024 Payment Notice (88 FR 25876), we finalized the requirement that all QHPs (except certain SADPs) [204] must use a network of providers. As a result of this, non-network plans are currently unable to meet all of the minimum certification criteria at § 155.1000(c), which means Exchanges cannot currently certify non-network plans as QHPs and consumers cannot enroll in non-network plans through the Exchanges.

b. The Basis for Reconsidering Our Existing Prohibition on Non-Network Plans as QHPs

As a preliminary matter, we first explain why we are revisiting our existing blanket prohibition of non-network plans as QHPs, including our approach to ensure non-network plans meet requirements to ensure a sufficient choice of providers in a manner consistent with section 1311(c)(1)(B) and (C) of the Affordable Care Act. One justification for revisiting our existing prohibition of non-network plans as QHPs is that circumstances have changed: when we finalized our blanket prohibition of non-network plans as QHPs, we had not developed an effective, administrable approach at the time we adopted the prohibition through which we could adequately measure whether non-network plans could ensure a ''sufficient choice of providers'' under section 1311(c)(1)(B) of the Affordable Care Act, or include ECPs through their plans, where available, under section 1311(c)(1)(C) of the Affordable Care Act. We continue to believe that consumers shopping on the Exchanges must be assured of the ability of every QHP to provide a sufficient choice of providers under section 1311(c)(1)(B) of the Affordable Care Act, and that a non-network plan should not be given a ''pass'' on demonstrating that it provides access to a sufficient choice of providers because it does not utilize a provider network. As described further below and in the next subpart, we now propose a new approach to measuring a non-network plan's compliance with section 1311(c)(1)(B) and (C) of the Affordable Care Act, which addresses our prior concerns. In doing so, we also revisit our original interpretation of section 1311(c)(1)(C) of the Affordable Care Act, including how our proposed approach would mitigate prior concerns over non-network plans being able to provide access to ECPs in a manner consistent with this provision.

First, we acknowledge that provider networks serve as a critical cost control tool, which has downstream impacts on a consumer's out-of-pocket costs that are important to consider when devising an alternative regulatory standard to continue to ensure broader access to care. Insurers with a provider network often have different cost-sharing requirements depending on if an enrollee sees a provider that is in-network versus out-of-network. A traditional network plan typically contracts with a certain number of providers (but rarely all) in each area who agree to accept the plan's negotiated rates as payment in full for covered services, ensuring that enrollees have reasonable access to a certain number of providers who will render services at specified costs; and often, these specified costs are lower if an enrollee sees an in-network provider since enrollees often have to pay more when seeking care from providers with whom the issuer did not contract.

In contrast, a non-network plan sets specified benefit amounts for covered services and communicates those benefit amounts to its enrollees in advance. Non-network plan enrollees use this benefit amount as a reference price for how much they should expect to pay for the receipt of covered services under the plan. With it, they can choose any provider for their care and compare and negotiate prices among available providers to find a provider who will accept the plan's benefit amount as payment in full, such that the provider will not balance bill the enrollee for additional amounts beyond the plan's benefit amount. This interaction between the enrollee and provider before services are rendered could limit the enrollee from incurring additional unforeseen out-of-pocket costs, particularly if the enrollee decides to pursue care with the provider at a cost below or equal to the plan's benefit amount. Thus, both plan models are capable of providing a pathway for enrollees to limit out-of-pocket costs. Non-network plans are capable of providing an opportunity for individual enrollees to participate in efforts to lower their health care costs through individualized price comparisons and negotiations, while network plans rely heavily on health insurers to do so.

However, while enrollees in a non-network plan can receive some benefit for covered services from virtually any provider, there is no guarantee that the plan's benefit amounts are actually

[204] *See* 45 CFR 156.230(a)(4).

sufficient to cover the provider's full charges, and there is no requirement imposed by the non-network plan on providers to accept the plan's benefit amount as payment in full. As a result, if or when these benefit amounts are too low, non-network plans can leave enrollees with additional out-of-pocket costs that make certain providers, as a practical matter, unavailable. That can be problematic for services that an enrollee could not have reasonably anticipated needing to negotiate for in advance. And, it can have a particular impact on low-income, medically underserved populations who may face disproportionate challenges in paying for large out-of-pocket costs.

Furthermore, if a non-network plan's benefit amount for a covered service is so low that virtually no providers in a particular area accept the benefit amount as payment in full, the non-network plan cannot credibly claim to provide a sufficient choice of providers of those services, and the non-network plan does not provide access to a sufficient choice of providers under section 1311(c)(1)(B) of the Affordable Care Act. Conversely, if the benefit amount is sufficient such that many providers in the area accept the benefit amount as payment in full, enrollees may choose between providers in their area who will accept the non-network plan's benefit amount as payment in full without incurring additional out-of-pocket costs. In this case, a non-network plan may be able to provide access to a sufficient choice of providers for those services. In other words, the set of providers in the applicable area that would accept the plan's benefit amount as payment in full is like a network plan's network. So long as that set of providers is adequate, a non-network plan can comply with requirements to ensure a sufficient choice of providers, and we describe our proposed method to measure that compliance in the next section.

As we stated in the discussions above, we raised concerns in the 2024 Payment Notice regarding the ability of a non-network plan to comply with section 1311(c)(1)(C) of the Affordable Care Act, due to our understanding that access to ECPs should be provided ''within health insurance networks.'' We inferred from Affordable Care Act section 1311(c)(1)(C)'s use of the word ''network'' that the statute meant that Exchanges could certify, as QHPs, only plans that have a contractual network of providers, not inclusive of non-network plans. Though, we recognize that the term ''network'' is never defined in the statute. And, as we have consistently noted, Congress never imposed a standalone requirement that QHPs structure their plans via contracts with providers nor was Congress specific on the requirements needed to constitute a network. We now interpret the statute to offer broad flexibility governing the status of a contractual relationship between a plan and provider as a precondition to constitute a network under section 1311(c)(1)(C) of the Affordable Care Act. In this regard, we believe that so long as non-network plans provide sufficient access to ECPs, where available, that serve predominately low-income, medically underserved individuals, a non-network plan could comply with requirements under section 1311(c)(1)(C) of the Affordable Care Act. This may be accomplished through a non-network plan demonstrating access to ECPs within their service area that would accept the plan's benefit amount as payment in full.

Furthermore, we have evaluated traditional networks to ensure enrollees have access to a sufficient choice of providers, consistent with section 1311(c)(1)(B) of the Affordable Care Act, and to promote access to ECPs, where available, for low-income, medically underserved individuals, consistent with section 1311(c)(1)(C) of the Affordable Care Act. To that effect, networks facilitate a multitude of different relationships between providers, insurers, and enrollees to ensure sufficient access to care, which can still be maintained through non-network plans through their greater focus on enrollees more directly participating in lowering the price of their care. Specifically, a non-network plan's ''network'' consists of the providers in the applicable area that would accept the plan's benefit amount as payment in full. By establishing payment amounts that providers can choose to accept as payment in full, non-network plans are capable of creating a *de facto* network of providers or suppliers even without formal contractual relationships. Thus, a non-network plan can comply with section 1311(c)(1)(C) of the Affordable Care Act by ensuring that a sufficient number of ECPs accept the plan's benefit amounts as payment in full. However, a non-network plan would not satisfy that requirement if its benefit amount is so low that many ECPs would not accept the benefit amount as payment in full from enrollees, because section 1311(c)(1)(C) of the Affordable Care Act would still require an Exchange to consider the practical availability of services from ECPs before certifying a QHP, including ECPs, where available. It would not be sufficient for an Exchange to simply conclude that a non-network plan provides access to providers in a manner consistent with section 1311(c)(1)(B) and (C) of the Affordable Care Act because the plan provides some benefit amount for covered services rendered by any provider. Thus, the availability of providers in a particular area that accept the benefit amount as payment in full is important to constitute a sufficient choice of providers consistent with section 1311(c)(1)(B) and (C) of the Affordable Care Act.

Moreover, there are additional reasons for our reconsideration of our blanket prohibition of non-network plans as QHPs. Specifically, recent efforts to improve health price transparency and its implementation across the health care system present an opportunity to reshape how health care services are delivered, and when enrollees have easier access to health care pricing information, market forces can and often do drive down costs through increased competition among providers.[205] Because enrollees directly negotiate the cost of care in non-network plans, non-network plans can more naturally leverage price transparency principles compared to network plans. By incentivizing patient involvement in health cost comparison, these plans have potential to reduce overall health care costs by empowering their enrollees to shop for and potentially negotiate lower prices. Such efforts could lead to a more efficient market where network formation becomes less critical for ensuring affordable health care access. Because providers are not bound by pre-negotiated network agreements, enrollees in such plans may face different pricing dynamics than in network-based plans, including the need to compare costs more proactively and, in some cases, negotiate payment amounts directly with providers. This model places greater emphasis on enrollee engagement and transparency but can also offer increased flexibility and broader provider choice while maintaining predictable plan liability through the use of clear and consistently applied reimbursement formulas.

[205] For example, *see* CMS. Hospital Price Transparency. Available at *https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency*. See also, The White House. (2025, February 25). Making America Healthy Again by Empowering Patients with Clear, Accurate, *and* Actionable Healthcare Pricing Information. Available at *https://www.whitehouse.gov/presidential-actions/2025/02/making-america-healthy-again-by-empowering-patients-with-clear-accurate-and-actionable-healthcare-pricing-information/*.

Overall, non-network plans have great potential to reduce overall health care costs. First, they can empower enrollees to use price information on benefit amounts, when available, to shop for lower prices and negotiate directly with providers, fostering increased competition and potentially driving down prices across the market. When enrollees have access to accurate, timely health care pricing information, they can make informed decisions about their health care spending and actively seek the best value for medically necessary services. We anticipate that this consumer-driven approach would create a more competitive marketplace where providers would need to consider their pricing strategies more carefully to attract and retain patients. Additionally, as more enrollees engage in shopping and direct price negotiations, providers may be incentivized to proactively offer more competitive rates to maintain their market share, potentially leading to broader market-wide price reductions that benefit many enrollees.

Second, non-network plans eliminate substantial administrative overhead associated with traditional network management, which in turn can result in lower premiums. The administrative cost savings are realized through four key areas: (1) the elimination of provider contract management costs (including legal fees, staff, and provider relationship development and maintenance); (2) the removal of provider credentialing expenses and directory maintenance; (3) reduction in claims processing complexity and network-specific prior authorization requirements; and (4) streamlined organizational structure with resources redirected to consumer support tools and education.

c. Proposed Alternative Regulatory Standard for Non-Network Plans (§ 156.236)

Based on these legal principles, we propose the following regulatory standards for non-network plans to demonstrate that they provide access to a sufficient choice of providers (including ECPs) to ensure compliance with section 1311(c)(1)(B) and, as relevant, section 1311(c)(1)(C) of the Affordable Care Act. First, we propose to add a new section to part 156, § 156.236, that contains the provider access sufficiency standards (including ECP access) specific to non-network plans, and to revise §§ 156.230 and 156.235 to make clear that those sections address the provider access sufficiency standards (including ECP access) for network plans.

We propose to add § 156.236(a) to state that a non-network QHP must ensure access to a range of providers that accept the non-network plan's benefit amount as payment in full, including ECPs and providers that specialize in mental health and substance use disorder services, to ensure that services will be accessible without unreasonable delay. Additionally, as discussed in sections III.D.18, III.D.19, III.E.10, and III.E.11.c of this proposed rule, we propose to allow FFE States, including States performing plan management, to conduct their own provider access and/or ECP certification reviews provided the State demonstrates sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program (for provider access reviews) and/or an Effective ECP Review Program (for ECP reviews). FFE States that elect to conduct provider access certification reviews and are determined by HHS to have an Effective Provider Access Review Program under proposed § 155.1050(d) would be permitted to perform such reviews of non-network plans if the State satisfies all applicable criteria. Similarly, FFE States that elect to conduct ECP certification reviews and are determined by HHS to have an Effective ECP Review Program under proposed § 155.1051 would be permitted to perform such reviews of non-network plans if the State satisfies all applicable criteria. For additional detail on the applicability of the proposed Effective Provider Access Review Program and Effective ECP Review Program to non-network plans under proposed § 156.236, please reference the discussions in sections III.D.18, III.D.19, III.E.10, and III.E.11.c of this proposed rule.

Furthermore, under § 156.236(b), we propose that a non-network plan applying for certification to be offered as a QHP through an FFE must report the following information to the FFE for the FFE's determination whether a non-network plan provides a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full (including ECPs and providers that specialize in mental health and substance use disorder services) to ensure that services will be accessible without unreasonable delay:

(1) The non-network plan's assessed percentage of available providers in each plan's service area that accept the plan's benefit amount as payment in full; and for ECPs, whether the non-network plan meets at least a minimum percentage, as specified by HHS, of available ECPs that accept the plan's benefit amount as payment in full in each plan's service area, collectively across all ECP categories defined under § 156.235(a)(2)(ii)(B), and at least a minimum percentage of available ECPs that accept the plan's benefit amount as payment in full in each plan's service area within certain individual ECP categories, as specified by HHS;

(2) For ECPs, whether the non-network plan offers the benefit amount as payment in full to at least one ECP in each of the eight ECP categories per county in the plan's service area described in § 156.235(a)(2)(ii)(B);

(3) For ECPs, whether the non-network plan offers the benefit amount as payment in full to all available Indian health care providers in the plan's service area;

(4) The non-network plan's strategy for conducting continuous outreach to available providers (including ECPs) in the plan's service area to determine whether they would accept the plan's benefit amount as payment in full;

(5) The non-network plan's strategy for making benefit amounts available to the public, including plan enrollees, potential enrollees, and providers (including ECPs), in an easily accessible and understandable format;

(6) The non-network plan's methodology for determining benefit amounts;

(7) The non-network plan's strategy for providing consumer-friendly and public information about potential balance billing scenarios and expected out-of-pocket costs, including historical data on actual out-of-pocket costs incurred by its enrollees while accessing providers (including ECPs) in the area;

(8) The availability of an exceptions process under the non-network program for enrollees who cannot find providers (including ECPs) willing to accept the benefit amount as payment in full; [206] and

(9) The non-network plan's strategy for providing adequate customer service or online provider directory assistance resources to assist plan enrollees and potential enrollees in finding providers (including ECPs) in their area who will accept the plan's benefit amount as payment in full.

These are among the factors that we have historically found useful in considering whether a non-network plan provides access to a sufficient choice of providers, including ECPs, to warrant the certification of non-network

[206] Such an exceptions process could, for example, ensure that the non-network plan covers any additional out-of-pocket costs incurred by an enrollee who could not locate an ECP willing to accept the plan's benefit amount as payment in full.

plans for the FFEs. HHS, as operator of the FFEs, considered the QHP application submitted by a non-network plan for PYs 2021 and 2022 in Ohio. In assessing whether the plan was in the interests of qualified individuals on the FFE in Ohio (under § 155.1000(c)), we used similar factors to assess whether the non-network plan provided protection against additional out-of-pocket costs for EHB in a manner consistent with § 156.130, and we believe this was appropriate because these factors provide a more complete picture of how well a non-network plan actually limits enrollees out-of-pocket costs.

The first proposed factor, the non-network plan's assessed percentage of available providers in each plan's service area that accept the plan's benefit amount as payment in full and, for ECPs, whether the non-network plan meets separate minimum percentage requirements of available ECPs that accept the plan's benefit amount as payment in full in each plan's service area, is an important indicator of how generous the non-network plan's benefit amounts actually are. It would provide an Exchange greater assurance that enrollees can actually access a sufficient number of providers, including ECPs, who will not seek additional payment from the enrollee after receiving the benefit amount from the plan. Requiring the non-network plan to have assessed the anticipated percentage of providers in the area who would accept the plan's benefit amount as payment in full also would provide Exchanges with assurance that the non-network plan issuer performed sufficient research and analysis in advance to determine sufficient benefit amounts for a relevant area. This would help ensure benefit amounts are generally sufficient to limit unanticipated additional out-of-pocket costs for enrollees.

The second proposed factor, whether the non-network plan offers its benefit amount as payment in full to at least one ECP in each of the eight ECP categories per county in the plan's service area described in § 156.235(a)(2)(ii)(B), is an important indicator of the plan's ability to cater to enrollee needs across a wide array of priority health needs and socioeconomic factors, which is required by the Affordable Care Act as a condition of QHP certification. Section 1311(c)(1)(C) of the Affordable Care Act requires access to ECPs, where available, that serve predominately-low income, medically underserved individuals, such as health care providers defined in section 340B(a)(4) of the PHS Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Act. In order to demonstrate that non-network plans comply with section 1311(c)(1)(C) of the Affordable Care Act and accordingly provide access to ECPs, where available, such as those under sections 340B(a)(4) of the PHS Act and 1927(c)(1)(D)(i)(IV) of the Act, Exchanges must be assured that the plan's benefit amounts are sufficient enough such that at least one ECP in each of the eight ECP categories per county within the plan's service area would accept the plan's benefit amount as payment in full.

The third proposed factor, whether the non-network plan offers its benefit amount as payment in full to all available Indian health care providers in the plan's service area, is an important indicator of the plan's ability to ensure Indian enrollees are able to receive applicable cost-sharing reductions for the plan variations described at §§ 156.420(b)(1) and (2) without incurring additional out-of-pocket costs. Additionally, Indian health care providers are among the providers described under section 340B(a)(4) of the PHS Act, which plans must demonstrate access to under § 156.235(a)(2)(ii), (b)(2)(ii), and (c), consistent with section 1311(c)(1)(C) of the Affordable Care Act.

The fourth proposed factor, the non-network plan's strategy for conducting outreach to available providers (including ECPs) in a particular area to determine whether they would accept the plan's benefit amount as payment in full, is an important indication of the non-network plan's recognition that whether any particular provider will accept a benefit amount as payment in full is a moving target. Providers that are not under contract to accept a non-network plan's payment as payment in full are generally not bound by any contract or law in setting prices. They may choose to change their charges for their services based on any multitude of factors, including changes in their operating expenses, changes in medical advancement, competitive pressure, or for no particular reason at all. And, they may choose to change this amount at any time. As a result, it is imperative that a non-network plan have in place a strategy for conducting continuous outreach to available providers (including ECPs) in a particular area to determine whether they would accept the plan's benefit amount as payment in full, so that the plan can make adjustments to its benefit amounts to ensure that enrollees can access a sufficient number of providers.

The fifth proposed factor, the non-network plan's strategy for making benefit amounts available to the public, including plan enrollees, potential enrollees, and providers (including ECPs), in an easily accessible and understandable format, is an important indicator of the non-network plan's ability to effectively communicate the plan's benefit amounts. Making this information widely available to providers would give notice to providers that charge more than the plan's benefit amount that their charges may be too high and they shoulder consider lowering them to attract plan enrollees. Non-network plans work best when information between the plan, the enrollee, and the provider is shared transparently; after all, an enrollee cannot be expected to shop for care if they do not understand what the plan will actually pay the provider.

The sixth proposed factor, the non-network plan's methodology for determining benefit amounts, is an important indicator that the non-network plan is not setting arbitrary benefit amounts for covered services; and, that the benefit amounts are well-informed through various analyses and research, so that the amounts reasonably cover costs associated with a particular service.

The seventh proposed factor, the non-network plan's strategy for providing consumer-friendly information to plan enrollees and potential enrollees about potential balance billing scenarios and expected out-of-pocket costs, including historical data on actual out-of-pocket costs incurred by its enrollees while accessing ECPs in the area, is an important indicator of the plan's ability to educate its enrollees about the plan's expectations on how the plan may be best utilized to minimize additional out-of-pocket costs. Non-network health plans do not currently exist in the individual and small group market, and are less commonly offered in the large group market and as excepted benefits products, so the plan design may not be immediately intuitive to enrollees. As such, it would be imperative that non-network plans have in place a cohesive strategy for providing consumer-friendly information about how the plan may be most effectively used to limit out-of-pocket costs and the impact of seeking care from providers who charge more than the plan's benefit amount.

The eighth proposed factor, the availability of an exceptions process under the non-network plan for enrollees who cannot find providers (including ECPs) willing to accept the benefit amount as payment in full, is an important indicator of the plan's commitment to be flexible for enrollees who have little choice in providers. The

provision of such an exceptions process would recognize that there may be some circumstances where a non-network plan may be unable to adequately protect consumers against out-of-pocket costs in circumstances where large numbers of providers refuse the plan's payment as payment in full. In recognition of this possibility, such an exceptions process would be able to shift the burden of paying any unavoidable, additional out-of-pocket costs from the enrollee to the non-network plan.

The ninth proposed factor, the non-network plan's strategy for providing adequate customer service or online provider directory assistance resources to assist plan enrollees and potential enrollees in finding providers (including ECPs) in their area who will accept the plan's benefit amount as payment in full, is another important indicator of the plan's ability to educate its enrollees about the plan's expectations on how the plan may be best utilized to minimize additional out-of-pocket costs.

Under this proposal, non-network plans would be subject to and allowed to demonstrate that they meet all of the general certification criteria at § 155.1000(c), which would allow Exchanges the ability to certify non-network plans as QHPs. These general certification criteria include the minimum certification requirements outlined in subpart C of part 156,[207] which include the requirement that each QHP must comply with benefit design standards as defined in § 156.20, which requires the provision of the EHB package. Thus, under this proposal, non-network plans would be required to provide this EHB package as a condition of QHP certification, which includes the provision of EHB in accordance with § 156.115, the cost-sharing requirements at § 156.130, and the levels of coverage requirement at § 156.140. This requirement to provide the EHB in accordance with § 156.115 would mean that the non-network plan would, among other things, provide benefits that are substantially equal to the relevant State's EHB-benchmark plan. This would require the non-network plan to ensure that any covered benefits under the plan that are not EHB in the State are not treated as EHB under the plan. Non-network plans that do not comply with these minimum certification requirements would be subject to denial of certification in accordance with § 155.1000(e) and decertification in accordance with § 155.1080(c).

Non-network plans that are applying for QHP certification or are QHPs would also be required to structure their plans so that they provide all the consumer protections that apply to individual and small group health coverage including, but not limited to, those specified in PHS Act title XXVII parts A through D, as all other plans applying for QHP certification are subject to providing. Under this proposal, a non-network plan would not be able to claim exemption from such protections merely because it does not enter into contracts with providers. Failure to offer these protections would also result in denial of certification in accordance with § 155.1000(e) and decertification in accordance with § 155.1080(c), even though they are not explicitly included in the minimum certification requirements outlined in subpart C of part 156. Under section 1311(e)(1)(B) of the Affordable Care Act and § 155.1000(c)(2), Exchanges have broad discretion to determine whether a plan is in the interest of qualified individuals and qualified employers, regardless of whether the plan meets other minimum certification requirements consistent with § 155.1000(c)(1). We confirm that an Exchange may use this authority to deny certification to a non-network plan that is not structured in a manner that provides all the consumer protections that apply to individual and small group health insurance coverage including, but not limited to, those specified in PHS Act title XXVII parts A through D. For example, the breadth of an Exchange's authority to deny certification under the interest standard extends to determinations that a non-network plan's benefit structure fails to provide protections against surprise medical bills in a manner similar to a network plan.[208]

The certification criteria at § 155.1000(c)(2) include the requirement that the Exchange determine that making the health plan available is in the interest of the qualified individuals and qualified employers. This proposal would not require States to approve non-network plans for sale nor would it require Exchanges to certify such plans. We have long maintained that Exchanges are free to exercise the authority at section 1311(e)(1) of the Affordable Care Act (as implemented at § 155.1000(c)(2)) to refuse certification to a plan if it determines that making available such health plan through such Exchange is not in the interests of qualified individuals and qualified employers in the State,[209] even if the plan otherwise meets all other QHP certification requirements. In the Exchange Establishment Rule (77 FR 18405), we stated that an Exchange may want to choose among one of several strategies for making this determination: (1) an Exchange may choose to utilize an ''any qualified plan'' strategy for certifying QHPs in its Exchange, such that an Exchange certifies all health plans as QHPs that meet and agree to comply with minimum QHP certification requirements; (2) an Exchange could undertake a competitive bidding or selective contracting process and limit QHP participation to only those plans that ranked highest in terms of certain Exchange criteria; (3) an Exchange may also choose to negotiate with health insurance issuers on a case-by-case basis and could request that an issuer, upon meeting the minimum certification standards, amend health plan offerings to further the interest of qualified individuals and qualified employers served by the Exchange; or (4) an Exchange may implement selection criteria beyond the minimum certification standards in determining whether a plan is in the interests of the qualified individuals and employers.[210]

We reaffirm these flexibilities under this proposal; Exchanges would be able to require non-network plans to meet additional criteria beyond those described in the model approach outlined above to be certified as QHPs, and they may determine that such plans are not in the interests of qualified individuals and qualified employers in the State, regardless of whether the non-network plan otherwise meets the

[207] Except for §§ 156.230 and 156.235, which would only be applicable to network plans.

[208] Section 1311(e)(1)(B)(i) of the Affordable Care Act and § 155.1000(c)(2)(i) prohibit Exchanges from excluding health plans from certification on the basis that such plan is a fee-for-service plan. We confirm that under this proposal, an Exchange may properly conclude that a non-network plan that is a fee-for-service plan may be denied certification under the interest standard for other criteria besides the fact that it is a fee-for-service plan.

[209] Except that the Exchange may not exclude a health plan: (i) on the basis that such plan is a fee-for-service plan; (ii) through the imposition of premium price controls; or (iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly (77 FR 18405).

[210] As explained in the Exchange Establishment Rule (77 FR 18405), some examples of such additional selection criteria include: (1) reasonableness of the estimated costs supporting the calculation of the health plan's premium and cost-sharing levels; (2) past performance of the health insurance issuer; (3) quality improvement activities; (4) enhancements of provider networks, including the availability of network providers to new patients; (5) service area of the QHPs (that is, the size of a service area and the amount of choice afforded to the consumers within that service area); and (6) premium rate increases from previous years and proposed rate increases.

certification criteria at § 155.1000(c)(1), and refuse them certification.

We are seeking comment regarding the PY 2027 effective date of this proposal. This includes comments from any QHP issuers that may be interested in submitting non-network plans for QHP certification for PY 2027, or whether PY 2028 may be the soonest that any QHP issuer could realistically consider submitting non-network plans for QHP certification.

In connection with this proposal, we have not identified any barriers to non-network plans' participation in the HHS-operated risk adjustment program. However, because these plans are not under contractual relationships with providers, we recognize that they may have difficulty obtaining medical records from providers for the purposes of HHS–RADV, which is a requirement for risk adjustment covered plans under § 153.630. EDGE-reported diagnoses for which no medical record can be obtained are considered to be non-validated diagnoses in the HHS–RADV process and would result in higher error rates and higher HHS–RADV adjustments. As such, we seek comment on considerations for non-network plans in the HHS–RADV process.

d. Effective Provider Access Review Program Requirements for Non-Network Plans

Under sections III.D.18 and III.E.10 of this proposed rule, we propose to allow FFE States, including States performing plan management, to elect to conduct their own provider access certification reviews of issuers' plans applying for certification as a QHP through an FFE, provided the State determines it has sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program under proposed § 155.1050(d)(2) through (d)(4), as determined by HHS. We propose that in FFE States that do not elect to conduct provider access reviews or that we determine do not have an Effective Provider Access Review Program, we would continue to conduct provider access certification reviews consistent with § 156.230 for network plans.

To ensure that non-network plans would be held to similar requirements as network plans in meeting regulatory requirements to provide sufficient choice of providers under section 131(c)(1)(B) of the Affordable Care Act, we also propose to apply the Effective Provider Access Review Program to FFE States, including States performing plan management, that wish to conduct provider access reviews of non-network plans. This means that if an FFE State elects to conduct their own provider access certification reviews of issuers' plans applying for certification to be offered as a QHP through an FFE and we determine that the State has satisfied all the applicable criteria to be considered to have an Effective Provider Access Review Program, then the State would have the ability to conduct provider access certification reviews of non-network plans. An FFE State would need to demonstrate that it meets applicable criteria for both network and non-network plans under proposed § 155.1050(d)(2) through (d)(4) prior to HHS determining that a State has an Effective Provider Access Review Program. This would mean an FFE State would not be permitted to elect to conduct provider access certification reviews for only network plans and not non-network plans, if they certify both such plans, or vice versa. However, should an FFE State notify us that it chooses not to certify non-network plans, and so does not offer non-network plans through the FFE operating in their State (regardless of if the State or HHS conducts the review), then we would determine whether it satisfies applicable criteria to be considered to have an Effective Provider Access Review Program under proposed § 155.1050(d)(2) through (d)(4) for network plans only. We seek comment on this approach. Additionally, similar to the approach for network plans, if we determine FFE States do not satisfy applicable criteria to be considered to have an Effective Provider Access Review Program, then we would conduct provider access certification reviews for non-network plans under new standards proposed at § 156.236.

We propose that an FFE State would need to demonstrate that it meets applicable criteria for both network plans and non-network plans under proposed § 155.1050(d)(2) through (d)(4), if they decide to certify such plans, to receive the designation to have an Effective Provider Access Review Program. This would mean that an FFE State would not be permitted to elect to conduct provider access certification reviews for only network plans and not non-network plans, if they certify such plans, or vice versa. We believe this is important, as some QHP issuers may choose to offer both network and non-network plans and centralizing reviews to a single entity, whether the FFE State or HHS, for the same issuer, would reduce administrative inefficiencies that may result if the FFE State and HHS have to coordinate provider access certification review results across a range of network and non-network plans. We also believe that review authority being limited to a single entity, either the FFE State or HHS, would allow both network and non-network plans to undergo consistent, standardized reviews conducted by the same reviewing entity. We believe this would ensure similar requirements and methodologies would be applied fairly across network and non-network plans and reduce potential differences in provider access review results. This may also reduce variabilities in access across the FFE State between enrollees in non-network plans versus network plans that may result if these plans undergo different levels and types of provider access certification reviews by separate review entities, and it could make it more difficult to effectively compare provider access review results between network and non-network plans during certification if alternative review methods are applied within the same FFE State. Overall, just as with network plans, non-network plans must ensure sufficient access to a range of providers in a manner consistent with section 1311(c)(1)(B) of the Affordable Care Act.

We propose to implement similar requirements for non-network plans as network plans under the Effective Provider Access Review Program at proposed § 155.1050(d). An FFE State must demonstrate it has sufficient authority and the technical capacity to conduct provider access certification reviews for non-network plans by satisfying all applicable criteria to be considered to have an Effective Provider Access Review Program under proposed § 155.1050(d)(2) through (d)(4), including criteria specific to non-network plans. Just as with network plans, an FFE State determined to have an Effective Provider Access Review Program would be expected to ensure sufficient access to providers under non-network plans. In this case, the FFE State would need to ensure that a QHP would be required to ensure access to a range of providers that accept the non-network plan's benefit amount as payment in full, including ECPs and providers that specialize in mental health and substance use disorder services, to ensure that services will be accessible without unreasonable delay.

Under our proposal, as with network plans, a State operating an FFE that elects to conduct its own provider access reviews, and which deems to certify non-network plans, must demonstrate it has established provider access standards that are set forth in State statute or regulation which are consistent with provider access standards set forth in §§ 156.230(a)(1)(ii)

and (iii) and are relevant to non-network plans. The FFE State would also need to demonstrate that the State's provider access review process includes reporting systems for State required provider access metrics related to non-network plans as well as documentation of methodology associated with non-network plan review; and that the State provides descriptions of all data collection systems, templates and methodologies used by the State, or the State's delegated entity, to collect and review provider access data for non-network plans and that this data and documentation received is sufficient to conduct an examination of non-network plans. The FFE State would also be required to establish and maintain clear procedures and timeline requirements for regular provider access reviews related to non-network plans, including processes that ensure reviews occur prior to each plan year's QHP certification cycle. Additionally, the FFE State would be required to have a process for monitoring and addressing consumer-related provider access complaints for non-network plans to ensure sufficient access to providers consistent with section 1311(c)(1)(B) of the Affordable Care Act and as set forth in State statute. The FFE State would also be required to have a process to collect and review information capable of demonstrating whether non-network plans provide access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full. We seek to understand whether the FFE State has a process for collecting and analyzing this information to demonstrate technical capacity during Effective Provider Access Review Program determinations. Additionally, we considered enumerating the information that non-network plans must submit to the FFE listed at 156.236(b)(4) through (b)(9) within 155.1050(d)(4)(vi) as requirements for FFE States with an Effective Provider Access Review Program to review non-network plans to ensure they be in alignment with HHS' proposed approach in an effort to further support consumer protectiveness in this novel plan design. These factors would include assessing a non-network plan's strategy for conducting outreach to providers in their area, making benefit amounts public to enrollees, methodologies for determining benefit amounts, strategy for publishing consumer-friendly information on balance billing and potential out-of-pocket costs, availability of exceptions processes for enrollees unable to locate providers who accept benefit amounts as payment in full, and customer services resources. However, as HHS is seeking to broadly restore flexibilities to FFE States as a part of some QHP certification reviews, and empower FFE States who understand their consumer needs and local conditions best, we opted in this proposal to provide deference to FFE States in how they will review non-network plans for a sufficient choice of providers who accept the plans benefit amount as payment in full in accordance with information listed at 156.236(b)(4) through (b)(9). We seek comment on whether HHS should better align the reviews of non-network plans for QHP certification as described above.

While these factors for assessing whether a State has an Effective Provider Access Review Program, as related to non-network provider access reviews, are comprehensive, we believe this approach would provide ample flexibility to States to determine the best methodology to assess provider access under non-network plans within the State. We anticipate each State's approach would be dependent on available resources and population needs unique to each State and that these proposed factors serve to appropriately evaluate overall State processes for review of non-network plans to ensure sufficient consumer protection.

e. Effective Essential Community Provider Review Program Requirements for Non-Network Plans

Under sections III.D.19 and III.E.11.c of this proposed rule, we propose to allow FFE States, including States performing plan management, to elect to conduct their own ECP certification reviews of issuers' plans applying for certification as a QHP through an FFE provided the State demonstrates sufficient authority and the technical capacity to conduct these reviews by meeting the applicable criteria, as determined by HHS, to be considered to have an Effective ECP Review Program under proposed § 155.1051. Additionally, as discussed in section III.E.11.c, we propose that if we determine an FFE State does not have an Effective ECP Review Program, we would continue to conduct ECP certification reviews consistent with § 156.235 for network plans. To ensure that non-network plans would be held to similar requirements as network plans in meeting regulatory requirements to ensure reasonable and timely access to ECPs for low-income, medically underserved individuals, we propose to also apply the Effective ECP Review Program under § 155.1051 to FFE States, including States performing plan management, that wish to conduct ECP certification reviews of non-network plans. That is, under this proposal, if FFE States elect to conduct their own ECP certification reviews of issuers' plans applying for certification to be offered as a QHP through an FFE and the State is determined by HHS to have satisfied all the applicable criteria to be considered to have an Effective ECP Review Program, then States would have the ability to conduct ECP certification reviews of non-network plans. An FFE State would need to demonstrate that it meets applicable criteria for both network plans and non-network plans under proposed § 155.1051(b) through (c), and demonstrate it has the sufficient authority and technical capacity to conduct reviews of such plans (as assessed by HHS under § 155.1051(e)), prior to HHS determining that a State has as an Effective ECP Review Program. This would mean an FFE State would not be permitted to elect to conduct ECP certification reviews for only network plans and not non-network plans, if they certify such plans, or vice versa. However, if an FFE State notifies us that it does not deem to certify such non-network plans, and consequently not offer these plans altogether through the FFE operating in their State (regardless of if the State or HHS conducts the review), then we would continue to review whether a State meets all applicable criteria for only network plans during the Effective ECP Review Program determination process. We seek comment on this approach. Lastly, similar to the approach for network plans, if FFE States do not satisfy criteria for having an Effective ECP Review Program, then we would perform ECP certification reviews for non-network plans under the proposed standards for non-network plans at § 156.236 discussed in section III.E.12.c of this proposed rule.

Furthermore, we believe HHS should primarily conduct ECP certification reviews as the default approach for issuers with non-network plans applying for certification as a QHP to be offered through an FFE, including States performing plan management, except if an FFE State elects to conduct ECP certification reviews and is determined to have an Effective ECP Review Program. We believe this is valuable for most of the same reasons that we propose to adopt this same approach for network plans under section III.E.11.c. of this proposed rule. In addition, as we stated in discussions above describing various characteristics of non-network

plans, there is no guarantee that a non-network plan's benefit amount is actually sufficient to cover the provider's full charges, which can leave enrollees with additional out-of-pocket costs that may disproportionately challenge low-income, medically underserved populations. These populations typically served by ECPs are often at a greater risk for lower health insurance coverage literacy and an increased risk for illness,[211] which may make it more difficult for these populations to understand how to use non-network plans to meet their needs. Additionally, the health care services furnished by ECPs are much more specialized and can be very expensive for enrollees, for example, HIV/AIDs treatment furnished by Ryan White program providers, cancer care furnished by Free-standing Cancer Centers, tuberculosis treatment furnished by Tuberculosis Clinics, hemophilia treatment furnished by Hemophilia Treatment Centers, and more.[212] Thus, if a non-network plan's benefit amount is not sufficient to cover these expensive, specialized services often furnished by ECPs, then these enrollees could potentially face larger out-of-pocket costs that are more regressive for low-income, medically underserved populations. This necessitates some minimum standard to ensure these plans are as consumer protective as possible for the low-income, medically underserved populations traditionally served by ECPs, including criteria under proposed § 155.1051 to ensure FFE States have the authority and technical capacity to conduct these ECP certification reviews in a such a way that continues to ensure low-income, medically underserved populations have adequate access to ECPs through non-network plans.

Additionally, based on our experience conducting ECP certification reviews of network plans, we believe having adequate and accurate data on available ECPs in a geographic area, sufficient tools to collect and calculate issuer submitted ECP data, and sound methodologies to quantitatively assess this data to ensure access to ECPs in accordance with section 1311(c)(1)(C) of the Affordable Care Act would be crucial for any FFE State to demonstrate the technical capacity to also conduct their own ECP certification reviews of non-network plans. This would include having data collection capabilities and structured analyses to measure the adequacy of a non-network plan in providing access to a sufficient number and geographic distribution of ECPs in their service area that accept the plan's benefit amount as payment in full. While existing resources (for example, the Federal ECP List, MPMS, etc.) at the Federal level can be leveraged to efficiently conduct ECP certification reviews of non-network plans, it is unknown what tools FFE States may utilize to collect ECP data from non-network plans or to assess adequate access to ECPs within these plans. Further, it is especially unclear to what extent FFE States may already have experience in conducting reviews of non-network plans and what existing requirements States may have in place to ensure these plans provide reasonable and timely access to ECPs. Thus, to broaden our knowledge in this area, we solicit comment on whether FFE States, including States performing plan management, have experience conducting reviews of non-network plans; and we welcome any information on current State-specific requirements that would ensure these plans provide reasonable and timely access to ECPs to medically underserved and low-income populations, including those ECPs that would accept a non-network plan's benefit amount as payment in full.

Moreover, we propose that an FFE State would need to demonstrate that it meets applicable criteria for both network plans and non-network plans under proposed § 155.1051(b) through (d), and the sufficient authority and technical capacity to conduct reviews of such plans (as assessed by HHS under § 155.1051(e)), to receive a designation as having an Effective ECP Review Program under proposed § 155.1051, as they decide to certify such plans. This would mean that an FFE State would not be permitted to elect to conduct ECP certification reviews for only network plans and not non-network plans, or vice versa. We believe this is important for several reasons. Some QHP issuers may choose to offer both network and non-network plans and centralizing the reviews to either the FFE State or HHS for the same issuer would reduce administrative inefficiencies that may result when FFE States and HHS have to coordinate ECP certification review results across a range of plans that may be offered by the same issuer.

Additionally, we believe that delegating reviews of both network and non-network plans to either the FFE State or HHS would allow both plan types to undergo consistent, standardized reviews conducted by the same reviewing entity, so that similar requirements and methodologies are applied fairly across all plan types to reduce differences in ECP certification review results. This may also reduce variabilities in access across the FFE State between enrollees in non-network plans versus network plans that may result if these plans undergo different levels and types of ECP certification reviews by separate review entities, and it could make it more difficult to effectively compare ECP review results between network and non-network plans during certification if alternative review methods are applied within the same FFE State. Under our proposal, non-network plans must still ensure sufficient access to ECPs in a manner consistent with section 1311(c)(1)(C) of the Affordable Care Act and must be held in parity with network plans to provide reasonable and timely access to ECPs.

Accordingly, we propose requirements at § 155.1051 that an FFE State must meet to be considered to have an Effective ECP Review Program and conduct ECP certification reviews of non-network plans. We propose that an FFE State must demonstrate that it

[211] Edward J, Wiggins A, Young MH, Rayens MK. Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform. Health Lit Res Pract. 2019 Nov 5;3(4):e250-e258. doi: 10.3928/24748307–20190923–01. Available at *https://pmc.ncbi.nlm.nih.gov/articles/PMC6831506/*. Karen Pollitz, Kaye Pestaina, Alex Montero, Lunna Lopes, Isabelle Valdes, Ashley Kirzinger, and Mollyann Brodie. KFF. (2023, June 15). KFF Survey of Consumer Experiences with Health Insurance. Available at *https://www.kff.org/mental-health/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/*. OASH, Health People 2023, Literature Review. Available at *https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty#:~:text=Unmet%20social%20needs%2C%20environmental%20factors,for%20people%20with%20lower%20incomes.&text=For%20example%2C%20people%20with%20limit*.

[212] For example, research indicates that among commercially insured adults with HIV, the mean all-cause and HIV-related per patient per month costs were $2,657 and $1,497, and all cause costs per patient per month for adults with PrEP were $1,761. Other research shows that the estimated direct costs of 4 to 6 months of tuberculosis treatment is an estimated $23,000 per person. Lastly, a meta-analysis found the average total annual costs for hemophilia treatment can start around $200,000 per patient and be as high as $869,940. Chen CY, Donga P, Campbell AK, Taiwo B. Economic Burden of HIV in a Commercially Insured Population in the United States. *JHEOR.* 2023;10(1):10–19. doi:10.36469/001c.56928. PMID:36721765. Available at *https://jheor.org/article/56928-economic-burden-of-hiv-in-a-commercially-insured-population-in-the-united-states*. Winston CA, Marks SM, Carr W. Estimated Costs of 4-Month Pulmonary Tuberculosis Treatment Regimen, United States. Emerg Infect Dis. 2023 Oct;29(10):2102–2104. doi: 10.3201/eid2910.230314. PMID: 37735769; PMCID: PMC10521593. Available at *https://pmc.ncbi.nlm.nih.gov/articles/PMC10521593/*. Chen Y, Cheng SJ, Thornhill T, Solari P, Sullivan SD. Health care costs and resource use of managing hemophilia A: A targeted literature review. J Manag Care Spec Pharm. 2023 Jun;29(6):647–658. doi: 10.18553/jmcp.2023.29.6.647. PMID: 37276036; PMCID: PMC10387983. Available at *https://pmc.ncbi.nlm.nih.gov/articles/PMC10387983/*.

has sufficient authority and the technical capacity to conduct ECP certification reviews of non-network plans by meeting all the applicable criteria to be considered to have an Effective ECP Review Program under § 155.1051, including criteria specific to non-network plans. We continue to believe that to protect low-income, medically underserved populations, and to ensure that enrollees in all FFEs are provided a minimum standard of consumer protection for reasonable access to providers and that disparities in access are minimized across States, Effective ECP Review Program States must continue to demonstrate that issuers without a network of providers applying for certification as a QHP through the FFE operating in their State meet various requirements described in this section. We propose under § 155.1051(b) that FFE States with an Effective ECP Review Program must ensure that a non-network plan applying for certification to be offered as a QHP through an FFE demonstrates that it provides reasonable and timely access to ECPs that accept the plan's benefit amount as payment in full to ensure that services will be accessible without unreasonable delay. In lieu of the requirements for network plans that are based on contracts executed with and/or offered to an ECP, non-network plans would instead be required to indicate benefit amounts as payment in full that were accepted by and/or offered to an ECP, as reflected under proposed § 156.236(b)(1) through (b)(3). Thus, under § 155.1051(c), we propose that FFE States with an Effective ECP Review Program must also demonstrate that their ECP requirements are comparable to ECP requirements under proposed § 156.236 for issuers' plans without a provider network so that plans: meet the minimum percentage requirements under proposed § 156.236(b)(1) for non-network plans; meet the Indian health care provider requirement under proposed § 156.236(b)(3) for non-network plans; and meet the category per county requirements under proposed § 156.236(b)(2) for non-network plans. Similarly, our proposal under § 155.1051(d) would also apply to non-network plans. Specifically, we propose that FFE States with an Effective ECP Review Program that have alternative ECP requirements, including ECP requirements specific to non-network plans, compared to those requirements described under proposed § 155.1051(c)(1) through (c)(3), must demonstrate how their requirements would continue to promote a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to ECPs, and an adequate level of service for low-income enrollees or individuals residing in Health Professional Shortage Areas. We understand that due to the newness of these plans, if this proposal is finalized, many FFE States would still be in the earlier stages of implementing new requirements for these plans. Thus, we would continue to work with FFE States to provide technical assistance to ensure any State ECP requirements (including alternative requirements) for non-network plans continue to ensure reasonable and timely access to ECPs across the State before and after making an Effective ECP Review Program determination.

Furthermore, consistent with the discussion in section III.E.11.c of this proposed rule for network plans, we would review information submitted by the FFE State to ensure the State receives adequate issuer data and documentation to conduct an examination of ECP requirements described in proposed § 156.236 for non-network plans to demonstrate it has the authority and technical capacity to conduct effective, timely reviews of a non-network plan's ECP data. Under §§ 155.1051(e)(1) through (10), as described in section III.E.11.c. of this proposed rule, we propose factors that we would consider in our review to determine if an FFE State has an Effective ECP Review Program, including factors related to a State's legal authority, State ECP requirements compared to ECP requirements under § 156.235 and proposed § 156.236, definition of an ECP, process for identifying qualified ECPs, data collection systems and methodologies to collect and review ECP data, delegation of ECP review to other entities, compliance and enforcement mechanisms, and consumer assistance. We would still consider all these criteria when determining if an FFE State has sufficient authority and the technical capacity to conduct ECP certification reviews including for non-network plans.

However, there are several additional criteria we would consider during our review of FFE States specific to only non-network plans. First, we propose under § 155.1051(e)(5) that we would consider if the FFE State utilizes the Federal ECP List or has a process they use to identify qualified ECPs that may accept a non-network plan's benefit amount as payment in full. We believe it is essential to have a means to identify the exact geographic location and distribution of ECPs that may be available within an issuer's service area that may accept a non-network plan's benefit amount as payment in full; this would ensure issuers fulfill statutory requirements under section 1311(c)(1)(C) of the Affordable Care Act to include ECPs ''where available'' so that enrollees have sufficient access to ECPs through their plans. Additionally, we propose to consider under § 155.1051(e)(7) whether the FFE State collects information from issuers regarding the status of offers of benefit amounts as payment in full to an ECP. We believe this type of data is an important metric to assess an issuer's compliance with the minimum percentage, category per county, and Indian health care requirements under proposed § 156.236(b)(1) through (b)(3), which would be evaluated based on measurements of benefit amounts as payment in full that were offered to or accepted by an ECP.

Moreover, as we have previously stated under section III.E.11.c. of this proposed rule, States possess unique knowledge on local factors that could strengthen ECP reviews, such as on market conditions, geographic constraints, areas in the State with limited economic resources, provider shortages, workforce issues, and population demographics, and we believe States can leverage this same knowledge on local factors when conducting ECP reviews of non-network plans. However, we considered enumerating the information that non-network plans must submit to the FFE listed at 156.236(b)(4) through (b)(9) as requirements for FFE States with an Effective ECP Review Program to review non-network plans to ensure they be in alignment with HHS' proposed approach in an effort to further support consumer protectiveness in this novel plan design. Information described under proposed § 156.236(b)(4) through (9) are specific to non-network plans and reflect additional safeguards to ensure these plans maintain access to providers without traditional network arrangements. These factors would include assessing a non-network plan's strategy for conducting outreach to ECPs in their area and for making benefit amounts public to enrollees, methodologies for determining benefit amounts, strategy for publishing consumer-friendly information on balance billing and potential out-of-pocket costs, availability of exceptions processes for enrollees unable to locate providers who accept benefit amounts as payment in full, and customer services resources. These reflect more qualitative measures that would likely

require different data collection methods compared to the more quantitative measures of minimum percentage, category per county, and Indian health care requirements under proposed § 156.236(b)(1) through (b)(3). As HHS is seeking to broadly restore flexibilities to FFE States as a part of ECP certification reviews and empower FFE States who understand their consumer needs and local conditions best, we opted to defer to FFE States in how they wish to review non-network plans for this type of information, as applicable. Though, we seek comment on whether HHS should better align the reviews of non-network plans across the FFE, regardless of whether HHS or an FFE State is conducting ECP certification reviews, by enumerating the factors under 156.236(b)(4) through (b)(9).

Altogether, in addition to the proposal to revise §§ 156.230 and 156.235, and add §§ 156.236 and 155.1051, we propose revisions to §§ 155.1050 (including its section heading), 156.275, and 156.810 to clarify that provisions within these sections would apply to the certification of non-network plans in the same manner that they apply to network plans.

We seek comment on these proposals.

13. Strengthening HHS' Oversight of the Administration of Advanced Payments of the Premium Tax Credit, Cost-Sharing Reductions, and User Fee Programs and Clarify HHS' Compliance Review Authority (§ 156.480)

We propose two proposals related to § 156.480. First, we propose to modify § 156.480 to clarify HHS' authority to audit or conduct a compliance review of an issuer that offers a QHP through an Exchange for the purposes of administering and providing oversight of the APTC, CSR, and user fee programs. Specifically, we propose to amend § 156.480(c) to provide that HHS or its designee may audit or conduct a compliance review to assess compliance with all requirements related to APTC, CSR, and user fee programs applicable to issuers offering a QHP in an Exchange, rather than only the requirements of 45 CFR subpart E and § 156.50 as is currently provided. For consistency, we also propose to make conforming changes to § 156.480(c)(6) to provide that in instances where HHS enforces compliance with any requirements related to APTC, CSR, and user fee programs with respect to QHP issuers participating in State Exchanges or SBE–FPs, HHS may do so in accordance with § 156.805. Second, we propose to clarify that HHS may conduct a compliance review to assess issuers' compliance with requirements related to these programs under § 156.480(c) as needed or on an annual basis rather than only on an ad hoc basis as previously stated in the preamble to part 2 of the 2022 Payment Notice (86 FR 24244 through 24247).

To explain our first proposal, in the 2014 Payment Notice (78 FR 65078), we established HHS' authority at § 156.480(c) to assess issuers' compliance with requirements in 45 CFR part 156 subpart E through audits to ensure the appropriate use of Federal funds related to the APTC and CSR programs. After several years of experience with operating the Exchanges, in part 2 of the 2022 Payment Notice (86 FR 24244, 24246), we expanded HHS' oversight tools at § 156.480(c) to include the authority for HHS to conduct compliance reviews, in addition to audits, and expanded the scope of such audits and compliance reviews to include requirements in § 156.50 related to the user fee program, in addition to those previously referenced in part 156 subpart E. We also provided that compliance reviews conducted under this oversight authority would follow the standards set forth in § 156.715. Now we are considering additional clarifications to HHS' authority on compliance reviews under § 156.480.

Currently, § 156.480(c) provides that in conducting APTC, CSR, and user fee audits or compliance reviews, HHS may assess an issuer's compliance with the requirements in 45 CFR part 156 subpart E and § 156.50. The regulatory text does not currently reference assessment of an issuer's compliance with other Exchange requirements related to administration of the APTC, CSR, and user fee programs that are outside of subpart E and § 156.50. For example, it does not include the assessment of grace period requirements at § 156.270(g), located in part 156 subpart C, which mandates that an issuer terminate an enrollee's enrollment after not receiving payments for any outstanding premium balance, or an amount within an issuer-established premium payment threshold, within the 3-month grace period. Noncompliance with this, and other enrollment and payment requirements can result in an issuer receiving APTCs on behalf of an enrollee who is not eligible for APTC due to the nonpayment of premiums, and to prevent these improper payments, it follows that HHS' administration and oversight of the APTC program should include assessment of issuers' compliance with these requirements.

To further explain, we have historically interpreted section 1313(a)(5) of the Affordable Care Act, which states that the Secretary shall implement any measure or procedure that the Secretary has authority to implement in title I of the Affordable Care Act or any other Act, to protect against fraud and abuse, and section 1321(c) of the Affordable Care Act to provide HHS with broad authority to implement oversight activities to assess compliance with all Exchange standards promulgated in accordance with section 1321(a)(1) of the Affordable Care Act. For example, compliance reviews conducted in accordance with § 156.715 as part of HHS' financial integrity oversight of QHP issuers in the FFE, and under the authority of Affordable Care Act section 1321(c), are not limited in scope to a set of listed regulatory requirements. Instead, § 156.715(a) identifies the scope of such compliance reviews as tools to generally ensure, ''ongoing compliance with Exchange standards applicable to issuers offering QHPs in a Federally-facilitated Exchange.'' Audits and compliance reviews conducted as part of HHS' oversight of the APTC, CSR, and user fee programs, which ensure fiscal responsibility of issuers and compliance with the requirements for QHP issuers, fall under this same broad statutory authority. While requirements related to the APTC, CSR, and user fee programs are concentrated in § 156.50 and subpart E, it was an unintended limitation to confine the scope of audits and compliance reviews conducted in accordance with § 156.480(c) to only these requirements. HHS has promulgated regulations that impact administration of these programs in other regulatory sections. For example, noncompliance with the premium payment requirements established in subpart C of part 156 may result in an issuer's receipt of improper APTCs on behalf of ineligible enrollees.

As we continue to conduct audits and compliance reviews, we want to ensure that we are clear on our authority to assess and enforce compliance with requirements related to the APTC, CSR, and user fee programs that are outside subpart E and § 156.50. Therefore, to provide this clarity, we propose to revise the introductory text in § 156.480(c) and make conforming revisions to paragraph (c)(6) to state that HHS may audit or conduct compliance reviews and enforce issuer compliance with all applicable requirements related to the APTC, CSR and user fee programs.

To explain our second proposal, we propose to revise our current position in

the preamble of part 2 of the 2022 Payment Notice (86 FR 24244 through 24247) stating that HHS conducts compliance reviews on an ad hoc basis, to provide that HHS may conduct compliance reviews as needed, including on an annual basis based on HHS' assessment of noncompliance with the applicable requirements and any identified issues related to noncompliance.

In part 2 of the 2022 Payment Notice (86 FR 24244 through 24247), we stated that compliance reviews would be conducted on an ad hoc basis to provide HHS with a mechanism to address situations where a systemic error or issue is identified during an audit, and if HHS suspects similarly situated issuers may have experienced the same systemic error or issue but were not selected for audit in the year in question. However, we have found that this approach is insufficient. For example, annual APTC, CSR, and user fee program audits of issuers in State Exchanges often identify data inaccuracies in issuers' enrollment and payment data that resulted in APTC over- or underpayments. While annual, these audits are conducted on benefit year data after the close of the 3-year window for resolution of payment inaccuracies described in § 156.1210(c).[213] Annual compliance reviews would provide issuers with an opportunity to proactively correct these data inaccuracies prior to the scheduled audits, which would ensure better compliance with APTC and other related requirements and, in turn, more quickly resolve any APTC over- or underpayments. With compliance reviews only occurring on an ad hoc basis, we are unable to regularly and fully address these issues prior to the audit process. As a result, we propose to revise our position such that HHS may conduct compliance reviews as needed including on an annual basis based on its assessment of identified issues related to noncompliance. We do not seek to make amendments to regulation text at § 156.480(c) to address this; rather we are proposing to clarify in the preamble of a final rule that the compliance review authority would allow us to conduct compliance reviews on an annual or as needed basis.

In summary, we propose to add language to the introductory text of § 156.480(c) which states that HHS may audit or conduct a compliance review of an issuer offering a QHP through an Exchange to assess its compliance with the applicable requirements related to administration of the APTC, CSR, and user fee programs. We also propose to add conforming language to § 156.480(c)(6) to state that in instances where HHS enforces compliance with any requirement related to APTC, CSR, and user fee programs with respect to QHP issuers participating in State Exchanges or SBE–FPs, HHS may do so in accordance with § 156.805. Finally, as discussed above, we propose to revise our position on the frequency of compliance reviews such that HHS would conduct compliance reviews as needed including on an annual basis based on its assessment of identified issues related to noncompliance, however, we are not proposing amendments to regulation text at § 156.480(c) to address this.

We seek comment on these proposals.

14. Factors Considered in Determining the Amount of CMPs and HHS' Authority To Impose CMPs Against Issuers in State Exchanges and SBE–FPs (§ 156.805)

We propose two proposals related to § 156.805. First, we propose to amend § 156.805(b) to reiterate what factors HHS considers when determining the amount of CMPs as enforcement remedies against QHP issuers in Exchanges. Specifically, to increase transparency in how HHS calculates the amounts of CMPs imposed against QHP issuers for violations described in § 156.805(a), including but not limited to substantial noncompliance with Exchange standards under parts 153 and 156 of title 45, we propose to reiterate in § 156.805(b) that in determining the amount of CMPs, in addition to the factors HHS takes into account when determining a CMP amount listed in § 156.805(b)(1) through (3), HHS would identify the lawful purpose or purposes of the CMP amount. As discussed in section III.A.1 of this proposed rule, to align with these proposed amendments to § 156.805(b), we also seek to clarify the factors considered in determining the CMP amount and the purpose of the CMP in § 150.317.

Second, we propose to amend § 156.805(f) to clarify the authority HHS has to impose CMPs against issuers in State Exchanges or SBE–FPs for identified violations. Specifically, we propose to amend § 156.805(f) to clarify that HHS' authority to impose CMPs against issuers in State Exchanges or SBE–FPs includes the authority to impose CMPs for identified violations of any Exchange requirements and standards applicable to issuers offering a QHP in an Exchange, when a State notifies HHS that it is not enforcing these requirements or HHS determines that a State is failing to substantially enforce these requirements. As detailed further below, we are not proposing any other changes to the legal bases for imposing CMPs against issuers in FFEs nor the circumstances in which HHS may exercise its enforcement authority against issuers in State Exchanges or SBE–FPs.[214]

Under the first proposal, sections 2723(b)(2), 2718(b)(3), and 2761(b) of the PHS Act and section 1321(c)(2) of the Affordable Care Act authorize the Secretary to impose CMPs when a QHP issuer fails to meet the required standards.[215] In prior rulemakings (78 FR 54121; 79 FR 15240, 15242 through 15243; 79 FR 30240, 30264; 81 FR 12204, 12313 through 12314; and 81 FR 61538, 61581), to implement these statutory provisions, we established provisions at § 156.805 to govern the bases and process for imposing CMPs against QHP issuers in Exchanges when HHS has reasonably determined that the issuer has engaged in one or more of the enumerated actions listed in § 156.805(a)(1)–(7), including noncompliance with issuer standards and requirements under 45 CFR parts 153 and 156. Further, in part 2 of the 2022 Payment Notice (86 FR 24242 through 24243), we set forth the framework for HHS' enforcement of the applicable Federal APTC, CSR, and user fee standards in situations where State authorities fail to substantially enforce those standards for the QHP issuers participating in State Exchanges and SBE–FPs, and HHS' authority to impose associated CMPs.

Since 2014, Exchange regulations have imposed standards and requirements on issuers offering QHPs participating in Exchanges, including, but not limited to, standards and requirements under 45 CFR subtitle A,

[213] Plan year data inaccuracies described to HHS or the State Exchange (as applicable) before the end of the 3-year period described in § 156.1210(c) beginning at the end of the plan year to which the inaccuracy relates are eligible for resolution and payment to the issuer of any confirmed APTC underpayments. Data inaccuracies identified after the 3-year period are not eligible for repayment to the issuer. However, should an issuer identify a payment error after the 3-year period, the issuer must notify HHS or the State Exchange (as applicable) and repay any overpayments.

[214] The bases and processes for imposing CMPs in FFEs and the circumstances in which HHS may exercise enforcement in State Exchanges would not be impacted by a State's decision to implement the proposed DE option under § 155.221(j), if finalized.

[215] See PHS Act sections 2723(b)(2)(G), 2718(b)(3), and 2761(b) (indicating CMPs shall be paid to the Secretary and shall be available without appropriation and until expended for the purpose of enforcing the provisions for which the penalty was imposed); see also Affordable Care Act section 1321(c)(2) (authorizing the Secretary to impose CMPs on the same basis as detailed in section 2723(b) of the PHS Act).

subchapter B, parts 153 and 156,[216] such as compliance with premium payment policies in part 156. Historically, to facilitate QHP issuers' compliance with Exchange standards and requirements, HHS conducted audits, the results of which played a critical role in ensuring that Federal funds are appropriately safeguarded. However, we exercised enforcement discretion and did not seek to impose CMPs to enforce the findings in such audits, to give issuers time to acclimate to a new market and learn the regulatory scheme, and relied instead on other mechanisms available, such as recouping overpayments, decertification of QHP issuers for egregious violations, and CAPs.[217] But as the markets have matured, HHS audits consistently reveal that in practice, issuers implement inconsistent policies, even after we have provided such issuers with guidance and recommendations to cure identified noncompliance. Continued violations put HHS at risk of making improper payments, such as APTC payments for enrollees with noncompliant effectuations or continued enrollment that should have been cancelled or terminated. Violations may be identified long after an improper payment is made,[218] and retroactive changes often involve loss of eligibility for APTC, disenrollment of coverage, and reversal of paid claims, which together can cause enrollees outsized financial harm. For example, if we were to find that an issuer maintained an enrollee's coverage in violation of an enrollment or payment requirement and directed the issuer to retroactively terminate the enrollee's coverage to correct the noncompliance, the enrollee would lose their APTC for the months they were covered, which may have tax implications, and the enrollee could be liable for claims costs previously covered under their plan which might, as a practical matter, be difficult for a QHP issuer to recover. To minimize these needless harms to enrollees and QHP issuers alike and bolster compliance with HHS standards and requirements applicable to issuers offering QHPs participating in Exchanges, HHS oversees QHP issuer compliance in this area.

We propose to amend § 156.805 to reiterate that HHS would identify the lawful purpose or purposes of the CMP when calculating CMP amounts. As noted above, section 2723(b)(2) of the PHS Act and section 1321(c)(2) of the Affordable Care Act authorize HHS to impose CMPs to enforce Exchange standards and requirements applicable to issuers offering QHPs participating in Exchanges. Section 2723(b)(2)(C)(i) of the PHS Act caps the amount of the CMP at $100 (as adjusted annually under the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 and other relevant laws) [219] for each day for each individual for which an entity fails to comply with a relevant statutory or regulatory requirement. Further, section 2723(b)(2)(C)(ii) of the PHS Act requires HHS to consider the previous record of compliance of the entity being assessed with the applicable legal provisions and the gravity of the violation.

That broad delegation of enforcement authority can encompass several traditional purposes of monetary remedies. For example, in some circumstances, when consistent with these provisions and applicable law, HHS might impose a CMP to penalize a QHP issuer when an audit reveals that it failed to comply with an applicable law in prior years and thereby collected payments for some period despite not being entitled to those payments under a public benefits program the government runs. In other circumstances, HHS might impose a CMP to bring a currently noncompliant QHP issuer into compliance with relevant laws, such as if HHS discovers that a QHP issuer is currently refusing to comply with particular laws. And in still other circumstances, HHS might impose a CMP to try to make a wronged party whole for harm caused by the QHP issuer's conduct, such as if HHS discovers violations that cost the public money and HHS is able to make the Government whole through its CMP authority.

These purposes for which HHS imposes CMPs related to enforcement of Exchange standards and requirements applicable to issuers offering QHPs participating in Exchanges are not mutually exclusive. To increase transparency in how HHS calculates the amounts of CMPs imposed against QHP issuers for violations described in § 156.805(a), including but not limited to substantial noncompliance with Exchange standards under parts 153 and 156 of title 45, we propose to clarify that HHS will identify the underlying lawful purpose or purposes of a CMP when calculating the relevant amount.

QHP issuers have been on notice of possible CMPs for noncompliance since the inception of the Exchange, through regulations, and directly through subsequent HHS communications. For example, in the 2019 CMS Program Integrity letter to FFE issuers,[220] we stated that CMPs may be imposed against QHP issuers for violations of applicable regulatory requirements with FFE audits of APTCs and user fees beginning for benefit year 2020. We added similar language to APTC and user fee audit reports for FFE issuers for benefit years 2016–2019,[221] and we restated that we may begin imposing CMPs starting with 2020 benefit year APTC and user fee audits of FFE (and SBE–FP) issuers in a Fall 2023 webinar for all FFE and SBE–FP issuers.[222] QHP issuers now have over a decade of experience implementing applicable Exchange standards and requirements. Given the duty to safeguard Federal funds, ongoing concerns with QHP issuers' inconsistent premium payment policies, and in light of ongoing audit observations and findings of noncompliance,[223] HHS plans to proactively monitor and enforce compliance with the Exchange standards and requirements applicable to issuers offering QHPs participating in Exchanges, including through the imposition of CMPs, as warranted.

Second, we propose to clarify the authority HHS has to impose CMPs against issuers in State Exchanges or SBE–FPs when a State notifies HHS that it is not enforcing the applicable requirements or HHS determines that a State is failing to substantially enforce these requirements. Specifically, we propose to amend § 156.805(f) to clarify that HHS' authority to impose CMPs against issuers in State Exchanges or SBE–FPs includes authority to impose CMPs for identified violations of the

[216] CMPs may be imposed on an issuer in an Exchange, if, based on credible evidence, HHS has reasonably determined that the issuer has engaged in one or more of the actions listed under § 156.805(a).

[217] *See, for example,* § 156.480(c)(4), which requires, in part, that a QHP issuer must comply with actions set forth in a final audit report and provide a written CAP for HHS approval and QHP issuer implementation.

[218] Improper payments are often discovered long after an improper payment is made because these audits are conducted on benefit year data after the 3-year window for resolution of payment inaccuracies described in § 156.1210(c) closes, which is well after an issuer receives an APTC on behalf of an enrollee and claims were processed.

[219] *See* Sec. 701 of Public Law 114–74; *see also* 45 CFR 102.3; see also 89 FR 64815.

[220] See CMS Issuer Letter, available at *https://www.cms.gov/files/document/ppfmgea-audit-communication-non-auditees5cr071819.pdf.*

[221] See, for example, materials available at *https://www.cms.gov/files/zip/2019-ffe-audit-report-part-1.zip.*

[222] Registration for Technical Assistance Portal (REGTAP), available at *https://regtap.cms.gov/reg_library_openfile.php?id=4647&type=l.*

[223] See CMS. The Center for Consumer Information & Insurance Oversight: Advance Payments of the Premium Tax Credit (APTC) Audits. Available at *https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/auditreports.*

requirements applicable to the noncompliant actions described in § 156.805(a) that are applicable to issuers offering a QHP in a State Exchange or SBE–FP, including substantial noncompliance with issuer standards and requirements under parts 153 and 156 of title 45, as opposed to just those requirements in subpart E or § 156.50, as currently written. We also propose to make a conforming change to § 156.800.

In prior rulemaking (86 FR 24248 through 24252), we set forth the framework, consistent with section 2723(b) of the PHS Act and section 1321(c)(2) of the Affordable Care Act, for HHS' authority to enforce applicable Exchange standards for QHP issuers participating in State Exchanges and SBE–FPs. We further clarified that this enforcement authority arises when a State authority notifies HHS that it is not enforcing these standards or HHS determines that a State has failed to substantially enforce these standards, and, that if HHS has this enforcement authority, HHS could impose a CMP. However, when establishing this framework, we inadvertently limited the scope of HHS' authority under § 156.805(f) to enforcement of only those requirements in subpart E of part 156 or in § 156.50.

To align with HHS' statutory authority, we propose to amend § 156.805(f) to expressly provide that when appropriately triggered, HHS has the authority to enforce the requirements applicable to the noncompliant actions described in § 156.805(a) that are applicable to issuers offering a QHP in a State Exchange or SBE–FP, and has the authority to impose CMPs against a QHP issuer in a State Exchange or SBE–FP on the same grounds for which it can impose CMPs for QHP issuers in a FFE under § 156.805. Further, amending the language to expressly address HHS' enforcement authority with respect to these requirements would help to ensure that HHS can hold all issuers accountable for violations of requirements that result in improper APTC payments.

This proposed amendment would not usurp States' power to enforce these requirements in their own Exchanges. As previously established in prior rulemaking, the process for imposing CMPs must either require that the State notify HHS that it is failing to enforce the requirements of subpart E or § 156.50 or that HHS make its own determination, following the standards in § 150.201, *et seq.,* that the State is failing to substantially enforce these requirements.

In summary, we propose to amend § 156.805(b) to reiterate that in determining the amount of CMPs, in addition to the factors HHS takes into account when determining a CMP amount listed in § 156.805(b)(1) through (3), HHS would identify the lawful purpose or purposes of the CMP amount. We also propose to amend § 156.805(f) to provide that when appropriately triggered, HHS would enforce the requirements applicable to the noncompliant actions described in § 156.805(a) that are applicable to issuers offering a QHP in a State Exchange or SBE–FP, and has the authority to impose CMPs against a QHP issuer in a State Exchange or SBE–FP on the same grounds for which it can impose CMPs for QHP issuers in an FFE.

We seek comment on these proposals.

15. Administrative Review of QHP Issuer Sanctions (§§ 156.903 and 156.935)

To improve the accuracy of hearing decisions and increase hearing efficiency, we propose to amend the review process that governs administrative appeals of QHP issuer sanctions imposed under § 156.800, including QHP decertification actions and CMPs imposed against QHP issuers for, among other actions, violations of Exchange standards. First, under § 156.903, we propose to allow an administrative law judge (ALJ) who presides over an administrative appeal of a QHP issuer sanction imposed in accordance with § 156.800 to issue subpoenas, upon his or her own motion or at the request of a party, if the subpoenas are reasonably necessary for the full presentation of a case. Second, to expedite the process of appeals and limit duplication, we propose to amend § 156.935 so that the discovery provisions set forth therein do not apply to administrative appeals of proposed CMPs for violations identified through audits of the APTC, cost sharing reduction, or user fee programs conducted in accordance with § 156.480(c). If finalized as proposed, these amendments would apply to appeals filed on or after the effective date of the final rule.

In the 2014 Payment Notice (78 FR 65079), we codified the administrative appeals process for QHP issuers in an FFE to challenge the imposition of a sanction, as described in § 156.800. These procedures include the opportunity for a hearing before an ALJ of the HHS Departmental Appeals Board (DAB). In part 2 of the 2022 Payment Notice (86 FR 24253), we further amended these procedures to affirm that the process applies to appeals of sanctions imposed against QHP issuers participating in any Exchange and to align with the DAB's internal practices for administrative hearings to appeal CMPs.

The DAB's internal practices include procedures that ALJs and parties must follow for appeals and administrative hearings, and ALJs and parties must also follow any relevant agency's administrative hearing procedures as prescribed by the agency through regulation for the agency's programs.[224] The DAB's procedures currently allow parties to request subpoenas, and they allow ALJs to issue a subpoena, if the ALJ is authorized by law to issue a subpoena and applicable regulatory requirements are met.[225] However, current 45 CFR part 156 subpart J does not provide the authority for the ALJ to issue subpoenas in hearings requested by parties to appeal the imposition of a QHP issuer sanction, as defined in § 156.800. Having the option to issue a subpoena would help the ALJ obtain necessary documentation, information, and potential testimony from witnesses to fully develop a case before issuing a decision, which could streamline hearing processes and improve the accuracy of DAB decisions, benefiting both parties. Granting ALJs the authority to issue a subpoena would also align with other similar programs.[226] Therefore, to further align HHS administrative appeal procedures with the DAB's procedures and improve the speed and accuracy of the hearing process, we propose add the ability to issue a subpoena in the ALJ's current authority under § 156.903.

As part of this provision, we also propose that a party must file a written request for a subpoena with the ALJ at least 5 calendar days before the date set for the hearing and that the request must identify the witness(es) or documents to be produced, describe their address(es) or location(s) with sufficient particularity to permit them to be found, and specify the pertinent facts the party expects to establish by the witness(es) or documents, and indicate why those facts could not be established without

[224] See HHS. Appeals to DAB Administrative Law Judges (ALJs). Available at *https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-alj/index.html.*

[225] *See HHS. Department Appeals Board (DAB): Discovery. Available at https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-alj/procedures/discovery/index.html. See also HHS. Department Appeals Board (DAB): Summoning Witnesses. Available at https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-alj/procedures/summoning-witnesses/index.html.*

[226] See, for example, 42 CFR 498.58; see also 42 CFR 422.1044.

use of a subpoena. Establishing these requirements in regulation would provide structure to the subpoena request thereby increasing the efficiency with which ALJs can exercise the proposed subpoena authority. These requirements would also ensure that parties requesting subpoenas provide ALJs with all relevant information they will need to determine if the subpoena is reasonably necessary for full presentation of the case.

Second, to expedite the process of appeals and limit duplication, we propose to amend § 156.935 to ensure that the discovery provisions set forth therein do not apply to administrative appeals of notices of proposed CMP assessments for violations identified through audits of the APTC, cost sharing reduction, or user fee programs conducted in accordance with § 156.480(c). To explain, current audit processes under § 156.480(c)(3) require that HHS conduct an audit entrance conference with each issuer selected for audit to discuss the scope of the audit, provide issuers with preliminary audit findings and an opportunity to refute the preliminary findings prior to receiving the final audit report, and provide issuers with an opportunity to discuss final audit findings during an exit conference. In addition, audits are collaborative, meaning at any point issuers can ask questions of the auditors or seek clarification on the information or documentation needed. Further, in conjunction with these audit processes and in accordance with § 156.806, when imposing a CMP, HHS must provide written notice to the issuer that describes the potential violation(s), provides 30 days from the date of the notice to respond and provide additional information to refute the allegations, and states that a CMP may be assessed if the allegations are not refuted as determined by HHS.

During the established audit processes, HHS makes relevant information that HHS relies on in making final audit determinations available to issuers, including written audit procedures, and provides issuers with multiple opportunities to ask HHS questions about the audit procedures and audit findings. Should HHS determine that a CMP is appropriate, HHS would also make relevant information that HHS relied on to determine the CMP amount available to the issuer during the audit process. Therefore, under these established audit processes, issuers are able to develop an extensive record that can inform a CMP appeal. For these reasons, we believe that issuers would not need to rely on the time-consuming process of discovery for information to develop a record for an administrative appeal.

Similarly, these established audit procedures allow HHS to obtain information necessary to inform final audit findings from the issuer during the audit process, limiting the need for discovery of information. Therefore, to prevent duplicative efforts for gathering documentation and information and to reduce burden on both parties to an appeal, we propose adding a new paragraph to § 156.935 which would exclude appeals of CMPs resulting from audits at § 156.480(c) from the process of discovery.

In summary, we propose to add a new paragraph to § 156.903 which provides the ALJ with the authority to issue subpoenas, upon his or her own motion or at the request of a party, if they are reasonably necessary for the full presentation of a case for an administrative appeal brought under § 156.805 or § 156.810. We also propose to add a new paragraph to § 156.935 to ensure that the discovery provisions set forth therein do not apply to appeals of proposed CMPs imposed under § 156.805 resulting from audits at § 156.480(c). If finalized as proposed, these amendments would apply to appeals filed on or after the effective date of the final rule.

We seek comment on these proposals.

16. Quality Standards: Quality Improvement Strategy (§ 156.1130)

We propose to require QHP issuers to submit quality improvement strategies (QISs) addressing any two of the five topic areas listed in section 1311(g)(1) of the Affordable Care Act, without mandating which specific topic areas a QHP issuer would be required to address to meet the QIS statutory certification requirement beginning with PY 2027.

In accordance with section 1311(c)(1)(E) of the Affordable Care Act, QISs described in section 1311(g)(1) of the Affordable Care Act must be implemented across Exchanges as a QHP certification requirement. Section 1311(g)(1) of the Affordable Care Act defines a QIS as a payment structure that provides increased reimbursement or other market-based incentives for implementing activities related to five health care topic areas identified in statute: improving health outcomes of plan enrollees, preventing hospital readmissions, improving patient safety and reducing medical errors, promoting wellness and health, and reducing health and health care disparities. Under § 156.1130(a), an issuer participating in an Exchange for two or more consecutive years must implement and report on a QIS, including a payment structure that provides increased reimbursement or other market-based incentives in accordance with the health care topic areas in section 1311(g)(1) of the Affordable Care Act, for each QHP offered in an Exchange, consistent with the guidelines developed by HHS under section 1311(g) of the Affordable Care Act In the 2016 Payment Notice (80 FR 10844 through 10848), we established a phase-in approach for QIS implementation standards and reporting requirements to provide QHP issuers time to understand the populations enrolling in a QHP offered through the Exchange and to build quality performance data on their respective QHP enrollees. In the 2023 Payment Notice (87 FR 27341 through 27345), we finalized a guideline to require QHP issuers to address health and health care disparities as a specific topic area within their QIS, in addition to at least one other topic area described in section 1311(g)(1) of the Affordable Care Act, beginning in 2023. We noted our commitment to addressing the persistent inequities in health care outcomes for QHP enrollees and aligning with health equity efforts across Federal governmental policies and programs.

We propose to modify the approach finalized in the 2023 Payment Notice (87 FR 27208) to instead require QHP issuers to submit QISs addressing any two of the five topic areas listed in section 1311(g)(1) of the Affordable Care Act, without mandating which specific topic areas a QHP issuer would be required to address to meet the QIS statutory certification requirement. We are not proposing any amendments to the regulatory text outlined in § 156.1130.

We believe this proposal would align with current Administration priorities, provide increased flexibility and reduced burden for QHP issuers that are required to submit QISs, and would better allow these QHP issuers to define the health outcome needs of their enrollees, set goals for improvement, and provide increased reimbursement to their providers or other market-based incentives to reward achievement of those goals, as initially described in the 2015 Payment Notice (79 FR 13744) when establishing the QIS program. Specifically, by allowing QHP issuers to select the two topic areas most relevant to their population and operational context, the proposal would empower issuers to focus resources on areas with the greatest potential for meaningful improvement, rather than adhering to a one-size-fits-all approach. This targeted

flexibility would support innovative strategies for improving patient outcomes, encourage adoption of best practices across diverse settings, and help ensure that incentives are aligned with measurable progress on priority health outcomes, consistent with the objectives articulated in the 2015 Payment Notice (79 FR 13744) when establishing the QIS program.

We continue to believe that improving health care quality and outcomes for all is important. QHP issuers have a critical role in promoting high quality health care by designing QISs that tie provider payments or other market-based incentives to measures of performance, such as when providers meet quality indicators or when enrollees make certain choices associated with improved health. For each QIS topic area, issuers may select quality measures, such as those from the Marketplace Quality Rating System, or other performance targets based on their programmatic goals and the needs of their enrollee populations, to monitor QIS progress.

Although QHP issuers would no longer be required to submit a QIS that addresses health and health care disparities as a specific topic area within their QIS under this proposal if finalized, they would be permitted to continue to choose this topic area as one of the two topic areas they address in their QIS. We further note that health and health care disparities may relate to various factors such as geographic, economic, educational, disability status, and other factors that impact high quality health care for all.

We seek comment on this proposal.

17. Netting and Establishment of Debt Regulations To Include CMPs (§ 156.1215)

We propose to amend the payment and collections processes set forth at § 156.1215. In particular, we propose to amend § 156.1215(b) to provide that any CMPs assessed [227] against health insurance issuers for violations of any applicable Exchange standards and requirements or PHSA requirements applicable to health insurance issuers would be subject to netting as part of HHS' integrated monthly payment and collections cycle. We propose to apply the netting provisions of the payment and collections process to CMPs assessed against health insurance issuers to allow the payment and collections process to evolve with the needs of the programs administered by HHS, ensure stability and consistency in the monthly payment and collections process, and improve HHS' ability to recover Federal debts by withholding funds payable by HHS to, or held by HHS for, health insurance issuers to satisfy a debt to HHS for CMPs assessed against health insurance issuers.

Since finalizing the netting rules at the beginning of the Affordable Care Act financial management programs (79 FR 13817, 81 FR 12317 through 12318), the programs under title XXVII of the PHS Act have evolved, and existing Exchange programs have matured and stabilized. We have undertaken efforts to adapt our payment and collections process to fit the current needs of the Exchanges and other programs administered by HHS. As we work to enhance enforcement of these maturing programs, we believe that the payment and collections process should reflect this change by further evolving to provide that CMPs assessed against health insurance issuers, for violations of any applicable Exchange standards and requirements or PHS Act requirements, including the No Surprises Act, applicable to health insurance issuers, are also subject to netting as part of HHS' integrated monthly payment cycle.

Accordingly, we propose to amend § 156.1215(c) to provide that any amount owed to the Federal Government by an issuer and its affiliates for these unpaid CMP amounts due to the Federal Government from these issuers and their affiliates, after HHS nets amounts owed by the Federal Government under these programs, would be the basis for calculating the determination of the debt.

HHS' current integrated monthly payment and collections cycle is designed to streamline payment processing for both health insurance issuers and HHS, and includes statements to health insurance issuers that reflect how payments have been netted in the monthly payment and collections cycle. The proposed changes, to provide for netting of CMPs assessed against health insurance issuers and their affiliates, would ensure stability and consistency in the monthly payment and collections process and support HHS' continued ability to recover Federal debts by withholding funds payable to (or held by HHS for) issuers to satisfy an outstanding balance due to HHS for CMPs. Netting supports HHS' integrated monthly payment and collections cycle by limiting the number of charges flowing back and forth between HHS and issuers, mitigates the need for additional steps for Federal debt collection when internal netting may resolve the outstanding balance due to HHS from a determined debt, and may prevent inappropriately enriching an issuer if a payment is made from HHS when the issuer has an outstanding CMP.

In summary, we propose to amend § 156.1215(b) to add language which applies the netting provisions of the payment and collections process to CMPs assessed for violations of any applicable Exchange standards and PHSA requirements applicable to health insurance issuers. We also propose to amend § 156.1215(c) to add language which provides that any amount owed to the Federal Government by an issuer and their affiliates for unpaid CMP amounts due to the Federal Government, after HHS nets amounts owed by the Federal Government under these programs is a determination of debt.

We seek comment on these proposals.

18. Technical Correction To Cross Reference (§ 156.1220(b)(1))

We propose a technical correction to § 156.1220(b)(1) to update a cross-reference in the regulation text from paragraph (a)(5) to (a)(6). The process for administrative appeals consists of requests for reconsideration, described in § 156.1220(a), followed by informal hearings, described in § 156.1220(b). Section 156.1220(b)(1) serves to explain the manner and timing of the request for an informal hearing, in the event that a request for reconsideration is not accepted by HHS. Currently § 156.1220(b)(1) references § 156.1220(a)(5) which is the scope of review of the reconsideration decision and we propose to correct this reference to § 156.1220(a)(6) on the reconsideration decision.

We seek comments on this technical correction.

F. Part 158—Issuer Use of Premium Revenue: Reporting and Rebate Requirements

1. Comment Solicitation on Potential Adjustment to the MLR for a State's Individual Market (Subpart C)

Section 2718(b)(1)(A) of the PHS Act requires individual market health insurance issuers to pay rebates to enrollees if issuers do not spend at least 80 percent or a higher percentage that a State may by regulation determine (the MLR standard) of their premium revenue (after certain adjustments) on reimbursement for clinical services provided to enrollees under health insurance coverage and on activities that improve health care quality.

[227] A CMP is assessed only after any applicable imposition and appeal processes set forth in 45 CFR subtitle A, subchapter B have been exhausted or expire.

Section 2718(b)(1)(A)(ii) of the PHS Act provides that the Secretary may adjust the 80 percent MLR standard in the individual market with respect to a State if the Secretary determines that application of the MLR standard may destabilize the individual market in such State. In an interim final rule relating to the MLR program issued in the **Federal Register** on December 1, 2010 (75 FR 74864), we set forth the framework for a State to request an adjustment of the MLR standard pursuant to section 2718(b) of the PHS Act, and under this framework, the State requesting the adjustment must demonstrate a reasonable likelihood that the 80 percent MLR standard would destabilize its individual market. The interim final rule also established a process and criteria for the Secretary to determine whether to grant a State's request to adjust the MLR standard in that State (75 FR 74910). In the 2019 Payment Notice (83 FR 16930), we finalized amendments throughout subpart C of part 158 to allow for adjustments to the individual market MLR standard in any State that demonstrates a reasonable likelihood that a different MLR standard will help stabilize its individual market, and to streamline the process for applying for such adjustments to reduce burdens for States and HHS. Subpart C of part 158 specifies that the adjustment request must be initiated by the State (§ 158.310), that the adjustment may be granted for up to 3 years at a time (§ 158.311), the information that the State must provide to support its request (§§ 158.320 and 158.321), and the criteria that HHS may consider in making a determination (§ 158.330). It also requires the Secretary to invite public comments on the adjustment requests (§ 158.342), allows States to hold optional public hearings (§ 158.343), and enables States to request reconsideration of adverse determinations (§ 158.346).

Given the instability in the individual market in recent years, we are seeking comment on the impact of the Federal MLR standard on individual market stability, including the impact of MLR on costs and premiums and how such impact, if any, may affect individual market stability. We are taking a comprehensive look at HHS regulations to determine whether any changes to these regulations could be proposed that would help stabilize the individual market, including potentially by lowering premiums for consumers, and, as such, are seeking comment on whether and how to amend subpart C of part 158 to enable HHS to adjust the Federal MLR standard in the individual market, under the authority provided in section 2718(b) of the PHS Act and 45 CFR 158.301, in States that do not request such an adjustment. We also seek comment on whether and how much HHS could adjust the Federal MLR standard in a given State and how to determine the amount of adjustment to best stabilize the individual market in those individual States. We seek comment on whether by making any adjustments to the 80 percent MLR standard, HHS could affect a given State's individual market stability, including by lowering premiums or reducing incentives for market consolidation. We welcome comments and data analysis on whether, by what mechanism, and to what extent, adjusting the MLR standard would benefit consumers as well as reduce volatility in the individual market in applicable States. We also seek comment on specific amendments to subpart C of part 158 that we should consider, such as whether the amendments should provide that HHS would consult with the State and/or provide an opportunity for public comments on a potential adjustment to the Federal MLR standard in a State, in the absence of a State-initiated request for such an adjustment; how HHS should resolve any disagreements between HHS and State determinations of whether an adjustment to the individual market MLR standard in that State would help stabilize the market or the size of the adjustment; and whether HHS should publish the data and analyses that led to its determination that an adjustment to the MLR standard was warranted.

After promulgating rules in the 2019 Payment Notice to better enable States to seek adjustments to the individual market MLR standard in a particular State, HHS has not received any requests from States to help stabilize their individual market by adjusting the MLR standard as allowed under subpart C of 45 CFR part 158. However, we seek comment on whether and what further burden reductions for States interested in adjusting the MLR standard for the individual market could further facilitate making such a request. Specifically, we seek comment on whether to modify § 158.311 to allow States to request an adjustment for up to 5 instead of 3 MLR reporting years. We also seek comment on whether to further reduce the information requirements in § 158.321 regarding the State's individual health insurance market that support the requests for an adjustment to the MLR standard. We further seek comment on whether to modify § 158.330, which specifies the criteria HHS uses for assessing a request for adjustment to the MLR standard, in a manner that would further reduce administrative burden on States and allow States more flexibility to design standards that are unique for their individual markets, and suggestions for specific modifications to the criteria in § 158.330.

G. Severability

As demonstrated by the number of distinct programs addressed in this rulemaking and the structure of this proposed rule in addressing them independently, we generally intend the rule's provisions, if finalized, to be severable from each other. For example, this proposed rule outlines proposed payment parameters and provisions for the HHS-operated risk adjustment program and HHS–RADV, the 2027 user fee rate for issuers in the risk adjustment program, the 2027 FFE and SBE–FP user fee rates, and provisions related to administration of CMPs. We also propose, among other proposals, to disallow APTC for individuals who are ineligible for Medicaid due to their immigration status and have income below 100 percent of the FPL for taxable years beginning after December 31, 2025, limit APTC eligibility among aliens lawfully present who are not ''eligible aliens'' effective January 1, 2027, and extend the removal of the 150 percent FPL SEP beyond PY 2026 to align with the WFTC legislation. We believe that the proposed provisions in this rule, if finalized, are generally capable of functioning sensibly on an independent basis. It is our intent that if any provision of this proposed rule, if finalized, is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, the other provisions in this proposed rule shall be construed so as to continue to give maximum effect as permitted by law, unless the holding shall be one of utter invalidity or unenforceability. In the event a provision if finalized is found to be utterly invalid or unenforceable, we intend for that provision to be severable.

We seek comment on the severability of these provisions in the proposed rule.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an

information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comments on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of the agency.
- The accuracy of our estimate of the information collection burden, including the validity of the methodology and assumptions used.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs).

A. Wage Estimates

To derive wage estimates, we generally use data from the Bureau of Labor Statistics to derive labor costs (including a 100 percent increase for the cost of fringe benefits and overhead) for estimating the burden associated with the ICRs.[228] Table 12 presents the median hourly wage, the cost of fringe benefits and overhead, and the adjusted hourly wage.

As indicated, employee hourly wage estimates have been adjusted by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly across employers, and because methods of estimating these costs vary widely across studies. Nonetheless, there is no practical alternative, and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

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TABLE 12: Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Median Hourly Wage ($/hr.)	Fringe Benefits and Overhead ($/hr.)	Adjusted Hourly Wage ($/hr.)
Business Operations Specialist	13-1199	$39.07	$39.07	$78.14
General and Operations Manager	11-1021	$49.50	$49.50	$99.00
Management Analyst	13-1111	$48.65	$48.65	$97.30
Compliance Officer	13-1041	$37.70	$37.70	$75.40
Computer and Information Systems Manager	11-3021	$82.31	$82.31	$164.62
Computer Systems Analyst	15-1211	$49.90	$49.90	$99.80
Computer Programmer	15-1251	$47.44	$47.44	$94.88
Secretaries and Administrative Assistants, Except Legal, Medical, and Executive	43-6014	$22.26	$22.26	$44.52
Insurance Sales Agent	41-3021	$29.02	$29.02	$58.04
Eligibility Interviewers, Government Programs	43-4061	$24.76	$24.76	$49.52
Database and Network Administrators and Architects	15-1240	$51.67	$51.67	$103.34
Actuary	15-2011	$60.47	$60.47	$120.94
Data Scientist	15-2051	$54.13	$54.13	$108.26
Claims Specialist	13-1031	$36.92	36.92	$73.84
Project Manager	13-1082	$48.44	$48.44	$96.88
Computer Programmer	15-1251	$47.44	$47.44	$94.88

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We propose to adopt an hourly value of time based on after-tax wages to quantify the opportunity cost of changes in time use for unpaid activities. This approach matches the default assumptions for valuing changes in time use for individuals undertaking administrative and other tasks on their own time, which are outlined in an Assistant Secretary for Planning and Evaluation (ASPE) report on ''Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices.'' [229]

[228] See U.S. Bureau of Labor Statistics (n.d.). Occupational Employment and Wage Statistics, May 2024 Occupation Profiles. Dep't. of Labor. *https://www.bls.gov/oes/current/oes_stru.htm.*

[229] Office of the Assistant Secretary for Planning and Evaluation. (2017, Sept. 17). Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices. Dep't of HHS. *https://aspe.hhs.gov/reports/valuing-time-us-department-health-human-services-regulatory-impact-analyses-conceptual-framework.*

We start with a measurement of the usual weekly earnings of wage and salary workers of $1,206.[230] We divide this weekly rate by 40 hours to calculate an hourly pre-tax wage rate of approximately $30.15. We adjust this hourly rate downwards by an estimate of the effective tax rate for median income households of about 17 percent, resulting in a post-tax hourly wage rate of approximately $25.02. We adopt this as our estimate of the hourly value of time for changes in time use for unpaid activities.

We seek comment on these burden estimates and assumptions.

B. ICRs Regarding Rate Filing Justification—OMB Control Number 0938–1141 (§ 154.215)

1. ICR Regarding Estimating CSR Load Factor Using the Standard Methodology

Pursuant to § 154.215(a)(1) through (3) and CMS's Unified Rate Review Instructions,[231] issuers are required to submit a rate filing justification that consists of three parts: (1) the URRT; (2) a written description justifying any premium rate increase when a plan within a product has a rate increase that is subject to review; and (3) an Actuarial Memorandum when a plan within a product has a rate increase, regardless of the size of the increase, when a product contains a QHP, or when a State requires it. Section 156.80(d)(2)(i) specifies that the actuarially justified plan-specific factors by which an issuer may vary premium rates for a particular plan from its market-wide index rate include the actuarial value and cost-sharing design of the plan, including, if permitted by the applicable State authority, accounting for CSR amounts provided to eligible enrollees under § 156.410, provided the issuer does not otherwise receive reimbursement for such amounts.

As discussed in section III.C. of this proposed rule, CSR loading is a permissible practice if permitted by the State and the amounts are actuarially justified plan-level adjustments which issuers must report when they submit a rate filing to the State or CMS for review, to ensure compliance with the Federal rating rules, including § 156.80. In order to provide regulators with information to help determine whether CSR loads are actuarially justified, this rule proposes that the actual CSR amount paid on behalf of eligible enrollees and the amount previously generated by any load factors be reported on the URRT and calculated using the most recent annual data available the standard methodology set forth in § 156.430(c)(2) and historical data.

Assuming a cross-functional team, we estimate that issuers would incur an initial one-time cost and burden in 2026 to develop and implement a claim-level re-adjudication process using the standard methodology set forth in § 156.430 to produce the required values. We estimate that for each issuer it would require 2,400 hours (at an hourly rate of $120.94) for Actuaries to define the plan mappings and business rules and set reasonableness thresholds, 3,000 hours (at an hourly rate of $108.26) for Data Scientists to design the approach and data flows, prototype the logic, and validate results, 3,000 hours (at an hourly rate of $94.88) for Computer Programmers to develop and maintain the production code and workflows, automate runs, and ensure reliability and performance, 2,000 hours (at an hourly rate of $73.84) for Claims Specialists to assemble and interpret claims, eligibility, and accumulator data, and 1,000 hours (at an hourly rate of $96.88) for a Project Manager to coordinate timelines, handoffs, and deliverables to produce the experience-period actual CSR amount paid on behalf of eligible enrollees (using the most recent annual data available, generally 2 years before the upcoming plan year, using the CMS standard methodology set forth in 156.430(c)(2)), the amount previously generated by any load factors from the most recent annual data available, the projection-period expected CSR amount to be paid on behalf of enrollees for the upcoming plan year, and the plan-level CSR load factor for the upcoming plan year, and the expected amount generated by the load factor for the upcoming plan year for URRT reporting, resulting in a total one-time burden of 11,400 hours, with an associated cost of approximately $1,144,236. For all 366 issuers, we estimate a total burden of 4,172,400 hours, with an associated cost of approximately $418,790,376.

TABLE 13: One-Time Cost and Burden to Implement and Run the Standard Methodology Calculations

Number of Respondents	Number of Responses per Respondent	Burden per Response (Hours)	Labor Cost per Response	Total Burden for all Respondents (Hours)	Total Cost for all Respondents
366	1	11,400	$1,144,236.00	4,172,400	$418,790,376.00

In subsequent years, we assume that issuers would require targeted updates to ensure their systems are accurately calculating the required values using the most recent data. We estimate that for each issuer it would require 1,200 hours (at an hourly rate of $120.94) for Actuaries to update plan parameters and CSR-to-standard-plan mappings using the most recent annual data that is available prior to the applicable filing year, 1,500 hours (at an hourly rate of $108.26) for Data Scientists to update specifications, oversee execution, and review outputs, 1,500 hours (at an hourly rate of $94.88) for Computer Programmers to reload data, apply configuration and code updates, and run and monitor the processing, 1,000 hours (at an hourly rate of $73.84) for Claims Specialists to reconcile corrected claims, and 500 hours (at an hourly rate of $96.88) for a Project Manager to manage review and sign-off for the cycle, resulting in an annual ongoing burden of 5,700 hours, with an associated cost of approximately $572,118. For all 366 issuers, we estimate a total burden of 2,086,200 hours, with an associated cost of approximately $209,395,188.

[230] U.S. Bureau of Labor Statistics. Employed full time: Median usual weekly nominal earnings (second quartile): Wage and salary workers: 16 years and over [LEU0252881500A], retrieved from FRED, Federal Reserve Bank of St. Louis. *https://fred.stlouisfed.org/series/LES1252881500Q.* Annual Estimate, 2024.

[231] See *Unified Rate Review Instructions at: https://www.cms.gov/files/document/unified-rate-review-instructions.pdf.*

TABLE 14: Annual Cost and Burden to Update and Run the Standard Methodology Calculations

Number of Respondents	Number of Responses per Respondent	Burden per Response (Hours)	Labor Cost per Response	Total Burden for all Respondents (Hours)	Total Cost for all Respondents
366	1	5,700	$572,118.00	2,086,200	$209,395,188.00

Some issuers could incur a lower one-time cost if they currently have a system in place that is able to calculate the load factor and other required values using the standard methodology, or if their systems only require updates and minor changes to function properly. We also acknowledge that some issuers could incur higher costs if they are required to develop and build a new system to meet the proposed requirements and calculate the appropriate values. We further acknowledge that some issuers could incur higher or lower annual costs depending on their volume of CSR-eligible claims.

2. ICR Related to the Submission of Unified Rate Review Templates (URRTs)

As discussed in section III.C. of this proposed rule, this rule proposes to change the instructions for the URRT so that issuers would enter the actual amount of CSRs they paid on behalf of eligible enrollees (using the most recent annual data that is available prior to the applicable filing year, generally two years prior to the upcoming plan years), the amount previously generated by any load factors from the most recent annual data available, the amount of CSRs they expect be paid on behalf of enrollees in the upcoming plan year, the CSR load factor for the upcoming plan year, and the expected amount generated by the load factors for the upcoming plan year.

Issuers would incur ongoing burden to gather all the required CSR-related data elements and enter them into the URRT in their appropriate places. We estimate that for each plan an issuer would require 0.5 hours (at an hourly rate of $120.94) for Actuaries to collect all required CSR-related data elements (actual CSR amounts paid on behalf of eligible enrollees, amount previously generated by load factors, expected CSR amounts to be paid on behalf of enrollees in the upcoming plan year, CSR load factor for the upcoming plan year, and expected amount generated by the load factor for the upcoming plan year) and ensure the data is accurately entered into the URRT, resulting in an ongoing burden of 0.5 hours, with an associated cost of approximately $60 per plan. We estimate that each issuer would need to submit data for an approximate average of 7 plans [232] that include CSR load factors and thus would incur an estimated burden of 3.6 hours, with an associated cost of approximately $430.[233] For all 366 issuers, we estimate a total burden of 1,300 hours, with an associated cost of approximately $157,222.

TABLE 15: Annual Cost and Burden to Provide CSR Related Information in the URRT – Part 1

Number of Respondents	Number of Responses per Respondent	Burden per Response (Hours)	Labor Cost per Response	Total Burden for all Respondents (Hours)	Total Cost for all Respondents
366	7	3.6	$429.57	1,300	$157,222.00

3. ICR Related to the Submission of Actuarial Memorandum

As discussed in section III.C. of this proposed rule, this rule proposes that information regarding CSR-related plan-level adjustments to the index rate should be provided in the URRT and should continue to be provided in the Actuarial Memorandum so that issuers provide numerical values in the URRT and explain how they reached those values in the Actuarial Memorandum.

Issuers would incur additional ongoing burden to develop, draft, and add the explanation of the methodology used to determine the load factor and an explanation of how the expected amount generated by the load factor for the upcoming plan year compares to the amount of CSRs expected to be paid on behalf of enrollees for the same period. We estimate that for each plan an issuer would require 2 hours (at an hourly rate of $120.94) for Actuaries to develop, draft the required explanations (methodology for determining the load factor for the upcoming plan year and comparison of expected load revenue to expected CSR payment on behalf of enrollees for the same period), and add them to the Actuarial Memorandum for submission via SERFF and/or MPMS, resulting in an ongoing burden of 2 hours, with an associated cost of approximately $242 per plan. We estimate that each issuer would need to submit explanations for an average of 7 plans and thus would incur an estimated burden of approximately 14.2 hours, with an associated cost of approximately $1,718. For all 366 issuers, we estimate a total burden of 5,200 hours, with an associated cost of approximately $628,888.[234]

[232] Average number of plans per issuer derived from the PY 2025 URRT data using the PUF found at *https://www.cms.gov/marketplace/resources/data/rate-review-data.*

[233] Certain values are rounded for readability and are indicated by the use of terms such as 'approximately' or 'average.' All cost and burden calculations are based on unrounded figures to ensure accuracy.

[234] Certain values are rounded for readability and are indicated by the use of terms such as 'approximately' or 'average.' All cost and burden calculations are based on unrounded figures to ensure accuracy.

TABLE 16: Annual Cost and Burden to Provide CSR Calculation Explanation in the Actuarial Memorandum – Part III

Number of Respondents	Number of Responses per Respondent	Burden per Response (Hours)	Labor Cost per Response	Total Burden for all Respondents (Hours)	Total Cost for all Respondents
366	7	14.2	$1, 718.27	5,200	$628,888.00

The information collection described in this section will be submitted as a revision to the currently approved PRA package CMS–10379 (OMB Control Number 0938–1141) for OMB review under the Paperwork Reduction Act.

Table 17 aggregates the burden and costs from Tables 13 through 16. The 2026 burden (11,418 hours per respondent) includes the one-time implementation (11,400 hours) plus ongoing URRT and Actuarial Memorandum submissions (18 hours total). The 2027–2028 burden (5,718 hours per respondent) includes annual system updates (5,700 hours) plus ongoing URRT submissions (18 hours total). The three-year averages are calculated by summing the annual figures and dividing by three.[235]

TABLE 17: Three-Year Average Cost and Burden to Implement, Update and Calculate, and Submit the Required URRT Values and the Actuarial Memorandum

Year	Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Costs
2026	366	2,600	11,418	4,178,900	$419,576,486.00
2027	366	2,600	5,718	2,092,700	$210,181,298.00
2028	366	2,600	5,718	2,092,700	$210,181,298.00
3-Year Average			**7,618**	**2,788,100**	**$279,979,694.00**

4. Cost to Federal Government Related To Review of URRT Reporting Requirements Related to CSR Estimates

In 2026, the Federal Government would incur costs to review and evaluate the data and actuarial memoranda submitted by issuers into MPMS or SERFF. To conduct the review of all required CSR-related data elements and explanations submitted, the Federal Government, at a minimum, would require staff at GS–14 level (at an hourly rate of $154.76 for GS–14 step 5) 6 hours per plan to review the materials submitted by issuers. The Federal Government would incur a burden of 15,600 hours, with an associated estimated cost of $2,414,256 to review all URRT and actuarial memoranda related material related to CSR data and explanations.

TABLE 18: Annual Cost and Burden to Federal Government to Review and Evaluate the Data and Actuarial Memoranda Submitted by Issuers

GS Pay Grade	Hourly Rate	# of Reviews	Burden per Response (hr)	Cost per Response	Total Burden	Total Cost
14 Step 5	$154.76	2,600	6	$928.56	15,600	$2,414,256.00

C. ICRs Regarding Mandating HHS-Approved and -Created Consumer Consent Form (§ 155.220)

As discussed in the preamble of this proposed rule, we propose amendments to § 155.220(j)(2)(ii)(A) and (j)(2)(iii)(A) to require agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review documentation requirements and consent documentation requirements. Our proposal would eliminate the current broad allowances for meeting these requirements. The language in the regulation would also be changed to clarify what types of actions constitute ''taking an action'' to meet the regulatory requirements. The goal of this policy is to reduce confusion among agents, brokers, and web-brokers on what constitutes compliant eligibility application review documentation and what constitutes compliant consumer consent by ensuring objective standards, which ultimately protects consumers. These proposals would also greatly improve HHS' investigative abilities into agent, broker, and web-broker eligibility application review documentation and consumer consent documentation review by creating a

[235] Certain values are rounded for readability and are indicated by the use of terms such as 'approximately' or 'average.' All cost and burden calculations are based on unrounded figures to ensure accuracy.

clear and objective standard for all applications clearly outlining what HHS deems complaint.

We estimate there would be very minimal costs in time associated with this proposal as agents, brokers, and web-brokers are already required to document and maintain eligibility application review documentation information and consumer consent documentation information. As a result, this proposal would not add to those requirements, rather, it would only require that a specific form be used.

According to our records, as of September 18, 2025, there are a total of 105,988 agents, brokers, and web-brokers who have presently completed the FFE training who are registered to assist consumers on the Exchanges. Pursuant to our records, the percentage of agents, brokers, and web-brokers that currently submit only audio files for eligibility application review documentation and consumer consent documentation is approximately 24 percent, which equals 25,437 agents, brokers, and web-brokers who are utilizing this method. Additionally, per our records, the percentage of agents, brokers, and web-brokers that currently submit partial audio files in connection with eligibility application review documentation and consumer consent documentation is approximately 42 percent, which equals 44,514 agents, brokers, and web-brokers who are utilizing this method.

Regarding the costs related to requiring agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review documentation requirements and the consumer consent documentation requirements, we estimate it would take approximately 10 minutes of time for an enrolling agent, broker or web-broker to meet eligibility application review documentation requirements and to obtain consumer, or their authorized representative, affirmation of their consent. Using the current adjusted hourly wage rate of $58.04 [236] for an insurance sales agent, each enrollment using the HHS-approved and -created consumer consent form would have approximately $9.87 (10 minutes, or 0.17 hours, at an hourly wage rate of $58.04) in additional cost associated with it based on the extra time commitment from these proposed policy changes. In PY 2024, agents submitted 9,800,000 policies. Based on this number of enrollments, the total annual burden is 1,666,000 hours (9,800,000 submitted policies x approximately 0.17 hours) with a total annual cost of $96,694,640 (1,666,000 hours × $58.04 per hour).

HHS would require agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review documentation requirements and the consumer consent documentation requirements. The HHS-approved and -created consumer consent form can be submitted electronically, so there would be no costs associated with printing or mailing the HHS-approved and -created consumer consent form.

The estimated cost of requiring agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review documentation requirements and the consumer consent documentation requirements is $96,694,640.

If this proposal is finalized, the new information collection requirements discussed in this section would be submitted for OMB review and approval in a new PRA package.

We seek comment on these burden estimates and assumptions.

D. ICRs Regarding Misleading Marketing (§ 155.220)

As discussed in the preamble of this proposed rule, we propose amendments to § 155.220(j), creating new standards of conduct section on marketing requirements, which would be housed in § 155.220(j)(3). These new regulations would prohibit agents, brokers, and web-brokers from engaging in misleading marketing, while adhering to the requirements in newly proposed § 155.220(j)(3)(iii), and require agents, brokers, and web-brokers to provide marketing materials to HHS upon request. We estimate costs that would be associated with this proposal are mainly those involved in responding to HHS' requests for documentation. Producing such documentation would require the submission of electronic documents to HHS upon request.

We do not anticipate many costs for the agents, brokers, or web-brokers we investigate for misleading marketing. Based on our current investigative methods and volume of misleading advertisements we have uncovered thus far, we currently only plan to send 70 notifications annually to agents, brokers, and web-brokers for misleading marketing. Based on analysis of existing enforcement outreach conducted on misleading marketing, about ⅔ of the notices we send would be part of our Technical Assistance (TA) enforcement workstream, only requires the agent, broker, or web-broker to indicate the ad(s) has been removed. The other ⅓ of the notices we send would be Notices of Intent to Terminate (NoITs). NoITs require the agent, broker, or web-broker to respond indicating (1) they removed the ad(s) in question and (2) they reviewed the marketing guidelines CMS sent them. Therefore, there would only be approximately 24 notifications sent annually that require agents, brokers, or web-brokers to submit documentation in response to HHS. We are proposing to allow HHS to request and review advertisements in new § 155.220(j)(3)(iv). If HHS were to utilize this regulatory authority and request advertisements from an agent, broker, or web-broker, it would be part of our NoIT requirements and the same 24 agents, brokers, or web-brokers would be impacted.

We believe responding to HHS requests to provide confirmation they removed the ads and/or reviewed the marketing guidelines would not be overly time-consuming or burdensome. Our notifications to the agents, brokers, or web-brokers detail what response is required and provide hyperlinks to the noncompliant ad(s). We estimate it would take each agent, broker, or web-broker one hour to remove any noncompliant ad(s), and/or review the marketing guidelines, and respond to HHS via email. This estimate incorporates the potential of HHS asking these 24 agents, brokers, and web-brokers to provide advertisements for HHS' review. Using the hourly wage rate for an insurance sales agent from Table 12, this means the total burden of responding to HHS regarding misleading marketing would be 24 hours at a cost of $1,392.96 ($58.04 per hour × 1 hour × 24 responses).

We seek comment on these burden estimates and assumptions.

E. ICRs Regarding State Exchange Enhanced Direct Enrollment (SBE–EDE) Option (§ 155.221)

Current State Exchanges that elect to implement the SBE–EDE option will need to revise their Exchange Blueprint to notify HHS that the State proposes to implement the SBE–EDE option in compliance with related requirements. We believe that any costs of revising the Exchange Blueprint will be nominal, as this process involves logging into a CMS web interface that serves as the repository for all States' Exchange Blueprints to input additional information on the updated processes and controls the State would implement

[236] *See* the U.S. Bureau of Labor Statistics (n.d.). Occupational Employment and Wage Statistics, May 2024 Occupation Profiles. Dep't. of Labor. *https://www.bls.gov/oes/current/oes_stru.htm.*

to manage its new SBE–EDE program. The burden related to completing the Exchange Blueprint is currently approved under OMB Control Number 0938–1172 (Blueprint for Approval of Affordable State-based Health Insurance Exchanges (CMS–10416)). We seek comment on the burden associated with this activity.

F. ICRs Regarding Limiting APTC Eligibility to ''Eligible Noncitizens'' (§§ 155.20, 155.305(f)(1), and 155.320)

1. Basic Health Program

The following proposed changes would be submitted for review under OMB Control Number 0938–1218 for BHP.

As discussed in section III.D.8. of this proposed rule, lawfully present noncitizens who are not ''eligible noncitizens'' remain eligible for enrollment in the BHP, provided they meet the eligibility requirements of section 1331(e) of the Affordable Care Act and 42 CFR 600.305. However, because section 71301 of the WFTC legislation amended section 36B of the Code to provide that PTC is not allowed for the coverage of noncitizens who are lawfully present but not ''eligible aliens,'' this population is no longer allowed PTC for their coverage beginning January 1, 2027, and as such, States will stop receiving Federal payments associated with members of this population who are BHP enrollees effective January 1, 2027. States that operate a BHP will need to modify enrollment data sent to CMS in accordance with this provision to enable CMS to accurately calculate the State's BHP funding.

We estimate that implementing this proposed policy would require ongoing costs for States to submit additional enrollment data to CMS. We estimate that it would take a Business Operations Specialist 2.5 hours at $78.14 per hour and a General Manager 0.5 hours at $99 per hour to compile and submit additional quarterly estimated enrollment data. We estimate that it would take a Business Operations Specialist 25 hours at $78.14 per hour and a General Manager 2.5 hours at $99 per hour to compile and submit additional quarterly final enrollment data. For the two States and DC currently approved to be operating a BHP in 2027 we estimate the in total annual ongoing cost to be $29,350.20.

2. Exchanges

The following proposed changes would be submitted for review under OMB Control Number 0938–NEW for Exchanges and OMB Control Number 0938–1218 for BHP.

As discussed in section III.D.8. of this proposed rule, we propose to align Exchange eligibility and verification rules with section 71301 of the WFTC legislation, which disallows PTC for the coverage of noncitizens other than ''eligible aliens.'' We propose to add a new definition of ''eligible noncitizen'' at 45 CFR 155.20 and update our regulations at § 155.305(f)(1)(ii) to align with 26 CFR 1.36B–1(d) and § 155.305(f)(1)(ii)(C) to clarify that an Exchange must grant eligibility for APTC to individuals defined as ''U.S. citizens, U.S. nationals, and eligible noncitizens,'' provided the other APTC eligibility requirements are met. For BHP, we propose to add a new definition of ''eligible noncitizen'' at 42 CFR 600.5 that cross-references to 45 CFR 155.20. This proposed change is effective beginning in PY 2027 and would apply to the 22 State Exchanges expected to be operating for PY 2027, Exchanges on the Federal platform, and to the two States that currently operate a BHP (Minnesota and Oregon) and to DC, which will begin operating a BHP in 2026.[237]

To implement these changes, the Federal Data Services Hub would need to make updates to its Verify Lawful Presence (VLP) service, to enable Exchanges to accurately verify whether an individual is an eligible noncitizen. In addition, Exchanges on the Federal platform and the 22 State Exchanges would need to update their eligibility and enrollment systems to collect applicant attestations regarding eligible noncitizen status, to correctly determine APTC and income-based CSR eligibility on the basis of such attestations, to determine whether such attestations can be considered verified, to set and process new inconsistencies in cases where such attestations cannot be verified. Exchanges would also need to ensure that current enrollees who would no longer be eligible for APTC or income-based CSRs as a result of this proposal have their APTC and CSR eligibility ended accordingly.

3. Implementation Costs

We estimate that implementing this proposed policy would require one-time costs for the Federal Government to make technical updates to its system. Based on preliminary analysis, we estimate that it would take the Federal Data Services Hub (the ''Hub'') 2,000 hours in 2025 to make these technical updates. Of the 2,000 hours for Hub updates, we estimate it would take a database and network administrator and architect 500 hours at $103.34 per hour and a computer programmer 1500 hours at $94.88 per hour. Given this, to make Hub updates, we estimate that the Federal Government would incur a one-time burden in 2025 of $193,990 [(500 hours × $103.34 + (1500 hours × $94.88)] to make these system updates.

We also estimate that it will take Exchanges on the Federal platform 7,000 hours to make the updates required to implement this provision. Of the 7,000 hours required to make updates for Exchanges on the Federal platform, we estimate that it would take a database and network administrator and architect 1,750 hours at $103.34 per hour and a computer programmer 5,250 hours at $94.88 per hour. Given this, Exchanges on the Federal platform would incur a one-time burden of $678,965 [(1,750 hours × $103.34) + (5250 hours × $94.88)].

Similar to the one-time costs incurred by Exchanges on the Federal platform, we estimate that implementing this proposed policy would require one-time costs for each State Exchange. Of the 7,000 hours required to make updates for each State Exchange, we estimate it would take a database and network administrator and architect 1,750 hours at $103.34 per hour and a computer programmer 5,250 hours at $94.88 per hour. State Exchanges would incur a one-time burden of $14,937,230 [(1,750 hours × $103.34) +(5,250 hours × $94.88)] × 22 State Exchanges) to implement these technical changes.[238]

4. Ongoing Burden Related to New DMI Type for ''Eligible Noncitizens''

We anticipate that this proposed policy would not result in ongoing burden changes for Exchanges and individuals related to the creation of a new DMI type for ''eligible noncitizens'' because these individuals would already be required to submit documentation to verify their eligibility to enroll in a QHP.

The total estimated annual burden for these information collection requirements is $15,810,185, representing 163,000 hours of burden.

[237] CMS. (2025, August 4). Fact Sheets & Frequently Asked Questions (FAQs): State-based Exchanges. *https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/state-marketplaces.*

[238] Section 3 figures are based on labor needs estimates internal to the FFM as well as Table 12: Adjusted Hourly Wages Used in Burden Estimates.

G. ICRs Regarding the Prohibition of APTC for Individuals Who Are Ineligible for Medicaid Due to Their Immigration Status and Have Income Below 100 Percent of the FPL (§ 155.305(f)(2))

1. Exchanges

We estimate that implementing this proposed policy would require one-time costs for Exchanges to make technical updates to their eligibility systems related to both APTC and the BHP. We estimate that it would take the Exchanges on the Federal platform 2,500 hours and each State Exchange 2,000 hours in 2025 to make these technical updates. Of those 2,500 hours for Exchanges on the Federal platform, we estimate it would take a database and network administrator and architect 625 hours at $103.34 per hour and a computer programmer 1,875 hours at $94.88 per hour. Of those 2,000 hours for State Exchanges, we estimate it would take a database and network administrator and architect 500 hours at $103.34 per hour and a computer programmer 1,500 hours at $94.88 per hour. Given this, we estimate that Exchanges on the Federal platform would incur a one-time burden in 2025 of $242,488 [(625 hours × $103.34) + (1,875 hours × $94.88)] to make these system updates. State Exchanges would incur a one-time burden of $4,073,790 [(500 × $103.34) + (1,500 × $94.88)] × 21 State Exchanges to implement these technical changes.[239]

2. Ongoing Burden Reduction—Medicaid Lawful Presence (MLP) and Annual Income (AI) Data Matching Issue (DMI) Processing

We anticipate that this proposed policy would result in ongoing burden reduction for Exchanges on the Federal platform related to no longer generating Medicaid Lawful Presence (MLP) Data Matching Issues (DMIs) and for all Exchanges related to no longer generating annual income (AI) DMIs for those who attest to income under 100 percent of the FPL. Today, these DMIs are generated when an individual attests that they are a lawfully present noncitizen and have an attested household income under 100 percent of the FPL, but the Exchange is not able to verify promptly whether their immigration status disqualifies them from full Medicaid coverage or verify their attested annual household income with trusted data sources. Currently, Exchanges must require individuals to submit documentation to verify their attested application information when trusted data sources cannot verify.

3. Medicaid Lawful Presence (MLP) Data Matching Issue (DMI) Reduction

These inconsistencies are not generated by State Exchanges, so we do not estimate any change in burden to State Exchanges. Based on historical data from the FFE, we estimate a reduction of approximately 275,000 inconsistencies[240] at the consumer level for the Exchanges on the Federal platform. The change would result in a decrease in burden on the Exchanges on the Federal platform. Once households have submitted the required verification documents, we estimate that it takes approximately 1 hour and 12 minutes (or 1.2 hours) for an eligibility support staff person (BLS occupation code 43–4061), at an hourly cost of $49.52,[241] to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes. The revisions to § 155.305 would result in a decrease in annual burden for the Federal government of 330,000 hours (275,000 inconsistencies at the consumer level × 1.2 hours) with savings of $16,341,600 (330,000 hours × $49.52 hourly wage rate).

4. Annual Income (AI) Data Matching Issue (DMI) Reduction

Based on historical data from the FFE, we estimate that approximately 77,000 inconsistencies[242] would not be generated at the household level for the Exchanges on the Federal platform. On the State Exchanges, we estimate this figure to be 54,000 inconsistencies.[243] The change would result in a decrease in burden on Federal and State Exchanges. Once households have submitted the required verification documents, we estimate that it would take approximately 1 hour and 12 minutes (or 1.2 hours) for an eligibility support staff person (BLS occupation code 43–4061), at an hourly cost of $49.52,[244] to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes. Therefore, removing these inconsistencies would result in a decrease in burden on the Federal Government of 92,400 hours (77,000 verifications × 1.2 hours per verification) with savings of $4,575,648 (92,400 hours × $49.52 per hour), and a decrease in burden on the State Exchanges of 64,800 hours (54,000 verifications × 1.2 hours per verification) with savings of $3,208,896 (64,800 hours × $49.52 per hour), and the cost decrease across all Exchanges would be approximately $7,784,544 (157,200 hours × $49.52 hourly cost of eligibility support staff person).

The total estimated annual reduction in burden for these information collection requirements, beginning in 2026, is $24,126,144 ($16,341,600 + $7,784,544), representing 487,200 (330,000 + 157,200) hours of burden across all affected entities.

We seek comment on these proposed burden estimates and assumptions.

H. ICRs Regarding Failure To File and Reconcile (§ 155.305)

We propose to amend paragraph § 155.305(f)(4) so that in PY 2028 and beyond, all Exchanges may not determine a tax filer or their enrollee eligible for APTC if: (1) HHS notifies the Exchange that APTC were paid on behalf of the tax filer, or their spouse if the tax filer is a married couple, for one year for which tax data would be utilized for verification of household and family size, and (2) the tax filer did not comply with the requirement to file a Federal income tax return and reconcile APTC for that year (referred to as the ''1-tax year FTR'' process). We also propose that at the option of the Exchange, an Exchange may choose to implement this policy earlier in PY 2027 if it has the resources and capability to adopt the 1-year FTR process or continue to follow the 2-year FTR process until PY 2028. Exchanges on the Federal platform intend to adopt the 1-year FTR process in PY 2027, as HHS has the resources possible to do so. Section 71303(a)(6) of the WFTC legislation amended section 36B(c) of the Code such that term ''coverage month'' does not include, with respect to any individual enrolled in a QHP through an Exchange, any month for which the Exchange does not meet the requirements of § 155.305(f)(4)(iii) as published in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074) for PY 2028 and beyond, where effectively Exchanges are required to find enrollees ineligible for APTC after they or their tax filer has failed to file and reconcile their APTC for 1-tax year. However, minimal changes to the language of the Exchange application questions for States served by *HealthCare.gov* would be necessary to obtain relevant information; as such, we anticipate that the amendment proposed in this rule would not impact the information collection burden for

[239] Section 1 figures are based on labor needs estimates internal to the FFM as well as Table 12: Adjusted Hourly Wages Used in Burden Estimates.

[240] This estimate is based on internal FFM data.

[241] See Table 12: Adjusted Hourly Wages Used in Burden Estimates.

[242] This estimate is based on internal FFM data.

[243] This population estimate is based on internal CMS data.

[244] See Table 12: Adjusted Hourly Wages Used in Burden Estimates.

consumers. We anticipate that for some Exchanges, there would no longer be a 2-year FTR population for PY 2027, and thus the notices sent to the 1-year FTR population would be similar to the current 2-tax year FTR notices in inciting an urgency to act. Other Exchanges may choose to delay the change until PY 2028, but that all consumers with an FTR status will be in a 1-tax year FTR status for PY 2028. Due to this, we do not anticipate PRA impacts related to noticing requirements (OMB Control Number: 0938–1207).

We seek comment on these proposed burden estimates and assumptions.

I. ICRs Regarding Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))

We propose to update § 155.320(c)(3)(iii)(A) to extend the requirement for applicants to submit documentation when their attested household income is within the APTC range, but data sources indicate income less than 100 percent of the FPL. As finalized in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074), Exchanges are required to generate income DMIs when a tax filer's attested annual household income would qualify the taxpayer as an applicable taxpayer according to 26 CFR 1.36B–2(b) and trusted data sources indicate that income is under 100 percent of the FPL only through PY 2026. We propose to implement this policy as a new and permanent verification process within the Exchange, as detailed below.

We anticipate that extending this income verification requirement would result in approximately 1 hour of time spent by consumers to complete associated questions in the application or to submit supporting documentation for each year of operation. Based on historical data from the FFE, we estimate that approximately 340,000 inconsistencies would be generated at the household level for the Exchanges on the Federal platform annually starting in 2027. On the State Exchanges, we estimate this figure to be 208,000 inconsistencies annually starting in 2027. Therefore, adding these inconsistencies would increase burden on consumers by approximately 548,000 hours across all Exchanges. Using the estimate of the hourly value of time for changes in time use for unpaid activities calculated at $25.02 per hour in section IV.A. of this proposed rule, we estimate that the increase in cost for each consumer in 2027 would be approximately $25.02, and the cost increase for all consumers who would generate this income inconsistency in 2027 and onwards would be approximately $13,710,960 (548,000 hours × $25.02 cost of unpaid activities) per year.

Additionally, we estimate that adding this income verification requirement would result in an increase in burden on the Exchanges on the Federal platform. Once households have submitted the required verification documents, we estimate that it would take approximately 1 hour and 12 minutes (1.2 hours) for an eligibility support staff person (BLS occupation code 43–4061), at an hourly cost of $49.52,[245] to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes. Therefore, adding these inconsistencies would result in an increase in annual burden on Exchanges on the Federal platform of 408,000 hours (340,000 verifications × 1.2 hours per verification) at a cost of $20,204,160 (408,000 hours × $49.52 per hour) starting in 2027, and an increase in annual burden on the State Exchanges of 249,600 hours (208,000 verifications × 1.2 hours per verification) at a cost of $12,360,192 (249,600 hours × $49.52 per hour) starting in 2027.

In addition to these administrative costs, we anticipate system expenses occurring in 2026 to establish this policy ahead of the proposed effective date in 2027. These costs are to support updating technical systems, including the eligibility system. In the 2025 Marketplace Integrity and Affordability final rule (90 FR 27185), we estimated that it would take the Exchanges on the Federal platform and each State Exchange 8,000 hours in 2026 to make these updates and sunset the policy. Of those 8,000 hours, we estimated that it would take a database and network administrator and architect 2,000 hours at $103.34 per hour and a computer programmer 6,000 hours at $94.88 per hour. Given this, we estimate that Exchanges on the Federal platform would incur a one-time burden in 2026 of $775,960 (2,000 × $103.34 + 6,000 × $94.88) to make these eligibility system updates. State Exchanges would incur a one-time burden of $16,295,160 ((2,000 × $103.34 + 6,000 × $94.88) × 21). Because we are now proposing this as a new and permanent verification process within the Exchange, we anticipate that many State Exchanges and the Federal Platform would incur the totality of these expenses to implement this policy as proposed.

We seek comment on these proposed burden estimates and assumptions.

J. ICRs Regarding Income Verification When Tax Data Is Unavailable (§ 155.320(c)(5))

We propose to remove § 155.320(c)(5), which would allow Exchanges to continue the income verification process when IRS is successfully contacted but IRS returns no data rather than accepting an applicant's annual household income attestation. We are proposing to implement this policy as a new permanent verification procedure, and we are presenting these estimates as costs inherent to implementing the policy as proposed in this proposed rule.

Based on internal historical DMI data, we estimate that approximately 1,722,000 inconsistencies would be generated annually at the household level for Exchanges on the Federal platform, and 1,056,000 would be generated at the household level for State Exchanges due to this final policy. Once households have submitted the required verification documents, we estimate that it would take approximately 1 hour and 12 minutes (1.2 hours) for an eligibility support staff person (BLS occupation code 43–4061), at an hourly cost of $49.52,[246] to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes. Therefore, the removal of § 155.320(c)(5) would result in an increase in annual burden for Exchanges on the Federal platform of 2,066,400 hours (1,722,000 verifications × 1.2 hours per verification) at a cost of $102,328,128 (2,066,400 hours × $49.52 per hour) starting in 2027 and an increase in annual burden on State Exchanges of 1,267,200 hours (1,056,000 verifications × 1.2 hours per verification) at a cost of $62,751,744 (1,267,200 hours × $49.52 per hour) starting in 2027.

In addition to the increased administrative burden on Exchanges, this change would increase the number of consumers who are required to submit documentation to verify their income. We estimate that consumers would each spend 1 hour to answer the associated question, or to submit documentation. Based on historical data from the FFE, we estimate that approximately 2,777,000 inconsistencies would be generated at the household level across all Exchanges yearly. Using the estimate of the hourly value of time for changes in

[245] See Table 12: Adjusted Hourly Wages Used in Burden Estimates.

[246] See Table 12: Adjusted Hourly Wages Used in Burden Estimates.

time use for unpaid activities calculated at $25.02 per hour in section IV.A. of this proposed rule, we estimate that the increase in annual cost for each consumer starting in 2027 would be approximately $25.02 and that the proposed change would increase burden on consumers by 2,777,000 hours per year at an associated cost of $69,480,540 (2,777,000 hours × $25.02 per hour).

In addition to these administrative costs, we anticipate system expenses occurring in 2026 to establish this policy ahead of the proposed effective date in 2027. We estimated that it would take Exchanges on the Federal platform and each State Exchange 9,000 hours in 2026 to implement this policy. Of those 9,000 hours, we estimated it would take a database and network administrator and architect 2,250 hours at $103.34 per hour and a computer programmer 6,750 hours at $94.88 per hour. Therefore, we estimated that Exchanges on the Federal platform would incur a one-time burden in 2026 of $872,955 (2,250 × $103.34 + 6,750 × $94.88) to make these eligibility system updates, and State Exchanges would incur a one-time burden total in 2026 of $18,332,055 ($872,955 × 21) associated with a total of 189,000 (9,000 × 21) burden hours. Because this proposed policy would be implemented as a new permanent verification procedure, we anticipate that the full costs described in this provision would be applied to the State Exchanges and Exchanges on the Federal platform prospectively.

We seek comment on these proposed burden estimates and assumptions.

K. ICRs Regarding Pre-Enrollment SEP Verification (§ 155.420(g))

In this proposed rule, we are proposing the provision allowing the Federal Exchange to conduct pre-enrollment verification for SEPs other than Loss of Minimum Essential coverage and adding the requirement that Exchanges on the Federal Platform conduct pre-enrollment verification for at least 75 percent of new enrollments.

We anticipate that maintaining this expansion of pre-enrollment verification for SEPs would result in approximately 1 hour of time spent by consumers to complete associated questions in the application or submit supporting documentation. Based on historical data from the FFE, we estimate that approximately 293,073 new SEP verification issues would continue to be generated at the household level for Exchanges on the Federal platform. Therefore, maintaining these inconsistencies would continue to increase burden on consumers by approximately 293,073 hours. Using the estimate of the hourly value of time for changes in time use for unpaid activities calculated at $25.02 per hour in section IV.A, we estimate that the cost increase for all consumers who generate this income inconsistency would be approximately $7,332,686 annually starting in 2027.

Additionally, we estimate that maintaining expanded pre-enrollment verification for SEPs would result in an increase in burden on Exchanges using the Federal platform. Based on historical FFE data, we anticipate that approximately 293,073 inconsistencies would be generated at the household level for Exchanges on the Federal platform. Once households have submitted the required verification documents, we estimate that it would take approximately 12 minutes (0.2 hours) for an eligibility support staff person (BLS occupation code 43–4061), at an hourly cost of $49.52,[247] to review and verify submitted verification documents. Therefore, expanding verification would result in an increase in burden on Exchanges on the Federal platform of 58,615 hours (293,073 verifications × 0.2 hours per verification) at a cost of $2,902,615 (58,615 hours × $49.52 per hour) annually starting in 2027.

We seek comment on these proposed burden estimates and assumptions.

L. ICRs Regarding Expansion of Hardship Exemption Eligibility (§ 155.605(d)(1))

Under this proposal, individuals ineligible for APTC or CSRs due to projected household income may apply for a hardship exemption to qualify for catastrophic coverage. While the FFE automatically grants these exemptions through the application system when consumers apply for catastrophic coverage, some consumers may submit paper applications for hardship exemptions.

The burden associated with this requirement includes the time for consumers to complete and submit paper hardship exemption applications, and the time for Exchanges to review and process these applications.

This information collection is currently approved under OMB control number 0938–1191 (CMS–10440), which covers hardship exemption applications and related documentation. The proposed expansion of hardship exemption eligibility would not create a new information collection but would expand the scope of an existing collection to include a new category of eligible applicants.

Based on current FFE implementation, we estimate that it will continue to require consumers approximately 16 minutes to complete and submit a paper hardship exemption application.

The four State Exchanges that process their own exemptions—California, Connecticut, Maryland, and the District of Columbia—would experience an administrative burden associated with reviewing and processing hardship exemption applications under the expanded eligibility criteria.

We estimate that Exchange staff will require approximately 19 minutes to manually review and process each paper hardship exemption application. Using the adjusted hourly wage of $49.52 for Eligibility Interviewers, Government Programs (occupation code 43–4061), we estimate the cost per application to be $15.75 [(19 minutes ÷ 60 minutes) × $49.52/hour].

Based on the FFE implementation data and accounting for the enrollment share of the four State Exchanges that process their own exemptions (estimated at approximately 10 percent of total Exchange enrollment), we estimate these four State Exchanges would collectively process approximately 1,072 applications annually under the expanded hardship exemption eligibility criteria. Using the per-application manual processing cost of $15.75, we estimate the total annual cost burden for these four State Exchanges in total to be approximately $16,884 (1,072 applications × $15.75 per application).

Individual State burden would depend on each State Exchange's enrollment volume and the proportion of consumers who fall into the expanded hardship exemption category. States with larger enrollment volumes and higher proportions of consumers with income below 100 percent FPL or above 250 percent FPL may experience higher application volumes than States with smaller enrollment or different demographic characteristics.

Additionally, if these four State Exchanges adopt automated exemption processing similar to the FFE system, then manual processing time estimates would essentially be eliminated as the system automatically grants the exemption when consumers apply for catastrophic coverage.

We note that the burden estimates presented above may not reflect the actual burden on both consumers and Exchanges. The FFE experience demonstrates that automated exemption processing significantly reduces the

[247] See Table 12: Adjusted Hourly Wages Used in Burden Estimates.

need for manual paper application review. Exchanges may implement similar automated systems that grant hardship exemptions automatically when consumers ineligible for APTC due to income apply for catastrophic coverage, thereby eliminating the need for separate exemption applications in most cases.

Additionally, State Exchanges currently processing their own exemptions may choose to delegate exemption processing to HHS, which would eliminate the direct administrative burden on the State while ensuring consumers have access to the expanded hardship exemption eligibility. This delegation option is available under existing regulations and would result in zero additional burden to the delegating States.

M. ICRs Regarding Amendment of Exchange Network Adequacy Standards (§ 155.1050)

The burden associated with QHP issuers and States in State Exchanges and SBE–FPs in implementing changes for PY 2026 to meet time and distance standards at § 155.1050 is covered by the currently approved information collection (OMB Control Number: 0938–1341 (CMS–10592)/Expiration date: April 30, 2027). We seek comment on these proposed burden estimates in the context of the proposed changes at § 155.1050(a)(2) discussed directly below.

We propose to amend § 155.1050(a)(2) to eliminate, for plan years beginning on or after January 1, 2027, the requirements under § 155.1050(a)(2)(i) and (ii) for State Exchanges and SBE–FPs to establish and impose quantitative time and distance network adequacy standards for QHPs that are at least as stringent as standards for QHPs participating on the FFEs under § 156.230 and to no longer require State Exchanges and SBE–FPs to conduct quantitative network adequacy reviews to evaluate a plan's compliance with network adequacy standards under § 156.230(a)(1)(ii), (a)(1)(iii), and (a)(2)(i)(A) prior to certifying any plan as a QHP. Instead, we would require that State Exchanges and SBE–FPs ensure that each QHP provides sufficient access to providers in a manner that meets applicable standards specified in § 156.230(a)(1)(ii) and (a)(1)(iii) for network plans, or proposed § 156.236(a) for non-network plans, as applicable. Many State Exchanges and SBE–FPs demonstrated to HHS that they have robust network adequacy standards and reviews in place beyond the requirements specified in § 156.230(a)(1)(ii) and (a)(1)(iii) for network plans, or § 156.236(a) for non-network plans. This approach recognizes that States are often best positioned to evaluate local provider networks and market conditions.

We estimate there would be minimal increase in burden to issuers associated with the modification of this policy as it was in effect for only one plan year, and prior to the PY 2026, each State Exchange and SBE–FP was evaluated by HHS to understand their current state of network adequacy reviews, with all States being deemed as already having sufficient authority and technical capacity in place to review for network adequacy in some capacity.

We previously estimated that the total annual burden associated with State Exchanges and SBE–FPs in establishing and conducting network adequacy reviews to be up to 900 hours, which we anticipate would still apply, as we do not anticipate State Exchanges or SBE–FPs would need to make changes to their systems or policies to support the restoration of flexibilities to conduct network adequacy. Assuming the compliance officer average hourly rate of $75.40,[248] we estimate the cost of the data collection, operations, and maintenance pertaining to these proposed requirements on each State Exchange and SBE–FP would be $67,860 per year (900 hours × $75.40 per hour). In total, for the 22 State Exchanges and 1 SBE–FPs anticipated to be operational in 2027, we estimate a burden of 20,700 hours (23 State Exchanges and SBE–FPs × 900 hours per Exchange) at an annual cost starting in 2027 of $1,560,780 (23 State Exchanges and SBE–FPs × 900 hours per Exchange × $75.40 per hour).

We seek comment on these proposed burden estimates and assumptions.

N. ICRs Regarding General Program Integrity and Oversight Requirements (§ 155.1200)

We propose to amend § 155.1200(d) to reduce duplication between the proposed SEIPM program described in proposed subpart Q and the annual independent external programmatic audit requirements and standards described at § 155.1200(c) and (d). We propose to add § 155.1200(e) to permit a State Exchange to satisfy certain annual independent external programmatic audit requirements, as described at § 155.1200(d), by completing the proposed required annual SEIPM program process. As a result, we estimate that there would be a general burden reduction for State Exchanges related to the programmatic audit requirement under § 155.1200(c). In particular, the 22 State Exchanges that operate their own eligibility and enrollment platforms would incur lower costs for contracts with independent external auditors, since many requirements under subparts D and E would be addressed through completion of the SEIPM process for the applicable benefit year.

Based on industry estimates of the average cost of contracting an auditor to perform an independent external programmatic audit, we project that the reduced audit scope would lower annual costs by approximately $45,000 for each State Exchange. This is based on an estimated average annual programmatic cost of $150,000. We anticipate the total cost annual reduction across 22 State Exchanges would be approximately $990,000 and that these savings could begin as early as 2027, coinciding with the submission of independent external audits for the PY 2026 SMART. However, this change would also introduce a new burden associated with completing the SEIPM process, as discussed in the section below.

We seek comment on these proposed burden estimates and assumptions and specifically seek feedback from State Exchanges regarding the annual cost of the programmatic audit process.

O. ICRs Regarding the State Exchange Improper Payment Measurement (SEIPM) (§§ 155.1600–155.1650)

As described in the preamble to § 155.1600, SEIPM is proposed to replace the previous IPPTA program with requirements related to mandatory participation in SEIPM. SEIPM is designed as a process for HHS to review payments of APTC that were determined by State Exchanges to produce an estimate of improper payments.

In the preamble to § 155.1615(a)(1), we propose that State Exchanges would provide to HHS: the State Exchange's Program Information which consists of policy, operational and technical documentation concerning business rules and calculations, entity relationships, data dictionaries, operating procedures, and system technology. This information is currently retained by State Exchanges in a digital format and can be electronically transmitted to HHS. We estimate that the burden associated with the collection and transfer of this information to HHS would be no more than 40 hours.

In the preamble to § 155.1615(a)(2), we propose that State Exchanges would

[248] See Table 12: Adjusted Hourly Wages Used in Burden Estimates.

provide HHS with the universe of tax household information respective to the plan year being reviewed, that being a listing of the population of tax households that were enrolled in a QHP, where payments of APTC were made. The listing must include an identifier for each tax household, an identifier for each QHP policy within that tax household, the tax household size, the total payment amounts for each sampled unit for the benefit year, and information about the existence of an eligibility verification inconsistency associated with each sampled unit. The burden associated with the proposed collection of information includes the time it would take each State Exchange to meet with HHS to review the submitted information. We estimate that the burden associated with this data collection and transfer would be no more than 40 hours.

In the preamble to § 155.1615(a)(3), we propose that State Exchanges would provide HHS with review unit data, that being the specific information that is required to review each of the sampled QHP tax household, which includes the following information at the tax household level:

- Information pertaining to the calculation of the APTC benefits paid. This would include monthly enrollment premium amounts, monthly APTC payment amounts, monthly Second Lowest Cost Silver Plan Premium amounts, and monthly essential health benefit amounts.
- Information provided by policy issuers relevant to enrollment reconciliation. This would include dates and amounts of effectuation payments, APTC and premium payment information, and policy start and end dates.
- Information relevant to the determination of eligibility for a SEP (where applicable), this would include consumer attestations and representations, copies of documentary evidence submitted by applicants, electronic verification information, and timing information.
- Information about timing of certification and coverage area of the associated QHP. This would include the coverage area of the QHP, timing of QHP certification or approval, and timing of QHP decertification or suppression.
- For each person on the policy who is included in the APTC payment calculation:
- Attestation and demographic information relevant to initial QHP. This would include the demographic information and consumer attestations and representations.
- Information relevant to electronic eligibility verifications and payment determinations. These include the electronic source consulted, the timing of the verification, and the results of the verification.
- Information relevant to QHP and APTC manual eligibility verifications and the resolution of electronic verification inconsistencies. This would include copies of documentary evidence submitted by applicants, the timing of submission, the timing of adjudication, and information about good faith extensions.

HHS would specify the manner in which the data is collected. HHS anticipates utilizing a standardized data request form with specific required fields for the collection of this information. The final collection instrument and methodology would be specified in subsequent guidance and would be designed to minimize burden while ensuring data quality and consistency across State Exchanges. HHS would provide State Exchanges with detailed specifications for data formatting, submission procedures, and technical requirements prior to implementation. We estimate that the burden associated with this data collection and transfer would be no more than 8 hours per sample. We anticipate each State Exchange would need to provide between 50 to 250 samples proportionate to the total amount of APTC payments processed by the State Exchange. At the aggregate level, a total sample size of approximately 2000 tax households would be used to support improper payment measurement across all State Exchanges. In future periods, the total sample size may be adjusted based on factors such as observed error rates, statistical precision requirements, State Exchange participation levels, and available program resources, while ensuring compliance with OMB statistical sampling guidance for improper payment measurement.

The burden associated with completion and return of the proposed required information would be the time it would take each State Exchange to meet with HHS to review the information being requested, analyze and design any database queries needed to produce the information, organize the information into a document or documents for the purposes of transmittal to HHS, electronically transmit the information to HHS, and meet with HHS to verify and validate the information.

We estimate that for each State Exchange, the total costs would range between $24,950 and $124,750 depending on the identified sample size. The calculation at the low end of the range was produced by multiplying 50 (the smallest number of samples that will be used in SEIPM) × $499 (the average cost per sampled record) = $24,950. The calculation at the high end of the range was produced by multiplying 250 (the largest number of samples that will be used in SEIPM) × $499 = $124,750.

The annual, aggregated burden for the total 22 State Exchanges to complete the SEIPM is estimated to be $1,097,800. This calculation was made by multiplying 2200 (the total number of samples to be used in SEIPM) × $499 (the average cost per sample). This cost estimate encompasses the processes at the State Exchanges that includes but is not limited to the following: sampling procedures, data collection protocols, and analytical frameworks required to produce an annual improper payment estimate while maintaining statistical validity and regulatory compliance standards.

To compile our estimates, we utilized industry-standard burden estimation methodologies commonly employed for Federal data collection initiatives. We conducted a comprehensive task analysis to identify specific personnel roles and time requirements across all phases of the data collection process, including transition and SEIPM preparation, system setup and maintenance, materials preparation, tool and data preparation for review processes, pre-engagement activities, sampling procedures, review conduct, collaborative observations, and closeout activities. This systematic approach ensures our estimates reflect realistic operational requirements based on established Federal data collection practices.

Hourly wage rates vary across the occupational specialties necessary to perform the information collection and are as follows:

Occupational Code Occupational Title Adjusted Median Hourly Wage

11–1021 General and Operational Manager $99.00
11–3021 Computer Information Systems Manager $164.62
13–1111 Management Analyst $97.30
15–1211 Computer Systems Analyst $99.80
12–1251 Computer Programmer $94.88

This establishes a mean hourly rate of $111.12 across all of the occupational specialties that would be needed for performing this collection.

While the initial burden estimate assumes 8 hours per sample as a baseline, HHS recognizes that State

Exchanges would realize significant economies of scale when processing multiple samples within the same collection period. The initial sample requires the upfront costs in system setup, query development, staff training, and process establishment. However, subsequent samples within the same collection cycle will benefit from:

- Established data extraction processes and validated database queries
- Trained personnel familiar with HHS requirements and submission procedures
- Streamlined workflows and standardized documentation templates
- Reduced coordination overhead through established communication channels

These efficiencies typically reduce the per-sample burden for subsequent samples after the initial setup. The 8-hour baseline represents the maximum expected burden per sample, with actual burden decreasing as State Exchanges leverage established processes and systems for additional samples within the same collection period, equating to an average hourly burden per sample of 4.49 hours.

The calculations in this paragraph demonstrate how the cost estimates were derived for the data collection process across State Exchanges. The mean hourly rate of $111.12 was calculated by averaging the five adjusted median occupational wage rates ($99.00 + $164.62 + $97.30 + $99.80 + $94.88 = $555.60 ÷ 5 = $111.12). While the baseline estimate assumes 8 hours per sample initially, economies of scale reduce the average burden to 4.49 hours per sample as State Exchanges develop efficient processes for subsequent samples. The cost per sample is calculated by multiplying the average burden hours by the mean hourly rate (4.49 hours × $111.12 = approximately $499 per sample). Finally, the aggregate cost estimate of $1,097,800 across all 22 exchanges represents the total expected cost when these efficiencies are realized across the entire sample collection process, which works out to an average of approximately $49,900 per State Exchange, calculated with the premise that each State Exchange would submit on average 100 samples. In summary, the total cost of $1,097,800 is derived from multiplying the estimated average cost per sample ($499) times the total samples (2200) to be drawn across all the State Exchanges.

The costs associated with the SEIPM program will begin in 2027, coinciding with the effective date of the regulation as specified in § 155.1605(a). These are annual recurring costs that State Exchanges will incur each year as part of the ongoing SEIPM requirements. The annual nature of these costs reflects the ongoing data submission processes that State Exchanges must perform to support HHS' annual improper payment measurement and reporting obligations under the Payment Integrity Information Act of 2019.

We will request to account for the associated information collection burden under OMB control number: 0938–NEW/CMS–10942.

Additionally, as described in the preamble to § 155.1535, we are proposing that State Exchanges may be required to develop and implement corrective action plans (CAPs) following a completed SEIPM measurement designed to reduce improper payments as a result of eligibility determination errors, beginning in 2029. The burden associated with this requirement is the time and effort put forth by State Exchanges to develop and submit a CAP to HHS. We estimate that it would take each selected State Exchange up to 1,000 hours to develop a CAP. We estimate that the total annual burden associated with this requirement for up to 22 State Exchange respondents would be up to 22,000 hours. Assuming the management analyst average hourly rate of $97.30 per hour, we estimate that the cost of a corrective action plan per State Exchange could be up to $97,300, and for all 22 State Exchanges, up to $2,140,600. The burden related to this information collection will be submitted to OMB for approval after future rulemaking has been completed regarding the CAP process and requirements.

We seek comment on these proposed burden estimates and assumptions.

P. ICRs Regarding the Discontinuation of Standardized Plan Options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv))

We propose to remove the following from our regulations effective beginning in PY 2027: the definition of ''standardized options'' at § 155.20; all requirements pertaining to standardized plan options at § 156.201 (the requirements for FFE and SBE–FP QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one another at paragraph (c)); the differential display of standardized plan options on *HealthCare.gov* at § 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv).

Under §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv), approved web-brokers and QHP issuers using a DE pathway to facilitate enrollment through an FFE or SBE–FP must differentially display standardized plan options in accordance with § 155.205(b)(1) in a manner consistent with how standardized plan options are displayed on *HealthCare.gov,* unless we approve a deviation. Any requests from web-brokers and QHP issuers seeking approval of an alternate differentiation format are reviewed based on whether the same or a similar level of differentiation and clarity is provided under the requested deviation as is provided on *HealthCare.gov.*

This information collection is currently undergoing renewal under *Non-Exchange Entities* (OMB Control Number: 0938–1329 (CMS–10666)/ estimated Expiration date: February 20, 2029). Given that we propose to discontinue the full suite of standardized plan option policies from our regulations (including standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv)), if this policy is finalized as proposed, we also anticipate requesting to discontinue this information collection—as these entities would no longer be required to submit a request to deviate from the form of display on *HealthCare.gov.*

We seek comment on these proposed burden estimates and assumptions.

Q. ICRs Regarding Non-Standardized Plan Option Limits (§ 156.202)

We propose to discontinue non-standardized plan option limits and exceptions at § 156.202. If this policy is finalized as proposed, we also anticipate requesting to discontinue the corresponding ICR, which is Non-Standardized Plan Option Limit Exceptions (OMB Control Number: 0938–1461 (CMS–10878)/Expiration date: July 31, 2027), since issuers that seek to offer plans that are tailored to the treatment of chronic and high-cost conditions would be able to do so without submitting information that is currently required under the exceptions process.

We seek comment on these proposed burden estimates and assumptions.

R. ICRs Regarding Provider Access Standards for Network Plans (§ 155.1050 and § 156.230)

We propose at § 155.1050(d), for PY 2027 and beyond, to allow FFE States, including States that perform plan management, that elect to do so, to conduct provider access reviews for issuers' plans that use and do not use a provider network, provided that the State has sufficient authority and the technical capacity to conduct such reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program, as described at proposed § 155.1050(d)(2) through (d)(4). We would continue to conduct network adequacy reviews consistent with § 156.230 for QHP issuers that use and do not use a provider network in FFE States that do not elect to conduct such reviews, or in FFE States that do not demonstrate sufficient authority and the technical capacity to conduct such reviews by satisfying the applicable criteria to demonstrate they have an Effective Provider Access Review Program, as described at proposed § 155.1050(d)(2) through (d)(4). Under this proposal, we would continue to collect network adequacy data, including time and distance and appointment wait time data. We would continue collecting this data from all FFE issuers, either to use to conduct Federal network adequacy reviews in FFE States that do not elect to do so, or do not demonstrate they have sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program as described at § 155.1050(d)(2) through (d)(4), or with a view to make it available in a standardized format to States that are determined to have an Effective Provider Access Review Program, to assist them in their network adequacy analysis. We do not believe this proposal would introduce new burdens associated with data collection, as we would continue to utilize the same systems, processes, and data requirements currently in place. We believe the ICRs associated with this proposal are assessed and are encompassed by the revised information collections for QHP certification and network adequacy data collection (Continuation of Data Collection to Support QHP Certification and other Financial Management and Exchange Operations (OMB Control Number 0938–1187 (CMS–10433)/Expiration date: June 30, 2025) and Essential Community Provider-Network Adequacy (ECP/NA) Data Collection to Support QHP Certification (OMB Control Number. 0938–1415 (CMS–10803)/Expiration date: December 31, 2027)). Overall, we expect any change in burden cost to be negligible under this proposal. We do expect the total burden cost associated with the network adequacy review process to decrease for QHP issuers in States with an Effective Provider Access Review Program, as outside of initial data submission and validation, these issuers would not be subject to review processes conducted by HHS. However, burden costs saved by QHP issuers on the Federal level may be lost at the State review level, depending on how a State implements network adequacy review processes. It is unknown how States would implement network adequacy data collection and certification reviews under this proposal and the number of States that would elect to conduct these reviews, thus the total burden associated with undergoing this provider access certification review process on the State-level is uncertain.

We seek comment on these proposed burden estimates and assumptions.

S. ICRs Regarding Essential Community Providers (§ 155.1051 and § 156.235)

In this proposed rule, we propose to reduce the minimum percentage requirements described under § 156.235(a)(2)(i) and (b)(2)(i) from 35 to 20 percent for the overall, FQHC, and family planning ECP thresholds. We also propose to amend the narrative justification requirement language at § 156.235(a)(3) and 156.235(b)(3) to reflect current operations and data submission requirements as part of ECP certification reviews, as narrative justifications are no longer required for issuers not meeting the ECP standard since they input contract statuses directly into the ECP User Interface in the MPMS. The ICRs associated with QHP certification and ECP Data Collection to Support QHP Certification have already been assessed and are encompassed by the currently approved information collections (*Continuation of Data Collection to Support QHP Certification and other Financial Management and Exchange Operations* (OMB Control Number 0938–1187 (CMS–10433)/Expiration date: June 30, 2025) and *Essential Community Provider/Network Adequacy (ECP/NA) Data Collection to Support QHP Certification* (OMB Control Number. 0938–1415 (CMS–10803)/Expiration date: December 31, 2027)).

We note that the proposed changes to minimum percentage requirements from 35 to 20 percent would not change the type of ECP data collected from issuers, as issuers would still be required to designate contracted ECPs included within their provider networks for each of their service areas to meet the ECP standard under § 156.235. However, we believe these proposed changes may contribute to decreases in issuer burden as part of ECP data submission for QHP certification reviews because issuers would have the flexibility to report fewer contracts with ECPs due to the reduced minimum percentage requirement. Issuers may also experience reductions in administrative costs due to fewer resources needed to demonstrate compliance with the ECP standard, and to pursue additional contracts and negotiations. Based on an analysis of PY 2025 FFE plan data among a total of 118 medical QHPs and 129 SADPs, an additional 18 medical QHPs would have been able to meet at least one of the thresholds (overall, FQHC, and family planning provider) if it were reduced from 35 to 20 percent, and an additional 15 SADPs would have been able to meet at least one of the thresholds (overall and FQHC). Specifically, among medical QHPs, an additional six would meet the overall threshold, five would meet the FQHC threshold, and seven would meet the family planning provider threshold. Among SADPs, an additional eight would meet the overall threshold and seven would meet the FQHC threshold. Therefore, these issuers may experience burden reductions as a result of the reduced minimum percentage requirements. Although some of these aforementioned issuers who previously did not meet the ECP standard may no longer choose to pursue additional contracts with ECPs if now meeting the ECP standard, it is unknown how many issuers would actually choose to reduce their number of contracts with ECPs to obtain a closer estimate on reduced burden associated with these proposed changes. Issuers that have consistently exceeded the minimum percentage may choose to maintain the number of contracted ECPs in their networks as opposed to not renewing or terminating their provider contracts, and those issuers that previously did not meet the 35 minimum percentage requirement but would now meet the 20 percent minimum percentage requirement may still choose to expand contracts with providers.

Furthermore, according to an analysis of PY 2025 FFE plan data, 14 medical QHPs (including one dual QHP) and eight additional SADPs would have been required to submit narrative justifications for not meeting the ECP

standard under § 156.235 if these data requirement collections were still in place. In the justification Excel format used prior to PY 2025, these 22 issuers would have had to spend on average an estimated minimum of at least 2 minutes per ECP inputting provider contact information and the status of negotiations. The modernizations to the ECP data collection process in the ECP UI implemented beginning for PY 2025 have contributed to burden reductions among these issuers, since the time spent reporting provider data would be reduced with issuers easily importing their prior year's ECP data into their current year's application or selecting ECPs with pre-populated contact information from the list embedded in MPMS. Additionally, in lieu of providing information on particular ECPs and writing responses to questions pertaining to monitoring and mitigating measures for ECP network gaps in the Excel justification format, these issuers now designate the status of negotiations with particular ECPs by selecting from a drop-down list in MPMS, which averages an estimated minimum of at least 5 seconds per ECP. As a whole, these efficiencies to the justification process through the ECP UI MPMS modernizations have reduced issuer burden as part of ECP certification reviews through reductions in the amount of time issuers spend submitting ECP data due to it being mostly prepopulated within MPMS, drop-down options to quickly append the status of contract negotiations, and by MPMS clearly identifying needed corrections and required fields for the issuer to complete a satisfactory justification to support their QHP certification.

In addition, we propose at § 155.1051 to allow FFE States, including States performing plan management, to elect to conduct their own ECP certification reviews of issuers plans' with or without a provider network provided the State demonstrates it has sufficient authority and the technical capacity to conduct these reviews by meeting the applicable criteria, as determined by HHS, to be considered to have an Effective ECP Review Program under § 155.1051. An FFE State would need to first express its interest to HHS and submit an attestation, and it would be granted an Effective ECP Review Program designation after HHS determines it meets all applicable requirements described for this program under § 155.1051. If we determine that an FFE State does not have an Effective ECP Review Program or an FFE State does not elect to conduct such reviews, then we would continue to perform ECP certification reviews consistent with § 156.235 for network plans and proposed § 156.236 for non-network plans. We are revising the information collection currently approved under OMB Control Number 0938–1415 (CMS–10803) (Essential Community Provider-Network Adequacy (ECP/NA) Data Collection to Support QHP Certification) in order to reflect new requirements proposed under § 155.1051 for the Effective ECP Review Program. Since we would perform ECP certification reviews for issuers in FFE States without an Effective ECP Review Program consistent with our current operations, processes, and data submission requirements as part of QHP certification, we do not believe this proposal would introduce any new burdens associated with data collection. In addition, for QHP issuers in Effective ECP Review Program States, we do expect the total annual hours and annual burden cost associated with the ECP certification review process to slightly decrease on the Federal level. While QHP issuers in FFE States with an Effective ECP Review Program would still need to submit ECP Data to HHS, issuers would not be required to undergo the extensive ECP review process to address corrections identified by HHS by resubmitting data, if they instead go through this process in FFE States with an Effective ECP Review Program. However, burden costs saved by QHP issuers on not undergoing the extensive ECP certification review process on the Federal level may be offset at the State level if FFE States impose new, additional ECP certification data collection and review procedures for QHP issuers that do not already exist in order to comply with § 155.1051. It is unknown how FFE States would implement ECP data collection and certification reviews and the number of FFE States that would elect to conduct these reviews, thus the total burden associated with undergoing this ECP certification review process on the State-level is uncertain.

We seek comment on these proposed burden estimates and assumptions.

T. ICRs Regarding QHP Certification of Non-Network Plans (§§ 155.1050, 156.230, 156.235, 156.236, 156.275, and 156.810)

In this proposed rule, we propose a number of revisions to Part 155 and Part 156 to allow plans that do not use a network (non-network plans) to receive QHP certification beginning with PY 2027 by demonstrating that they ensure a sufficient choice of providers in a manner consistent with sections 1311(c)(1)(B) and (C) of the Affordable Care Act. We propose to add new section § 156.236, that contains the provider access sufficiency standards (including ECP access) specific to non-network plans, and to revise §§ 156.230 and 156.235 to make clear that those sections address the provider access sufficiency standards (including ECP access) for network plans. Additionally, we clarify that non-network plans would be subject to and be able to meet all of the general certification criteria at § 155.1000(c), which would allow Exchanges the ability to certify non-network plans as QHPs. Furthermore, we propose to allow FFE States, including States performing plan management, to conduct provider access and/or ECP certification reviews provided the State elects to conduct these reviews and demonstrates it has sufficient authority and the technical capacity to conduct these reviews by meeting the applicable criteria, as determined by HHS, for each review program it wishes to administer; these review programs include the Effective Provider Access Review Program for provider access certification reviews under proposed § 155.1050(d) and/or the Effective ECP Review Program for ECP certification reviews under proposed § 155.1051. Accordingly, FFE States that elect to conduct provider access certification reviews, and are determined by HHS to have sufficient authority and the technical capacity to conduct these reviews by satisfying applicable criteria to be considered to have an Effective Provider Access Review Program under proposed § 155.1050(d)(2) through (d)(4) would be permitted to perform such reviews of non-network plans. Similarly, FFE States that elect to conduct ECP certification reviews, and are determined by HHS to have sufficient authority and the technical capacity to conduct these reviews by meeting applicable criteria to be considered to have an Effective ECP Review Program under proposed § 155.1051 would be permitted to perform such reviews of non-network plans. Accordingly, we are revising the information collection currently approved under OMB Control Number 0938–1415 (CMS–10803) (Essential Community Provider-Network Adequacy (ECP/NA) Data Collection to Support QHP Certification) to reflect proposed requirements under § 156.236 for non-network plans.

We believe that most of the current provider access data collection and submission requirements that apply to network plans would also apply to provider access reviews for non-network

plans. Relevant to provider access reviews, pursuant to proposed § 156.236(b)(1), non-network plans would be required to report their assessed percentage of providers in a service area that accept the plan's benefit amount as payment in full.

Additionally, to comply with proposed § 156.236(b)(4) through (9), non-network plans would be required to attest to a list of questions to indicate they meet these regulatory requirements. Non-network plans would be required to indicate they have processes and/or methodologies in place to conduct continuous outreach to available providers in a particular service area to determine whether they would accept the plan's benefit amount as payment in full; to make benefit amounts publicly available and accessible; to determine benefit amounts; to provide consumer-friendly and public information about potential balance billing scenarios and expected out-of-pocket costs; to offer an exceptions process for enrollees who cannot find providers (including ECPs) willing to accept the benefit amount as payment in full; and to provide adequate customer service or online provider directory assistance resources to assist plan enrollees and potential enrollees in finding providers (including ECPs) in their area who will accept the plan's benefit amount as payment in full. It is uncertain approximately how many non-network plans would apply for QHP certification to reasonably estimate the total annual burden cost and hours for attesting to these requirements. However, we expect the time for responding to the attestation questions for a single non-network plan would range between thirty seconds to one minute for each of the six attestation questions, likely requiring a maximum of six minutes total to complete. Overall, we believe the extra time and costs associated with completing this section would be negligible to flat.

Furthermore, we believe that many of the current ECP data collection and submission requirements that already apply to network plans would also apply to non-network plans. First, non-network plans applying for QHP certification would similarly use MPMS, which has extensively streamlined data collection and submission, reducing burden among issuers during QHP certification. The MPMS ECP UI only displays qualified and eligible ECPs in the issuer's State, reducing the burden of filtering through the entire ECP List for applicable facilities. Instead of spending time and effort inputting individual ECP data (such as facility name, facility address, ECP reference number, NPI, etc.) for each applicable facility in each of the plan's applicable network and/or service area, QHP issuers, including SADPs, are able to use MPMS to select prepopulated ECPs from a list of available and eligible ECPs within the user interface. MPMS is also updated regularly during QHP certification to remove ECPs that have closed or are no longer eligible such that issuers do not spend time entering in ECP data that is no longer valid or applicable to their QHP application.

Non-network plans must submit ECP data in MPMS in order to demonstrate they meet ECP related requirements at § 156.236(b)(1) through (3) such as: whether the non-network plan meets at least a minimum percentage, as specified by HHS, of available ECPs that accept the plan's benefit amount as payment in full in each plan's service area collectively across all ECP categories defined under § 156.235(a)(2)(ii)(B), and at least a minimum percentage of available ECPs in each plan's service area within certain individual ECP categories, as specified by HHS; whether the non-network plan offers the benefit amount as payment in full to at least one ECP in each of the eight ECP categories per county in the plan's service area described in § 156.235(a)(2)(ii)(B); and whether the non-network plan offers the benefit amount as payment in full to all available Indian health care providers in the plan's service area. Network plans currently satisfy data collection requirements by designating contract statuses, including whether a contract was offered or fully executed, with select ECPs within their application in MPMS. To satisfy proposed § 156.236(b)(1) through (3), non-network plans would submit ECP data by similarly selecting ECPs within their application in MPMS, but instead of contract statuses they would select modified statuses describing whether a select ECP was offered or accepted their benefit amount as payment in full. Thus, we do not believe the proposed ECP requirements under § 156.236(b)(1) through (3) for non-network plans would impose significantly new, additional information collections. Thus, we believe new ECP requirements under proposed § 156.236(b)(1) through (3) would be negligible in both total annual burden hours and cost.

In summary, we are revising the information collection currently approved under OMB Control Number 0938–1415 (CMS–10803) (Essential Community Provider-Network Adequacy (ECP/NA) Data Collection to Support QHP Certification) to reflect proposed requirements under § 156.236 for non-network plans. However, as stated in the discussions above, since non-network plans would be required to meet many of the current NA and ECP data collection and submission requirements that already apply to network plans, and since the additional total annual burden cost and hours associated with answering attestation questions consistent with proposed § 156.236(b)(4) through (9) would be negligible, the proposed revised information collection is not expected to increase total annual burden hours or costs compared to the previous information collection OMB Control Number 0938–1415 (CMS–10803) (Essential Community Provider-Network Adequacy (ECP/NA) Data Collection to Support QHP Certification)(Expiration Date: December 31, 2027).

U. ICRs Regarding Quality Improvement Strategy (§ 156.1130)

There is no information collection associated with this proposed policy and no changes are proposed to the QIS data collection requirements applicable to QHP issuers. QIS data collection from QHP issuers to the Exchange has been approved under OMB Control Number 0938–1286.

V. Summary of Annual Burden Estimates for Proposed Requirements

TABLE 19: Proposed Annual Recordkeeping and Reporting Requirements

Regulation Section(s)	OMB Control Number	Total Annual Burden (hours)	Total Cost ($)
154.215	0938-1141	9,068,800	$911,365,624.00
155.1050	0938-1341	20,700	$1,560,780.00
155.1600 – 155.1650	0938-NEW	31,878	$3,238,400.00
155.220	0398-NEW	1,666,000	$96,694,640.00
155.220	0938-NEW	24	$1,392.96
155.20, 155.305(f)(1), 155.320	0938-1218	91.5	$29,350.20
155.20, 155.305(f)(1), 155.320	0938-NEW	163,000	$15,810,185.00
155.305(f)(2)	0938-1191	(442,700)	($19,809,866.00)
155.320(c)(3)(iii)	0938-1191	1,381,600	$63,346,432.00
155.320(c)(5)	0938-1191	6,308,600	$253,765,422.00
155.420(g)	0938-1191	351,688	$10,235,301.00
155.605(d)(1)	0938-1191	343.04	$16,884.00
TOTAL		**18,550,025**	**$1,336,254,545**

X. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed above, please visit CMS' website at *www.cms.hhs.gov/Paperwork* Reduction Act of 1995, or call the Reports Clearance Office at 410–786–1326.

We invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule and identify the rule [CMS–9883–P], the ICR's CFR citation, CMS ID number, and OMB control number.

ICR-related comments are due [DATE].

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

A. Statement of Need

This proposed rule includes payment parameters and provisions related to the HHS-operated risk adjustment and risk adjustment data validation (HHS–RADV) programs, as well as 2027 benefit year user fee rates for issuers that participate in the HHS-operated risk adjustment program and the 2027 benefit year user fee rates for issuers offering qualified health plans (QHPs) through FFEs and SBE–FPs. This proposed rule also includes proposed revisions to the defrayal policy; removal of the requirement for a State to operate a SBE–FP before operation of a State Exchange; amendment of the requirement to operate a centralized eligibility and enrollment consumer interface on the State Exchange's website; expanded marketing prohibition regulations and mandated use of the HHS-approved and created form for agents, brokers, and web-brokers; strengthened ability to take administrative actions against agents, brokers, and web-brokers; implementation of the State Exchange Direct Enrollment (DE) option; coordination of the new SEIPM process with existing independent external programmatic audit requirements; a prohibition on including routine non-pediatric dental services as an essential health benefit (EHB); cost-sharing changes for catastrophic and bronze plans; clarifications for how catastrophic plans may have plan terms of up to 10 consecutive years; repeal of standardized plan options and non-standardized plan options limits and exceptions; revisions to network adequacy reviews ; participation by QHPs that do not use a provider network; reduction of the essential community provider (ECP) thresholds; implementation of an Effective Essential Community Provider Review Program; modification to require QHP issuers to submit any two of five quality improvement strategies (QISs) topic areas listed in section 1311(g)(1) of the Affordable Care Act; imposition of civil monetary penalties (CMPs) against issuers in State Exchanges or SBE–FPs; revisions to rate filing justification; and income verification requirements. Finally, this proposed rule includes updates needed to align Exchange regulations with the WFTC legislation.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 14192,

''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA) (Pub. L. 96–354); section 1102(b) of the Social Security Act; and section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or Tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impacts of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) was prepared for this rule in keeping with Executive Order 12866. Based on our estimates, the Office of Management and Budget's (OMB) Office of Information and Regulatory Affairs (OIRA) has determined that this rulemaking is ''significant'' per section 3(f)(1). We have prepared an RIA that, to the best of our ability presents the costs and benefits of the rulemaking.

C. Impact Estimates of the Proposed Payment Notice Provisions and Accounting Table

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/2025/08/CircularA-4.pdf*), we have prepared an accounting statement in Table 20 showing the classification of the impact associated with the provisions of this proposed rule.

This proposed rule implements standards for programs that would have numerous effects, including providing consumers with access to affordable health insurance coverage, reducing the impact of adverse selection, and stabilizing premiums in the individual and small group health insurance markets and in Exchanges. We are unable to quantify all the benefits and costs of this proposed rule. The effects in Table 20 reflect qualitative assessment of impacts and estimated direct monetary costs and transfers resulting from the provisions of this proposed rule for Exchanges, health insurance issuers and consumers. The annual monetized transfers described in Table 21 includes changes to costs associated with the risk adjustment user fee paid to HHS by issuers.

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TABLE 20: Accounting Table

Benefits:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	$24.66 Million	2026	7 percent	2026-2030
	$24.67 Million	2026	3 percent	2026-2030
Quantitative: • Annual savings to the Federal Government of $20.9 million and to States of $3.2 million beginning in 2026 due to not needing to determine DMI outcomes for individuals attesting that they are a lawfully present noncitizen with an income under 100 percent of the FPL. • Annual savings to State Exchanges of approximately $990,000 due to reduction of duplicate requirements between the independent external programmatic audit under 155.1200(c) and the SEIPM program established under new subpart Q, beginning in 2027. • Beginning in 2027, annual reduction of $300,000 in Federal spending and reduction in income for the contractor for discontinuing the vendor program that conducts agent and broker training, sets standards for vendor participating in the program, requires publication of the approved list of vendors, states how participating vendors will be monitored by HHS, and describes applicable appeal rights available to vendors.				
Qualitative: • Reduction in abusive conduct by agents, brokers, and web-brokers, and increased transparency around program integrity oversight of the FFE. • Improved ability of HHS to investigate agent, broker, and web-broker eligibility application review and consumer consent review as a result of the proposal to require use of the HHS-approved and created form. • Increased consumer protections, such as avoiding surprise tax liabilities, as a result of the use of the mandatory forms containing all regulatory requirements and the proposed marketing standards of conduct. • Increased State flexibility regarding consumer interfaces supporting eligibility application submission and QHP enrollment functionality, allowing State Exchanges to deliver these services primarily through consumer interfaces provided by web-brokers and other non-Exchange entities via the SBE-EDE option. • Potential direct benefit of reducing improper payments, with secondary effects including a boost of issuer confidence in State Exchanges, through implementation of the SEIPM. • Reduced potential for APTC recipients to incur large tax liabilities in 2027 as a result of the policies regarding income verification. • The enhanced CSR reporting would enable issuers to potentially increase the accuracy of their CSR payment amounts and improve future projections for rate setting, resulting in more accurate premium levels. • Potential increased accuracy in issuers' calibrated CSR load factors that would more adequately cover actual CSR costs, potentially leading to more stable and accurate premium pricing over time. • Potential for more predictable multi-year coverage arrangements for consumers enrolling in multi-year catastrophic plans withreduced need to navigate annual open enrollment periods and decreased risk of coverage gaps due to missed enrollment deadlines. • Potential enhanced access to care for enrollees in multi-year catastrophic plans with terms of at least 2 years through pre-deductible coverage for certain benefits designed to improve long-term health • Reduced administrative burden for issuers offering multi-year catastrophic plans through decreased annual re-enrollment activities and lower operational expenses.				

Costs:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	$605.99 Million	2026	7 percent	2026-2030
	$608.28 Million	2026	3 percent	2026-2030
Quantitative: • Information collection costs incurred by State Exchanges related to SEIPM, estimated to be a recurring annual cost of approximately $1,097,800 across all required State Exchanges beginning in calendar year 2027, and $2,140,600 beginning in 2029 for State Exchanges submitting corrective action plans (CAPs). Additionally, annual Federal contracting costs of $19.5 million and Federal staffing costs of $2.3 million beginning in 2027. • Increased costs to issuers of approximately $91,131 associated with conducting APTC, CSR, and user fee program compliance reviews beginning in 2026. • Costs of $96,694,640 for agents, brokers, and web-brokers annually beginning in 2027 to use the HHS-approved and -created consumer consent form. • Costs of $1,392.96 for agents, brokers and web-brokers annually beginning in 2027 to respond to HHS regarding misleading marketing.				

• One-time costs in 2026 of $242,488 to the Federal Government and $4.1 million to State Exchanges for updating systems to comply with the policy prohibiting APTC for individuals who are ineligible for Medicaid due to their immigration status and have income below 100 percent of the FPL under the WFTC legislation. • One-time costs in 2026 of $872,955 to the Federal Government and $14.9 million to State Exchanges to implement the provision to limit APTC eligibility to "eligible noncitizens" under the WFTC legislation. • Annual costs beginning in 2026 of $29,350 for the three States anticipated to be operating a BHP to comply with the provision to limit APTC eligibility to "eligible noncitizens" under the WFTC legislation. • Increased annual costs to the Federal Government of $20.2 million and to State Exchanges of $12.4 million beginning in 2027 for generating income DMIs when trusted data sources indicate an income under 100 percent of the FPL. • Regulatory review costs of $5,968,281.42 for interested parties to review and analyze this proposed rule in 2026. • Increase in annual burden of approximately $102.3 million for the Federal Government and approximately $62.8 million total for State Exchanges starting in 2027 to review and verify submitted documents, communicate with consumers, and process DMIs for applicants whose tax return data is unavailable. • Increase in burden of $13.7 million starting in 2027 for consumers with incomes below 100 percent of the FPL to fulfill income verification requirements addressing DMIs. • One-time costs in 2027 of approximately $19.4 million total for State Exchanges and approximately $969,950 for the Federal Government due to not needing to complete the necessary system changes and other technical changes to reimplement the policy to require Exchanges to find consumers ineligible for APTC after failing to file their income taxes and reconcile their APTC after one tax year. • One-time costs in 2026 of approximately $16.3 million total for State Exchanges and $775,960 for the Federal Government for necessary system and other technical changes to implement the policy to conduct additional verifications when applicants attest to income that would qualify the taxpayer as an applicable taxpayer per 26 CFR 1.36B-2(b) but trusted data sources show income below 100 percent of the FPL. • Increase in annual burden of $69.5 million starting in 2027 for consumers whose tax return data is unavailable to fulfill income verification requirements addressing DMIs. • One-time costs in 2026 of approximately $18.3 million total for State Exchanges and approximately $872,955 for the Federal Government for necessary system and other technical changes to remove the policy to require Exchanges to accept an applicant's income attestation without further verification when tax return data is unavailable. • Annual cost increase for consumers of approximately $7,332,686 beginning in 2027 associated with the policies regarding SEP verification. • Annual cost to the Federal Government of $14,602,615 beginning in 2027 to develop and code changes and comply with the policies regarding SEP verification. • One-time implementation costs in 2026 of $418,790,376 for issuers to implement the standard methodology and generate new URRT entries. • Annual ongoing costs beginning in 2027 of $209,395,188 for issuers to update systems and recalculate URRT values. • Annual ongoing costs beginning in 2026 of $157,222 for issuers to enter all required CSR-related data elements in the URRT. • Annual ongoing costs beginning in 2026 of $628,888 for issuers to provide explanations in the Actuarial Memorandum of the methodology used to determine the CSR load factor and comparison of expected load revenue to expected CSR payment. • Annual ongoing costs beginning in 2026 of $2,414,256 for the Federal Government to review all required CSR-related data elements and explanations in submitted rate filing information. • Annual cost to State Exchanges of $16,884 beginning in 2027 to manually process documentation and one-time cost to State Exchanges of $643,160 in **2026** to develop an automated processing system related to the expansion of the hardship exemption eligibility.
Qualitative: • Increased administrative burden on issuers that operate in multiple States as a result of the proposal to remove the requirement for State Exchanges and SBE-FPs to conduct network adequacy reviews. • Potential costs to State governments and private hospitals in the form of charity care for individuals who become uninsured due to administrative burden or income ineligibility as a result of the policies in this proposed rule. • Issuers would incur costs related to developing new pricing models for multi-year catastrophic plans, and States and the Federal Government would face costs associated with reviewing and approving multi-year catastrophic plan filings. • Possible higher out-of-pocket costs for enrollees in catastrophic plans and bronze plans who incur health costs in excess of the current annual limitation on cost sharing if they enroll in catastrophic plans or bronze plans at lower premiums under the provision to change the permissible cost-sharing parameters for bronze plans and updated requirements for catastrophic plans.

Transfers:	Low Estimate (million)	High Estimate (million)	Year Dollar	Discount Rate	Period Covered
Annualized	(3,550.47)	(6,465.63)	2026	7 percent	2026-2030
Monetized ($/year)	(3,617.37)	(6,574.62)	2026	3 percent	2026-2030

Quantitative:

- Annual reduction in APTC transfers from the Federal Government to [*] of $213 million starting in 2027 for consumers across all Exchanges who receive fewer months of APTC due to reinstatement of DMIs where households attest to income that would qualify the tax payer as an applicable taxpayer per 26 CFR 1.36B-2(b) and data sources show income below 100 percent of the FPL.
- Annual reduction in APTC transfers from the Federal Government to [*] of $1,069 million starting in 2027 for households across all Exchanges that receive fewer months of APTC due to reinstatement of DMIs when IRS data is not available.
- Annual reduction in APTC transfers from the Federal Government to [*] of $179 million starting in 2028 associated with the provision implementing section 71303 of the WFTC legislation for households across all Exchanges that receive fewer months of APTC due to losing their APTC eligibility due to failing to file and reconcile for one tax year as opposed to two consecutive tax years.
- Annual reduction in APTC transfers from the Federal Government to[*] of approximately $105.4 million due to pre-enrollment verification requirements for SEPs, associated with a reduction in premiums of approximately 0.5-1.0 percent, beginning in 2027.
- Annual reduction in APTC transfers across all Exchanges due to reductions in enrollment associated with the provisions implementing section 71302 of the WFTC legislation prohibiting APTC for individuals who are ineligible for Medicaid due to their immigration status and have income below 100 percent FPL of $1,869,180,495 beginning in 2026. [*]
- Annual reduction in Federal BHP expenditures due to reductions in the number of individuals for whom the Federal Government can make a payment, associated with the provisions implementing section 71302 of the WFTC legislation prohibiting APTC for individuals who are ineligible for Medicaid due to their immigration status and have income below 100 percent FPL and limiting APTC eligibility to eligible "noncitizens" of $100 million in 2026, $118 million in 2027, $111 million in 2028, $112 million in 2029, and $113 million in 2030. [*]
- Annual reduction in APTC transfers of $9,672,048,360 across all Exchanges beginning in 2027 due to the provisions implementing section 71301 of the WFTC legislation limiting APTC eligibility to eligible "noncitizens". [*]
- Annual reduction in APTC transfers from the Federal Government to [*] of $3.8 billion starting in PY 2027 associated with the provision implementing section 71304 of the WFTC legislation for the removal of the 150 percent FPL SEP beyond PY 2026.

[*] Transfers may be experienced most directly by issuers and are ultimately experienced by some combination of issuers, enrollees (or potential enrollees), public jurisdictions and private entities that bear the cost of charity/uncompensated care, and programs such as Medicaid.

Qualitative:

- Potential adjustments to PTCs as a result of silver plan premium changes due to CSR load calculations.

TABLE 21: Estimated Federal Government Outlays and Receipts for the Risk Adjustment and Reinsurance Programs from Fiscal Year 2027-2031, in billions of dollars[249]

Year	2027	2028	2029	2030	2031	2027-2031
HHS Risk Adjustment and Reinsurance Program Payments	16	15	15	15	16	77
HHS Risk Adjustment and Reinsurance Program Collections	-15	-15	-15	-16	-16	-77

Note: Risk adjustment program payments and receipts lag by one quarter. Receipts will fully offset payments over time. Source: Congressional Budget Office. Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections. Table 2. June 2024. https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf.

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1. HHS–RADV Error Estimation Modification To Incorporate IVA Sampling Changes [249]

In the 2026 Payment Notice, we finalized excluding enrollees with HCCs from IVA sampling beginning with benefit year 2025 HHS–RADV. As a consequence of this change to the IVA sampling methodology, we now propose to add an additional scaling factor to the error estimation methodology to ensure that HCC-associated error rates continue to apply to only the proportion of total PLRSs that are associated with HCC components of EDGE risk scores. The additional scaling factor will serve to capture the proportion of issuer's total population's risk that is associated with enrollees with HCCs.

In simulating the impact of the additional scaling factor, we found that HHS–RADV adjustments to RA transfers decreased in magnitude by 11.7 percent in the individual market (going from $148 million to $139 million) and by 13.8 percent in the small group market (from $81 million to $69.8 million). Table 22 shows only the impact on positive HHS–RADV adjustments. Because HHS-operated risk adjustment, and HHS–RADV adjustments, are budget neutral, we would see the same impact on negative risk adjustment transfers, in that both would decrease in magnitude. When examining the impact of the additional proposed scaling factor on HHS–RADV adjustments over premium, we see that there is only a 0.01 percent change in positive HHS–RADV adjustments in both markets between results with no additional factor and results with the additional scaling factor. This corresponds with a percentage point (PP) change of –0.02. This helps to contextualize the change in the magnitude of HHS–RADV adjustments. This proposal would more accurately assess the proportion of an issuer's population's risk that arises as a result of enrollees with HCCs.

We solicit comments on the estimated impacts of this proposal.

TABLE 22: Impacts of Proposed Scaling Factor on HHS-RADV Adjustments

	Positive* RADV Adjustments			Positive* RADV Adjustments Over Premium		
Market	No Factor	Proposed	% Change	No Factor	Proposed	PP Change
Individual	$148,025,028	$130,639,483	-11.7%	0.13%	0.12%	-0.02 pp
Small Group	$81,069,952	$69,873,392	-13.8%	0.12%	0.11%	-0.02 pp

*Note: Because the HHS Risk Adjustment program is budget neutral, total HHS-RADV Payments always net to zero. Therefore, to capture the impact of the proposal, we have used only positive adjustments.

2. HHS Risk Adjustment User Fee for 2027 Benefit Year (§ 153.610(f))

For the 2027 benefit year, HHS will operate risk adjustment in every State and the District of Columbia. As described in the 2014 Payment Notice (78 FR 15416 through 15417), HHS' operation of risk adjustment under section 1343 of the Affordable Care Act on behalf of States is funded through a risk adjustment user fee. For the 2027 benefit year, we propose to use the same methodology to estimate our administrative expenses to operate the HHS risk adjustment program as was used in the 2026 Payment Notice. As discussed previously in this proposed rule, risk adjustment user fee costs for the 2027 benefit year are expected to be similar to the prior 2026 benefit year budget estimates. Expected enrollment changes are minor compared to the overall enrollment in the individual and small group markets. Therefore, they do not significantly impact expected collections under this user fee rate. For these reasons, we propose a risk adjustment user fee of $0.20 PMPM for the 2027 benefit year. We expect the proposed risk adjustment user fee for the 2027 benefit year to retain the amount transferred from issuers of risk adjustment covered plans to the Federal Government and therefore there is no change in the transfer to the Federal government.

We seek comment on these proposed impact estimates and assumptions.

3. Submission of Rate Filing Justification (§ 154.215)

This rule proposes to collect as part of the rate filing justification information on adjustments to the index rate to account for unreimbursed CSRs. As detailed in section III.C of this preamble, issuers would be required to report on the URRT actual CSR amounts paid on behalf of eligible enrollees and additional revenue collected from the previous applied CSR load (using the most recent annual data that is available prior to the applicable filing year, generally two years prior, using the standard methodology set forth in 156.430(c)(2)), the amount previously generated by any load factors from the most recent annual data available, projected CSR amounts expected to be paid on behalf of enrollees in the upcoming plan year and additional revenue to be collected as a result of the CSR load factor, and CSR load factors in a new dedicated line item. Issuers would also be required to report the expected amount generated by the load factor for the upcoming plan year. This rule also proposes to require issuers to provide an explanation in the Actuarial Memorandum of the methodology used to determine the load factor for the upcoming plan year and an explanation of how the expected amount generated by the load factor compares to the amount of CSRs expected to be paid on behalf of enrollees for the same period as part of the Actuarial Memorandum.

The proposed provisions would primarily affect health insurance issuers offering qualified health plans in the individual market, Federal and State regulators in their review capacity, and indirectly, Marketplace enrollees who receive cost-sharing reductions. The enhanced CSR reporting would enable issuers to more accurately determine their CSR payment amounts and improve future projections for rate setting. This increase in accuracy and

[249] Reinsurance collections ended in FY 2018 and outlays in subsequent years reflect remaining payments, refunds, and allowable activities.

transparency could result in more appropriate premium levels if current CSR load factors are determined to be inaccurate or unreasonable, enabling issuers to better calibrate their load factors to adequately cover actual CSR costs, potentially leading to more stable and accurate premium pricing over time.

Issuers would incur a one-time cost, in 2026, of $418,790,376 to implement the standard methodology and generate the new URRT entries, followed by annual ongoing costs, beginning in 2027, of $209,395,188 to update their systems and recalculate the URRT values. Additionally, issuers would incur annual ongoing costs, beginning in 2026, of $157,222 to enter the proposed values in the URRT and $628,888 to provide an explanation in the Actuarial Memorandum of how the CSR load factor was determined. Costs might vary with issuer scale, data systems, and product complexity. Additionally, the Federal Government would incur annual ongoing costs, beginning in 2026, of $2,414,256 to review the additional information submitted. These costs are discussed in detail in the Collection of Information section IV.B.4 of this proposed rule.

Enrollees could potentially experience changes in out-of-pocket costs as more accurate CSR reporting may lead issuers to adjust their load factors and premium pricing; the direction of these changes would depend on whether the current CSR load factors overestimate or underestimate actual CSR costs. If issuers have been overestimating actual CSR costs, they may decrease load factors and premiums, which could result in lower out-of-pocket costs for enrollees through decreased premiums. Conversely, if issuers have been underestimating CSR costs, load factors and premiums could increase.

Changes in CSR load calculations could result in corresponding adjustments to PTCs, as more accurate CSR load factors may increase or decrease silver plan premiums. If CSR loads decrease, silver plan premiums should decrease with corresponding Federal PTC outlays decreasing and offsetting changes in consumer net premiums. To the extent that improved estimates would change plan pricing, there might also be distributional enrollment shifts among enrollees across metal levels on-Exchange and in silver plans offered off-Exchange.

4. Approval of a State Exchange (§ 155.105)

We propose to remove § 155.105(b)(4) to rescind a requirement made in the 2025 Payment Notice,[250] such that for a State seeking to operate a State Exchange, it must first operate for at least one plan year an SBE–FP. The original amendment was intended to give States sufficient time to create, staff, and structure a State Exchange. However, HHS recognizes that requiring States to first operate as an SBE–FP for at least one plan year could potentially create unnecessary barriers and delays for States that are well-prepared to implement a State Exchange more immediately. Ultimately, a State must demonstrate its ability to operationalize State Exchange functional requirements through a well-established and robust review process with HHS. Whether a State first operates an SBE–FP does not change our review process for determining whether a State is ultimately prepared to implement a State Exchange. The proposed changes therefore do not impose any new requirements on States in operating State Exchanges or SBE–FPs and instead returns flexibility to States regarding implementation of either a SBE–FP or State Exchange.

We seek comments on the practical utility of this data collection from potential users of this CSR amount data (for example, State regulators).

5. Approval of a State Exchange (§ 155.106)

We propose to amend § 155.106(a)(2) to rescind a requirement made in the 2025 Payment Notice [251] that, as part of a State's activities for its establishment of a State Exchange, the State must provide supporting documentation demonstrating progress toward meeting or implementing State Exchange Blueprint requirements. States recognize the need for HHS to request supplemental documentation in order for HHS to assess a State's readiness to operate a State Exchange, which assessment supports a State's successful State Exchange operation. States have provided such supplemental documentation upon HHS request similarly both before and after this requirement was originally finalized The Blueprint Application already provides that we may require supporting documentation from a State as evidence of its progress toward meeting State Exchange Blueprint Application requirements, which is part of HHS' overall process for providing a State with approval to operate a State Exchange. The proposed changes do not impose any new requirements on States in establishing a State Exchange.

We seek comment on these proposed impacts and assumptions.

6. Amending Requirements for State Exchanges To Operate a Centralized Eligibility and Enrollment Infrastructure (§§ 155.205(b) and 155.221(k))

a. Amending the Requirement for State Exchanges To Operate a Centralized Eligibility and Enrollment Consumer Interface on the State Exchange's website (§ 155.205(b))

We propose to amend § 155.205(b) to specify that a State Exchange is not limited to operating a centralized eligibility and enrollment consumer interface on the State Exchange's website as the only model for supporting consumer eligibility application submission and QHP enrollment functionality. Additionally, we propose revisions to § 155.302(a)(1) to require a State Exchange to make all determinations of eligibility for QHP coverage and insurance affordability programs and maintain records of all QHP enrollments, even if the Exchange no longer maintains a consumer interface on the State Exchange's website. These regulatory changes make clear that a State Exchange can also deliver consumer eligibility application submission and QHP enrollment services exclusively through the websites of non-Exchange entities, including a web-broker or direct enrollment entity under § 155.220 or § 155.221, that demonstrate operational readiness and compliance with applicable requirements via a robust approval and oversight process in accordance with § 155.221(j). The State Exchange must continue to maintain a centralized eligibility and enrollment system to process all determinations of eligibility for QHP coverage as well as a website providing standardized comparative information on such plans to enrollees and prospective enrollees of QHPs and related insurance affordability programs and maintain records of all QHP enrollments.

We expect minimal, if any, financial impact to current State Exchanges and States in the process of establishing their own State Exchange. All current State Exchanges operate an eligibility and enrollment consumer interface on the State Exchange's website. States that are presently in the process of establishing their own State Exchange for PY 2026 and PY 2027 plan to operate an eligibility and enrollment consumer interface on their website. Costs assumed by a State planning to transition from the FFE to establish and

[250] See 89 FR 26259 through 26261.

[251] See 89 FR 26261 through 26263.

operate their own State Exchange after PY 2027 may vary depending on whether they choose to have an eligibility and enrollment consumer interface on their website to provide consumer eligibility application submission and QHP enrollment functionality.

b. SBE-Enhanced Direct Enrollment Option (§ 155.221(k))

We propose to add § 155.221(k) to establish a new State Exchange enhanced direct enrollment (SBE–EDE) option by which State Exchanges can leverage direct enrollment technology to transition primarily to private sector-focused enrollment pathways operated by QHP issuers, web-brokers, and agents and brokers, instead of or in addition to a centralized eligibility and enrollment website operated by an Exchange. State Exchanges can elect, subject to HHS approval, to implement the SBE–EDE option. The impact of the new SBE–EDE option would depend on the number of States that take advantage of the new option. There are various interested parties in States that elect to implement the SBE–EDE option that could be impacted, including consumers, State Exchanges, web-brokers, issuers, and agents and brokers, as well as the Federal Government.

The SBE–EDE option may have varied impacts on consumers relating to the corresponding increase in the number of potential websites through which consumers could shop for QHP coverage might impact consumers and consumer behavior for QHP enrollment.

Current State Exchanges that elect to implement the SBE–EDE option would be responsible for meeting certain requirements for approval, in particular revising their Exchange Blueprint under new § 155.221(k) to describe precisely how the State proposes to implement the SBE–EDE option. We believe that any costs of revising the Exchange Blueprint would be nominal, as this process involves logging into a CMS web interface that serves as the repository for all States' Exchange Blueprints to input additional information on the updated processes and controls the State would implement to manage its new Exchange EDE program. However, we seek comment on the burden associated with this activity, noting that the Exchange Blueprint is currently approved under the PRA under OMB Control Number 0938–1172.

For States seeking to transition to a State Exchange in future plan years and implement the SBE–EDE option, we anticipate that start-up costs may potentially be higher than the start-up costs for States seeking to transition to a State Exchange without implementing the Exchange EDE option, due to the additional interfaces that must be implemented between the Exchange's eligibility platform and each approved EDE entity and managed on an ongoing basis by the Exchange. States transitioning to an SBE–EDE would be required to complete the Exchange Blueprint in the same manner as required prior to the final rule and would be required to meet all required minimum functions of an Exchange. In terms of implementation costs, these States can realize savings by virtue of not having to maintain and operate a consumer-facing enrollment website capable of handling all Exchange-related internet traffic for all State residents, instead relying on EDE entities and their websites to provide the majority of the Exchange's consumer-facing enrollment functionality.

The costs associated with consumer-facing enrollment functionality may be relatively lower than those associated with building the back-end Exchange eligibility platform, interfaces with EDE entities to accept Exchange applications and complete eligibility determinations, the connections required from an Exchange's back-end eligibility platform to the Federal Data Services Hub for eligibility verifications, connections from the Exchange's back-end eligibility platform to the respective State Medicaid agency for coordinating Medicaid and CHIP eligibility determinations, and the Exchange's data management and reporting functionality necessary to submit required eligibility and enrollment data regarding all Exchange enrollees to HHS and the IRS. Based on recent State transitions to the State Exchange model, the design, development, and implementation (DDI) costs for an Exchange depend on a number of factors. DDI costs have ranged from $4 million for a smaller State, to almost $24 million for a larger State based on self-reported budget figures. Only one State Exchange to date has implemented EDE while also transitioning to a State Exchange, with design, development, and implementation IT and call center costs during the transition year of $25 million. States may be able to partner with existing Federal EDE partners who are already fully-compliant with Federal operational requirements to achieve administrative savings related to the approval process for EDE entities seeking to operate in their State. Any operational cost increases or savings may, in turn, affect a State Exchange's user fee and premium costs.

We anticipate that a State Exchange electing the SBE–EDE option would have increased operational costs for ongoing monitoring and oversight of the approved EDE entities, as well as for maintaining and managing the individual interfaces and transactions with each EDE entity. However, any savings achieved through a decrease in call center volume or other consumer supports due to EDE partners assisting consumers with enrollment would offset any increased operational costs. Any operational cost increases or savings stemming from implementation of the Exchange EDE option could, in turn, affect a State Exchange's user fee and consumer premium costs.

We also anticipate that the Exchange EDE option can have significant impacts on prospective EDE entities (including web-brokers, agents and brokers, and issuers) and the Federal Government as a result of start-up, approval, and implementation costs. Such costs may be incurred by entities who enter a State's market as a new EDE entity for the first time, or by existing DE entities that expand into new markets. We presume that EDE entities would act rationally and enter a State's market or expand into new markets if the benefits exceed the costs.

In terms of privacy/security approval and startup costs, prospective EDE entities would be required to implement almost 300 security and privacy controls consistent with a system security and privacy plan provided by CMS. After control implementation, prospective EDE entities must contract with an independent third-party auditor to complete a security and privacy controls assessment test plan, which must be submitted to CMS for review. Once approved, an EDE entity must submit quarterly Plan of Action and Milestones (POA&Ms) to CMS to document the identification and resolution of any new or existing security or privacy risks. EDE entities must also incur costs to contract with a third-party auditor to perform an annual assessment of their security and privacy posture consistent with continuous monitoring requirements published by CMS, and feedback provided on their quarterly POA&Ms.

In terms of approval and startup costs of implementing appropriate business controls, prospective EDE entities that wish to participate and host an eligibility application also would be required to implement a dynamic user interface (UI) that adapts to consumer scenarios based on complex business rules and integration with a range of application programming interfaces (APIs). They must also implement post-enrollment support functionality.

There are additional technical startup and approval costs related to the

eligibility application functionality that EDE entities are required to implement. They must have the ability to provide the State Exchange with all the information necessary for it to determine eligibility to enroll in QHPs, as well as to determine eligibility for APTC, CSRs, Medicaid, and CHIP. Consumers who complete an eligibility application on an EDE entity's website must be provided with an eligibility determination notice (EDN) from the State Exchange, and related information must display within the EDE entity's website UI about consumers' eligibility. Therefore, if a consumer is determined eligible for Medicaid or CHIP after completing an eligibility application through an EDE entity's website, they would receive the same information in their EDN about that eligibility and next steps as if they completed the application on the State Exchange website.

We also anticipate that there would be costs specific to web-brokers and issuers that choose to enter into fee-based arrangements with other agents, brokers, or issuers, or that choose to enter new economic or legal arrangements with States, that help to offset the costs of the EDE services provided. In terms of costs to issuers, generally any changes in issuer costs associated with the SBE–EDE option could have downstream effects on premium rates. Issuers would be impacted by adjustments in State Exchange user fees and may have an incentive to promote direct enrollment if user fees are lower under the SBE–EDE option, and the savings achieved through those lower user fees exceed the new costs of arrangements with web-brokers. Issuers may also be impacted if the SBE–EDE option leads to shifts in consumer enrollment patterns, such as movement from a QHP offered by one issuer to another QHP. If issuers choose to build out standalone consumer-facing applications to enroll in coverage under the SBE–EDE option, this would be another cost to consider that could impact them directly and have downstream impacts.

There are some anticipated costs to the Federal Government associated with the SBE–EDE option. We anticipate that any HHS costs associated with supporting the additional monitoring and oversight in States that elect to implement the SBE–DE option would be nominal given that State Exchanges would retain primary responsibility for overseeing their approved DE entities and HHS can leverage its existing State Exchange oversight mechanism and associated processes to ensure that this is occurring.

7. Additional Required Benefits (§ 155.170)

We propose to amend § 155.170(a)(2) to provide that any State-required benefits would be considered ''in addition to EHB'' (and thus not EHB) if they are: required by a State action taking place after December 31, 2011; applicable to the small group and/or individual markets; specific to required care, treatment, or services; and not required by State action for purposes of compliance with Federal requirements. Under this proposal, such State-required benefits would be considered in addition to EHB regardless of whether the mandated benefits are embedded in the State's EHB-benchmark plan. We propose that this change would be effective beginning with PY 2027. We also propose revisions to §§ 155.170(a)(2) and 156.115(a) to align with this proposal and to have State and issuer responsibilities with respect to State-required benefits appear in a more logical reading order in the CFR.

We believe that this revision would have a mixed effect on the cost to States and the Federal Government. A small number of States and issuers have taken significant action based on current § 155.170, including some States having sought or seeking EHB-benchmark plan changes under § 156.111 to add certain State-required benefits as EHB with the understanding that the cost of these additions would not require defrayal by the State. In such States, this proposal may frustrate such efforts should it become effective in PY 2027, as any State-required benefit that fulfills the four proposed conjunctive elements at proposed § 155.170(a)(1)(i) through (iv) would require defrayal, regardless of whether the benefit is included in the State's EHB-benchmark plan.

In States that ceased defraying the cost of State-required benefits included in their EHB-benchmark plans beginning in PY 2025 under the current regulation but would be required to defray the cost of State-required benefits beginning in PY 2027 if this proposal is finalized, the percentage of premium attributable to coverage of EHB for purpose of calculating APTC may decrease. Under this proposal, in a State that enacts a mandate for a benefit that is currently covered in its EHB-benchmark plan, there would be a decrease to Federal Government expense as the benefit would no longer be permitted to be included in the percentage of premium attributable to coverage of EHB for purpose of calculating APTC. States should evaluate the overlap between mandates and benefits covered in the State's EHB benchmark-plans for benefits for which they would be required to defray the cost if this proposal is finalized. Specifically, a State that wants to avoid defrayal obligations for State-required benefits that are already in the State's EHB-benchmark would be able to do so by repealing the applicable State requirement as being applicable to QHPs. While we expect that there should not be any measurable operational implications or infrastructure changes needed for States to implement this provision, we seek comments from States on any administrative costs that would be incurred as a result of implementing this provision. We likewise recognize that States that opt to retain benefit-mandates that carry defrayal obligations would incur defrayal costs. The scale of these costs would depend on the cost attributable to the State-required benefit. We seek comments from States on such estimates where applicable. Issuers may have to make modifications to their plan designs and plan filings to reflect any possible changes in designation of benefits as EHB because of this proposal, if finalized, in the regular course of updating those annual materials. Given variation in State legislative calendars and session timing, and the need for issuers to update their plan filings and rates to account for benefits that will be defrayed by the State, we solicit comment on finalizing an effective date for PY 2028 instead of PY 2027.

We seek comment on these proposed impact estimates and assumptions.

8. Mandating the HHS-Approved and -Created Consumer Consent Form—Eligibility Application Review and Documenting Receipt of Consumer Consent (§ 155.220(j))

As discussed in the preamble of this proposed rule, we propose amendments to §§ 155.220(j)(2)(ii)(A) and (j)(2)(iii)(A) to require agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review requirements and consent documentation requirements. Our proposal would eliminate the current broad allowances for meeting these requirements. The language in the regulation would also be changed to clarify what types of actions constitute ''taking an action'' to meet the regulatory requirements. The goal of this policy is to reduce confusion among agents, brokers, and web-brokers on what constitutes compliant eligibility application review documentation and what constitutes compliant consumer consent by ensuring objective standards,

which protects consumers ultimately. These proposals also greatly improve HHS' investigative abilities into agent, broker, and web-broker eligibility application review and consumer consent review by creating a clear and objective standard for all applications clearly outlining what HHS deems complaint.

Given this proposal would require the usage of the HHS-approved and -created consumer consent form, agents, brokers, and web-brokers who had previously relied exclusively on phone recordings, text messaging, or other non-HHS-approved and -created consumer consent form methods would be particularly impacted by this change. Consumers who had exclusively been interacting with agents, brokers, and web-brokers via phone may perceive this new requirement using the HHS-approved and -created consumer consent form (electronically or in person) as burdensome. Importantly, the HHS-approved and -created consumer consent form guarantees and ensures all regulatory requirements are in the documentation provided to the consumer, as well as making documentation review of potentially noncompliant agents, brokers, and web-brokers more streamlined and efficient. The HHS-approved and -created consumer consent form [252] we propose to become standard also went through a readability analysis, which entails a review of language to help make text easier to understand, especially with documentation that may contain industry terms of art, such as healthcare. Mandating that this form be used in all consumer interactions would help ensure consumers are reviewing documentation that has been reviewed to be consumer-friendly but still contains the regulatory requirements. Agents, brokers, and web-brokers would still be able to provide more details than what is listed on the documentation and answer specific questions a consumer may have about a plan, policy, or the enrollment process.

As estimated in section IV.C of this proposed rule, the estimated annual cost of requiring agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review requirements and the consumer consent documentation requirements is $96,694,640, beginning in PY 2027.

We seek comment on these proposed impact estimates and assumptions.

[252] See CMS Model forms, OMB Control Number: 0938–1438, Expiration Date: 07/31/2028. *https://www.cms.gov/files/document/cms-model-consent-form-marketplace-agents-and-brokers.pdf.*

9. Misleading Marketing (§ 155.220(j)(3))

As discussed in the preamble of this proposed rule, the proposed regulatory amendments would create a new standards of conduct section in § 155.220(j) describing marketing requirements. These requirements would list certain prohibited practices, provide HHS audit authority, and put agents, brokers, and web-brokers on notice that they are responsible for marketing created by their downstream entities. This proposal would allow HHS to increase its efforts to engage in compliance actions for misleading marketing by providing agents, brokers, and web-brokers notice of the types of activities that are prohibited, allowing HHS to review marketing materials for compliance, and ensure agents, brokers, and web-brokers are not able to push responsibility to third-parties. Creating a marketing standards of conduct section is necessary to protect consumers and maintain the integrity of the Exchanges.

The proposals would provide instructive language agents, brokers, and web-brokers may utilize when creating Exchange marketing materials. This would help ensure agents, brokers, and web-brokers are creating compliant marketing from the beginning and would not be subject to enforcement actions.

As estimated in section IV.D, the estimated total cost for the burden of responding to HHS regarding misleading marketing would be $1,392.96, beginning in 2027.

We seek comment on these proposed impact estimates and assumptions.

10. Removal of the Vendor Program (§ 155.222)

As outlined in the preamble of this proposed rule, we propose to remove the vendor program requirements established at § 155.222, that allow for certain training and information verification functions to be provided by HHS-approved vendors. Removing these requirements would permit HHS to discontinue the vendor program.

Considering the lack of utilization of this program by agents and brokers, as well as dwindling interest on the part of potential vendors, as outlined in the preamble, we do not anticipate potential vendors, nor agents and brokers, to be substantially impacted by these proposals. Agents and brokers would continue to have the ability to complete the annual training and information verification requirements through the MLMS at no cost.

This proposal would additionally save the government approximately $300,000 each plan year beginning in 2027 by removing the contractual costs required to facilitate the program.

We seek comment on these proposed impact estimates and assumptions.

11. Limiting APTC Eligibility to ''Eligible Noncitizens'' (§§ 155.20, 155.305(f)(1), and 155.320)

We estimate that there are currently 1,227,000 individuals receiving APTC through Exchanges who are lawfully present noncitizens, but who are not ''eligible noncitizens,'' and would therefore become ineligible for APTC and income-based CSRs beginning in PY 2027 under section 71301 of the WFTC legislation. This estimate is based on evaluating internal FFE data regarding ''eligible noncitizen'' enrollees and extrapolating that data to estimate the size of the impacted population in State Exchanges. Based on average monthly APTC expenditures of $ 656.89 per person, we project that this population becoming ineligible for APTC would reduce annual APTC expenditures by $9,672,048,360 (1,227,000 enrollees × $ 656.89 average APTC × 12 months), beginning in 2027.

We also anticipate that this proposed change would result in costs to State Exchanges and the Federal Government to update eligibility systems in accordance with this proposal. As discussed further in section IV.F of this proposed rule, in aggregate we estimate $15,810,185 in PY 2026 in estimated one-time costs for implementation ($193,990 Federal government + $678,965 Exchanges on the Federal platform + $14,937,230 State Exchanges). For the three States in total anticipated to be operating a BHP beginning in 2026, we estimate the annual ongoing cost to be $29,350.20.

As some non-citizens would no longer be eligible for PTCs under this new provision, there are also individuals for whom the Federal Government would not make a payment if enrolled in a BHP. We estimate that this provision would affect 1.6 percent of BHP enrollees starting in 2027 (using the same baseline as described in the previous subsection). These estimates are based on analysis of citizenship and residence status of enrollees in the health insurance exchanges. This would impact about 2,000 individuals each year and reduce Federal spending by about $17 million in 2027. To develop these estimates, we reviewed the number of eligible non-citizens receiving PTCs through the Exchanges in 2025 using the Multidimensional Insurance Data Analytics System (MIDAS) database. We found about 1.6 percent of all individuals receiving PTC were eligible non-citizens who would

not be eligible for PTC under this section of the legislation. We multiplied projected BHP enrollment by this percentage, which resulted in about 2,000 affected individuals annually. We multiplied the enrollment change by the projected average per member per year Federal BHP costs (see Table 25) to develop the expenditure amounts. The annual estimates are shown in Table 23.

TABLE 23: Projected Impacts of Section 71301 on BHP Enrollment and Total Spending by Year

	2026	2027	2028	2029	2030
Enrollment – eligible for Federal BHP payment	0	-2,000	-2,000	-2,000	-2,000
Total spending (in millions of real 2026 dollars)	$0	-$17	-$16	-$16	-$16

We seek comments on these proposed impact estimates and assumptions, the details of which may be found in section IV.F of this proposed rule.

12. Prohibition of APTC for Individuals Who Are Ineligible for Medicaid Due to Their Immigration Status and Have Income Below 100 Percent of the FPL (§ 155.305(f)(2))

As described in the Collection of Information Requirements in section IV.G of this proposed rule, we estimate that implementing this proposed policy would require one-time costs for Exchanges to make technical updates to their eligibility systems totaling $4,316,278 ($242,488 for Exchanges on the Federal platform + $4,073,790 for State Exchanges) in PY 2026. We also estimate that this proposed policy would result in a reduction of the amount of DMIs with a total estimated annual reduction in burden for these information collection requirements of $24,126,144($16,341,600 for removal of MLP DMIs for Exchanges on the Federal platform + $4,575,648 for removal of AI DMIs for Exchanges on the Federal platform + $3,208,896 for removal of AI DMIs for State Exchanges), beginning in 2026.

As of the end of the Open Enrollment period for 2025, there were 237,125 enrollees who were part of the population of consumers with an annual household income of less than 100 percent of the FPL, who were also ineligible for Medicaid due to their immigration status and were enrolled in Marketplace coverage with APTC on the FFE. We estimate the average monthly value of that APTC was $656.89. Through this proposed policy and subsequent elimination of APTC across all exchanges, we estimate $1,869,180,495 (237,125 enrollees × $656.89average APTC × 12 months) in APTC cost savings per year, beginning in PY 2026.

In 2025, we estimate there are about 138,000 BHP enrollees in 2 States based on the quarterly enrollment estimates that States submit to CMS. With DC starting BHP in 2026, we project that enrollment would increase by 11.3 percent in 2026 and by 1.2 percent in 2027, prior to any of the changes made by legislation and described in this proposed rule. We project enrollment would decrease in 2028 due to other legislative changes by 7.7 percent to about 143,000 and remain at about that level through 2030.

We also estimate that the current Federal BHP payment in 2025 is about $644 per member per month, based on payments the Federal Government has made to the 2 BHP States this year. We project that these would increase by 0.2 percent in 2026 (due to the combination of increases in QHP premiums and the expiration of the temporary PTC increases after 2025) and increase 3.8 percent in 2027, with an average monthly payment of $670 in 2027 prior to changes made by legislation. We project payments would increase at an average rate of about 5.2 percent after 2027.

TABLE 24: Projected BHP Enrollment, Federal Payment Rate, and Total Spending by Year Prior to Changes Made by the WFTC Legislation

	2025	2026	2027	2028	2029	2030
Enrollment	138,000	154,000	155,000	143,000	144,000	144,000
Federal payment (PMPM)	$644	$645	$670	$710	$742	$779
Total spending (in millions of nominal dollars)	$1,068	$1,190	$1,250	$1,222	$1,282	$1,345

We estimated the impact of disallowing PTC during periods of Medicaid ineligibility on BHP enrollment and spending. Prior to the enactment of the WFTC legislation, some noncitizens would have been eligible for Medicaid on the basis of income and other criteria except for the 5-year waiting period for lawful permanent residents (LPRs) to be allowed to enroll in Medicaid. For those individuals, they would have instead been eligible for PTC through enrolling in a QHP on the health insurance exchanges assuming they met all other criteria. Similarly, those individuals would have been included in Federal BHP calculations in States that had

elected to operate a BHP. Generally, these are individuals with household incomes up to 100 percent of the FPL.

Under section 71302 of the WFTC legislation, these individuals would no longer be eligible for PTC, and therefore the Federal Government would not make a payment for these individuals if enrolled in a BHP. We reviewed current BHP enrollment data based on the quarterly enrollment estimates, and we estimate that in 2026 about 12,000 BHP enrollees would no longer be eligible for PTC under this section, and thus there would not be BHP payments made for these enrollees. The annual estimates are shown in Table 25.

TABLE 25: Projected Impacts of Section 71302 on BHP Enrollment and Total Spending by Year

	2026	2027	2028	2029	2030
Enrollment – eligible for Federal BHP payment	-12,000	-13,000	-12,000	-12,000	-12,000
Total spending (in millions of real 2026 dollars)	-$100	-$101	-$95	-$96	-$97

We seek comment on these proposed impact estimates and assumptions.

13. Failure To File and Reconcile (FTR) (§ 155.305(f)(4))

We propose to amend paragraph § 155.305(f)(4) so that in PY 2028 and beyond, all Exchanges may not determine a tax filer or their enrollee eligible for APTC if: (1) HHS notifies the Exchange that APTC were paid on behalf of the tax filer, or their spouse if the tax filer is a married couple, for one year for which tax data would be utilized for verification of household and family size, and (2) the tax filer did not comply with the requirement to file a Federal income tax return and reconcile APTC for that year (referred to as the ''1-tax year FTR'' process). We also propose that, at the option of the Exchange, an Exchange may choose to implement this policy earlier in PY 2027 if they have the resources and capability to adopt the 1-year FTR process or continue to follow the 2-year FTR process until PY 2028. Exchanges on the Federal platform intend to adopt the 1-year FTR process in PY 2027, as HHS has the resources possible to do so. To conform with this proposal, we further propose to amend the notice requirement at § 155.305(f)(4)(iii), which is where the notice requirements have been reorganized. Our changes are aimed at addressing the notice messaging for tax filers who are at risk for losing APTC under a 1-year FTR policy, either for the Exchanges that adopt this option in PY 2027, and for all Exchanges in PY 2028. Exchanges operating under a 1-year FTR policy should use the more urgent language currently contained in the second year notice of the 2-year FTR policy notices in order to accurately convey to tax filers or their enrollees that they are at imminent risk of losing APTC if they do not file and reconcile.

This provision is proposed to align with the WFTC legislation starting in PY 2028, but we additionally propose that Exchanges can choose to implement this as early as PY 2027.

In light of the proposed policy changes for FY 2027 and beyond, we estimate that it would take the Federal Government and each State Exchange, if they choose to implement the 1-year FTR policy for PY 2027, instead of PY 2028 as required by the WFTC legislation, approximately 10,000 hours in 2026 to develop and code changes to the eligibility systems to evaluate and verify FTR status under the revised FTR process, such that enrollees are found to be FTR after 1 tax year of failing to file and reconcile their APTC. Of those approximately 10,000 hours, we estimate it would take a database and network administrator and architect 2,500 hours at $103.34 per hour and a computer programmer 7,500 hours at $94.88 per hour based on our prior experience with system changes. In aggregate for the State Exchanges, we estimate a one-time burden in 2026 of 200,000 hours (20 State Exchanges × 10,000 hours) at a cost of $19,399,000 (20 States × [(50,000 hours × $103.34 per hour) + (150,000 hours × $94.88 per hour)]) for completing the necessary updates to State Exchange eligibility systems in 2026, if State Exchanges implement the 1-year FTR process for PY 2027. If Exchanges choose to implement the 1-year FTR process for PY 2028, these estimated costs would be delayed by one year to 2027. For the Federal Government, we estimate a one-time burden in 2026 of 10,000 hours at a cost of $969,950 ((2,500 hours × $103.34 per hour) + (7,500 hours × $94.88 per hour)). In total, the burden associated with all system updates to revert back to the 1-year policy would be 210,000 hours at a cost of $20,368,950.

We also estimate that by switching to the 1-year policy from the current 2-year policy in PY 2028 or at the Exchange's option in PY 2027, the Federal Government would save APTC from the population of 1-year FTR consumers who would otherwise have retained APTC eligibility for an additional coverage year under the 2-year FTR policy. We estimate that total enrollment for the Exchanges would decrease by approximately 725,000 to 1,800,000 individuals in PY 2026. This reduction in Exchange enrollment, along with the reduction in enrollment due to the expiration of enhanced APTC subsidies and the WFTC legislation, would also affect the total amount of expected households in FTR status. For PY 2025, the total FTR 1-year population dropped from almost 1.5 million households prior to Open Enrollment to less than 400,000 households during FTR Recheck. The total FTR 2-year population dropped from approximately 350,000 households prior to Open Enrollment, to approximately 300,000 households at FTR Recheck, and then after the final check of IRS data, HHS terminated APTC for approximately 200,000 households. Under our proposed 2028 1-year policy with the option to early adopt in 2027, we would expect to remove APTC from all households still in an FTR status in our final Recheck. Based on historical FTR data and expectations for Exchange population size due to changes from the PI final rule, expiration of enhanced APTC subsidies, and the WFTC legislation, we expect that the total amount of households that lose APTC could be approximately 28,500. This is the population that would otherwise retain their APTC in a 2-year policy during PY 2028. The annual savings generated by removing their APTC based on 8 months of enrollment and the average amount of APTC removed per household of $784

per month is approximately $179 million. Depending on how many Exchanges elect to adopt the 1-year FTR policy in PY 2027, the savings could be achieved as early as PY 2027, as the Exchanges on the Federal platform plan to early adopt the 1-year FTR policy.

For the purposes of this RIA, we assume the scenario that Exchanges will comply with the policy in PY 2028 to align with the WFTC legislation. We seek comment on these proposed impact estimates and assumptions.

14. Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))

In this proposed rule, we propose amending § 155.320(c)(3)(iii)(A) to indefinitely extend the requirement for applicants to submit documentation when they attest to income that would qualify the taxpayer as an applicable taxpayer per 26 CFR 1.36B–2(b), but trusted data sources show income below 100 percent of the FPL starting in 2027.

As discussed further in section IV.I of this proposed rule, we estimate an approximate increase in burden costs of $20.2 million for Exchanges using the Federal platform and $12.4 million for State Exchanges starting in 2027 to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes for applicants below 100 percent of the FPL. The implementation of this proposal would result in a one-time cost of $775,960 to Exchanges on the Federal platform and approximately $16.3 million total State Exchanges in 2026 to update the eligibility systems and perform other technical updates to implement the additional verification of an applicant's annual household income attestation when tax data is returned that is under 100 percent of the FPL while the household's annual income attestation is at or above 100 percent of the FPL. Finally, we estimate an increase in burden of approximately $13.7 million across all Exchanges in 2027 and annually onwards for consumers to submit documentation to fulfill income verification requirements. We recognize the burden the continuation of policy may place on State Exchanges, and we seek comment from these and other impacted interested parties to inform this decision.

While there would be additional annualized budget impacts of this policy on State Exchanges and the Federal Platform, there may be some savings associated with an anticipated reduction in APTC for consumers. Based on our analysis of enrollment data from DMI generation numbers from when this DMI was previously in place, we estimate creating DMIs that require additional verification would reduce the number of people who receive APTC by 50,000 for Exchanges on the Federal platform. We estimate the reduction of people who receive APTC in the State Exchanges to be 31,000. Using an estimated average four months reduced APTC and an average monthly APTC rate of $656.89per person, we estimate total APTC expenditures would be reduced by approximately $213 million per year for the period in which we maintain this policy ($50{,}000 \times \$656.89 \times 4 + 31{,}000 \times \$656.89 \times 4$).

We seek comment on these proposed impact estimates and assumptions.

15. Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))

In this proposed rule, we propose to remove § 155.320(c)(5), which would allow Exchanges to continue the income verification process when IRS is successfully contacted but IRS returns no data rather than accepting an applicant's annual household income attestation.

As further discussed in section IV.J of the proposed rule, we estimate an increase in annual burden costs of approximately $102.3 million for Exchanges on the Federal platform and approximately $62.8 million total for State Exchanges starting in 2027 to receive, review, and verify submitted verification documents as well as conduct outreach and determine DMI outcomes for applicants whose tax return data is unavailable. The implementation of this proposal would result in a one-time cost of $872,955 to Exchanges on the Federal platform and approximately $18.3 million total State Exchanges in 2026 to update the eligibility systems and perform other technical updates to implement the additional verification of an applicant's annual household income attestation when tax data is unavailable. As also further discussed in section IV.J of this proposed rule, we also estimate an increase in annual burden of $69,480,540 for consumers in 2027 and beyond to submit documentation to fulfill income verification requirements associated with this proposal.

Based on our analysis of enrollment data from DMI generation numbers from when this DMI was previously in place, as well as historical enrollment data, we estimate creating DMIs that require additional verification would result in a decrease in APTC, potentially to zero, for 252,000 enrollees for Exchanges on the Federal platform and 155,000 enrollees on State Exchanges. Using an estimated average 4 months reduced APTC, as estimated based on internal 2016–2020 APTC data, with an average monthly APTC rate of $656.89 per person, we anticipate that this change could result in an annual reduction of $1,069 million ($252{,}000 \times \$656.89 \times 4 + 155{,}000 \times \$656.89 \times 4$) in APTC expenditures starting in 2027. We accept comments on whether this number may be slightly less because of potential decreased enrollment if the enhanced PTC are no longer in effect.

We seek comment on these proposed impact estimates and assumptions.

16. Extend the Removal of the 150 Percent FPL SEP Beyond Plan Year 2026 (§ 155.420)

We propose to no longer ''sunset'' the prohibition on Exchanges offering the 150 percent FPL SEP, in alignment with section 71304 of the WFTC legislation. As explained in preamble in section III.D.15 of this proposed rule, section 71304 of the WFTC legislation prohibits APTC for plans enrolled in through the 150 percent FPL SEP, and therefore eliminates the SEP's ability to facilitate access to affordable coverage. We are therefore proposing to no longer permit Exchanges to offer the 150 percent FPL SEP.

Absent the WFTC legislation, and assuming that the prohibition on Exchanges offering the 150 percent FPL SEP had ''sunset'' on December 31, 2026, we assume that all Exchanges would have elected to begin offering the 150 percent FPL SEP again in PY 2027. This assumption is based on past experience with the overwhelming majority of Exchanges choosing to offer this SEP.

If all Exchanges offered the 150 percent FPL SEP beginning in PY 2027, we assume that this would result in increased adverse selection, which would result in increases to premiums and APTC expenditures.

As a result, we estimate that this proposal would reduce premiums by 3 to 4 percent, as a result of improvements to the risk pool since the removal of this SEP would limit consumers' ability to wait until they need services to enroll in coverage. We estimate that the reduced premiums would result in an overall decrease in APTC expenditures of $3.4 to $4.5 billion per year, beginning in PY 2027. For the purposes of this RIA, we use $3.8 billion as the estimated annual decrease in APTC expenditures, beginning in PY 2027.

We seek comment on these proposed impact estimates and assumptions.

17. Pre-Enrollment Special Enrollment Period Verification (§ 155.420(g))

In this proposed rule, we are proposing the provision to allow Exchanges on the Federal Platform to continue to conduct pre-enrollment verification for SEPs other than Loss of Minimum Essential coverage and add the requirement that Exchanges on the Federal Platform conduct pre-enrollment verification for at least 75 percent of new enrollments.

We anticipate that revisions to § 155.420 would have a positive impact on program integrity by verifying eligibility for SEPs. Increasing program integrity through continuing this policy would reduce improper subsidy payments and could contribute to keeping premiums low and therefore, further protecting taxpayer dollars. This policy may deter enrollments among younger people at higher rates, which could worsen the risk pool and increase premiums. However, we expect any such deterrence would impact a very small number of young people and, therefore, have only a minimal impact on the risk pool and premiums. We estimate that the net effect of pre-enrollment verification would reduce premiums by approximately 0.5–1.0 percent and would maintain the reduction in APTC spending of approximately $105.4 million.[253]

We anticipate this policy would moderately increase the regulatory burden on Exchanges using the Federal platform. Based on past experience, we estimate that maintaining the expansion in pre-enrollment verification to most individuals seeking to enroll in coverage through all applicable SEPs offered through Exchanges on the Federal platform would result in an additional 293,073 individuals having their enrollment delayed or ''pended'' annually until eligibility verification is completed, although for the vast majority of individuals the delays would be less than 1–3 days. As mentioned in section IV.K of this proposed rule, we anticipate that maintaining the expansion of SEP verification would result in increased inconsistencies, with an associated cost increase for consumers of approximately $7,332,686 beginning in 2027. There would also be an increase in ongoing costs for Exchanges on the Federal platform due to an increase in the number of SEP enrollments for which they must conduct verification. We estimate that the total increase in ongoing processing costs to maintain compliance with this requirement for the FFE would be approximately $11.7 million annually (293,073 additional SVI x $40 cost per SVI). Furthermore, as mentioned in section IV.K, we anticipate that expanding verification would result in an increase in annual burden of labor costs on Exchanges on the Federal platform at a cost of $2,902,615 annually.

We seek comment on these proposed impact estimates and assumptions.

18. Expansion of Hardship Exemption Eligibility (§ 155.605(d)(1))

This proposed rule would amend § 155.605(d)(1) to codify and expand hardship exemption eligibility to individuals who are ineligible for APTC or CSRs due to projected household income (below 100 percent or above 250 percent of the FPL). This expansion would allow these individuals to qualify for catastrophic coverage under section 1302(e) of the Affordable Care Act.

Most State Exchanges currently delegate hardship exemption processing to HHS. However, four State Exchanges—California, Connecticut, Maryland, and the District of Columbia—currently process their own exemptions. Following HHS guidance published on September 4, 2025, this policy expansion has been implemented for consumers in all States that currently delegate exemption processing to HHS. This proposed rule would extend the same hardship exemption eligibility to consumers in the four State Exchanges that currently process their own exemptions, ensuring that consumers in all States have access to affordable coverage.

We assume the four State Exchanges that process their own exemptions would experience an administrative burden associated with processing hardship exemption applications under the expanded eligibility criteria. Based on previous experience, we estimate that Exchange staff will require approximately 19 minutes (0.32 hours) to review and process each hardship exemption application. Using the median hourly wage of $24.76 for Eligibility Interviewers, Government Programs (occupation code 43–4061), and adjusting for fringe benefits and overhead, we calculate an adjusted hourly wage of $49.52. Based on these figures, we estimate the cost per application to be $15.75, calculated as follows: (19 minutes ÷ 60 minutes) × $49.52/hour = $15.75 per application.

Based on our analysis of operational FFE data regarding existing hardship exemption requirements and the new requirement proposed in this rule, we estimate these four State Exchanges would collectively process approximately 1,072 applications annually under the expanded hardship exemption eligibility criteria when considering their combined share of approximately 10 percent of total Exchange enrollment.

Using the per-application manual processing cost of $15.75, we estimate the total annual cost burden for these four State Exchanges in total to be approximately $16,884 (1,072 applications × $15.75 per application). Individual State burden would vary depending on each State Exchange's enrollment volume and the proportion of consumers who fall into the expanded hardship exemption category. States with larger enrollment volumes and higher proportions of consumers with income below 100 percent FPL or above 250 percent FPL may experience higher application volumes than States with smaller enrollment or different demographic characteristics.

We note that the actual burden may be lower over time than estimated if State Exchanges implement automated exemption processing similar to the FFE system. The FFE experience demonstrates that automated processing significantly reduces the need for manual paper application review, as the system automatically grants hardship exemptions for consumers ineligible for APTC due to income when they apply for catastrophic coverage. State Exchanges that adopt similar automated systems would experience reduced administrative burden while ensuring consumers have seamless access to hardship exemptions and catastrophic coverage.

To estimate the cost of developing an automated exemption processing system, we analyzed personnel and time requirements across three major phases: system development, testing and quality assurance, implementation and training. The hour estimates presented below are illustrative examples intended to demonstrate the general magnitude of costs that might be associated with automated system development.

We estimate that Computer Systems Analysts would need approximately 400 hours at an adjusted hourly wage of $99.80, resulting in a cost of $39,920. Computer Programmers would require the most substantial time investment, with an estimated 600 hours at an adjusted rate of $94.88 per hour, totaling $56,928. Database and Network Administrators would need approximately 200 hours at $103.34 per hour to configure the necessary data

[253] The reduction in APTC was calculated by multiplying the estimated new SVIs by the previous SVI expiration rate (293,073 × 0.137 = 40,151) and then multiplying that number by the estimated annual APTC amount per SEP consumer (40,151 x $2,625 = $105,396,375).

infrastructure and system architecture, costing $20,668. A Project Manager would oversee the development effort for approximately 160 hours at $96.88 per hour, adding $15,501 to the total. The combined system development cost would be approximately $133,017, requiring 1,360 total staff hours.

Following initial development, the system would require comprehensive testing to ensure accuracy, compliance with Federal regulations, and proper integration with existing Exchange systems. Computer Systems Analysts would conduct approximately 120 hours of testing at $99.80 per hour, costing $11,976. Compliance Officers would review the system for regulatory compliance for approximately 80 hours at $75.40 per hour, adding $6,032. The total testing and quality assurance cost would be approximately $18,008, requiring 200 staff hours.

The final phase would involve deploying the automated system and training staff on any residual manual processes or system monitoring requirements. Management Analysts would coordinate the implementation for approximately 80 hours at $97.30 per hour, costing $7,784. Eligibility Interviewers would require approximately 40 hours of training at $49.52 per hour to understand the new automated processes and handle any exceptions, totaling $1,981. The implementation and training phase would cost approximately $9,765, requiring 120 staff hours.

Combining all three phases, the total estimated one-time cost in PY 2026 to develop an automated exemption processing system would be approximately $160,790, so in total $643,160 for four State Exchanges. This estimate represents 1,680 total staff hours across multiple occupational categories and assumes a standard development timeline and complexity level.

We recognize that this cost estimate could vary significantly depending on several factors. States with more modern and flexible existing system infrastructure may experience lower development costs due to easier integration. Conversely, States with legacy systems may face higher costs. State-specific requirements, customizations, or additional compliance considerations could also increase costs.

We seek comment on these proposed burden estimates, including the estimated number of applications, time required for consumers to complete applications, and time required for Exchanges to process applications. We also seek comment on opportunities to further reduce burden through automation or other streamlined processes.

19. Modification of Exchange Network Adequacy Standards (§ 155.1050)

We propose to amend § 155.1050(a)(2) to eliminate the requirements under § 155.1050(a)(2)(i) and (ii) for State Exchanges and SBE–FPs to establish and impose quantitative time and distance network adequacy standards for QHPs that are at least as stringent as standards for QHPs participating on the FFEs under § 156.230 and to no longer require State Exchanges and SBE–FPs to conduct quantitative network adequacy reviews to evaluate a plan's compliance with network adequacy standards under §§ 156.230(a)(1)(ii), (a)(1)(iii), and (a)(2)(i)(A) prior to certifying any plan as a QHP. Instead, we would require that State Exchanges and SBE–FPs ensure that each QHP provides sufficient access to providers in a manner that meets applicable standards specified in § 156.230(a)(1)(ii) and (a)(1)(iii) for network plans, or proposed § 156.236(a) for non-network plans, as applicable. State Exchanges and SBE–FPs have traditionally managed their respective network adequacy reviews, and many State Exchanges and SBE–FPs demonstrated to HHS that they have robust network adequacy standards and reviews in place beyond the requirements specified in § 156.230(a)(1)(ii) and (a)(1)(iii) for network plans, or proposed § 156.236(a) for non-network plans. We recognize that State Exchanges and SBE–FPs are often best positioned to evaluate local provider networks and market conditions.

We anticipate this proposal would maintain the regulatory burden on the 22 State Exchanges and 1 SBE–FP we expect for PY 2027, providing them with more flexibility to regulate and review for network adequacy in a manner that best protects their respective consumers. We estimate this impact to be $1,560,780 beginning in PY 2027, as outlined in section IV.M of this proposed rule. We anticipate this proposal might increase the administrative burden on issuers that operate in multiple States as they navigate varying regulatory frameworks and standards. The impact to consumers is not known at this time but there is a risk of potential decreased access to care for consumers if those State standards and their reviews are less consumer protective than the Federal network adequacy review framework.

We seek comment on these proposed impact estimates and assumptions.

20. General Program Integrity and Oversight Requirements (§ 155.1200)

We propose to amend § 155.1200(d) to reduce duplication between the proposed SEIPM program described in subpart Q and the annual independent external programmatic audit requirements and standards described at § 155.1200(c) and (d). We propose to add § 155.1200(e) to permit a State Exchange to satisfy certain annual independent external programmatic audit requirements, as described at § 155.1200(d), by completing the proposed required annual SEIPM program process. As a result, we estimate that there would be a general burden reduction for State Exchanges related to the programmatic audit requirement under § 155.1200(c). In particular, the current 22 State Exchanges that operate their own eligibility and enrollment platforms would incur lower costs for contracts with independent external auditors, since many requirements under subparts D and E would be addressed through completion of the SEIPM process for the applicable benefit year.

Based on industry estimates of the average cost of contracting an auditor to perform an independent external programmatic audit, HHS projects that the reduced audit scope would lower annual costs by approximately 30 percent or $45,000 for each State Exchange. This is based on an estimated average annual programmatic audit cost of approximately $150,000 for a medium-size State Exchange. We anticipate the total cost annual reduction across 22 State Exchanges would be approximately $990,000 and expect that these savings could begin as early as 2027, coinciding with the submission of independent external audits for the PY 2026 SMART. However, this change would also introduce a new burden associated with completing the SEIPM and the related CAP process, as discussed in the section below. For an estimate of the burden created under SEIPM, please refer to section VI.D.21.

We request comment on the reduction in burden proposed and specifically seek feedback from State Exchanges regarding the annual cost of the programmatic audit process.

21. State Exchange Improper Payment Measurement (§§ 155.1600 Through 155.1650)

This policy would allow HHS to implement the Payment Integrity Information Act of 2019 (PIIA) requirements for State Exchanges. As described in the preamble earlier in this

proposed rule, the PIIA requires that agencies measure the improper payments rate for programs susceptible to significant improper payments. HHS already undertakes annual measurements for Medicare, Medicaid, FFEs, and SBE–FPs. This proposed rule would lay the groundwork to complete the Exchanges' measurement program by including State Exchanges and to enable HHS to estimate a comprehensive APTC improper payment rate as mandated by statute.

This policy would allow HHS to measure improper payments that are resultant from State Exchange operations related to the determination of eligibility and payment amounts for APTC and would require State Exchanges to provide Corrective Action Plans responsive to the findings of the measurement. Even slight decreases in this rate would accrue large taxpayer savings. To delineate the range of estimated burden across the State Exchanges, cost estimates were created at the State Exchange level using an average cost per sample of $499. State. State Exchanges with proportionally smaller amounts of APTC are planned to produce a sample size of 50 while the largest States are planned to produce a sample size of 250. Using these numbers multiplied by the average cost estimate per sample of $499, the SEIPM will incur a range of approximately $24,950.00–$124,750.00 in costs per respondent. As stated in the Information Collection in IV.O, the total costs for the State Exchanges to produce the proposed information and to undergo the proposed review process is estimated as being $1,097,800. Additionally, State Exchanges would incur a cost to develop and submit a corrective action plan (CAP) to HHS following an SEIPM cycle beginning in 2029. We estimate that it would take each State Exchange up to 1,000 hours or $97,300 to develop a CAP. We estimate that the total annual burden associated with this requirement for up to 22 State Exchange respondents would be up to 22,000 hours and $2,140,600. The burden related to this information collection will be submitted to OMB for approval after future rulemaking has been completed regarding the CAP process and requirements.

Additionally, we estimate that six Full Time Equivalents (FTEs) will be necessary to complete the activities associated with SEIPM and SEIPM contract management. This estimate is based upon our experience with staffing the Improper Payment Pre-Testing and Assessment (IPPTA) which has been operationalized in a similar manner and format as will be the proposed SEIPM. The estimated annual cost per Full-Time Equivalent (FTE) is $376,075. This figure was derived by identifying the maximum salary for a Federal employee on the general pay table in the Baltimore area, which was $183,500 in 2023. To ensure conservative budgeting and sufficient funding, this salary was used as the base. The base salary was then multiplied by a factor of two to account for employee fringe benefits and overhead costs. Consequently, the total annual estimate per FTE is $376,075, leading to an aggregate annual cost of $2,256,450 for all FTEs.

Finally, we anticipate total estimated annual contracting costs of $19.5 million incurred by HHS. These costs include but are not limited to: collecting the information from the State Exchanges, building and completing automated review systems, creating the statistical methodology and identifying the sample, appeal adjudication, estimating the improper payment rate, generating required reports, and IT support and infrastructure costs.

In summary, we expect total annual costs incurred across the State Exchanges to being $3.2 million, total HHS contracting costs to being $19.5 million, and total HHS staffing costs to being $2.3 million for a total cost of $24.8 million annually.

We believe that the potential benefits of this regulatory action justify the present costs. We seek comment on these proposed impact estimates and assumptions.

22. FFE and SBE–FP User Fees (§ 156.50)

We propose an FFE user fee rate of 2.5 percent for the 2027 benefit year, which is the same as the 2.5 percent FFE user fee rate finalized for 2026 benefit year. We also propose an SBE–FP user fee rate of 2.0 percent for the 2027 benefit year, which is the same as the 2.0 percent SBE–FP user fee rate we finalized for the 2026 benefit year.

Because we are retaining the same FFE and SBE–FP user fee rates from 2026 benefit year to 2027 benefit year, the FFE and SBE–FP user fee transfers from issuers to the Federal Government would remain the same compared to those estimated for the prior benefit year. We expect that available user fee collections from current and prior years would be sufficient to fund Exchange operations through 2027 at the proposed 2027 benefit year user fee rates.

We seek comment on these proposed impact estimates and assumptions.

23. Provision of EHB (§ 156.115(d))

We propose to revise § 156.115(d) to prohibit issuers from including routine non-pediatric dental services as an EHB. We do not anticipate any immediate costs to the Federal Government, States, issuers, or enrollees because of this proposed policy. This proposed policy would once again prohibit issuers from covering routine non-pediatric dental services as an EHB, which avoids the potential imposition of premium increases associated with these services. However, we do not expect that the removal of routine non-pediatric dental services as an EHB would have a significant impact on premium reduction, as all benefits a State adds to their EHB-benchmark plan are subject to the typicality standard at § 156.111(b)(2)(ii), which limits how generous the updated plan would be. For example, if a State added routine non-pediatric dental services as an EHB under the existing policy, as we explained in the 2025 Payment Notice final rule (89 FR 26348), they may have needed to consider removing and/or adjusting other benefits to make room for the non-pediatric dental services to ensure the scope of benefits falls within the typicality range.

Additionally, this proposed change only has a premium impact to the extent States already updated their EHB-benchmark plans to include routine non-pediatric dental services under the policy finalized in the 2025 Payment Notice that allows States to add routine non-pediatric dental services as an EHB beginning with PY 2027. Since no State has taken this action, this proposal has no premium impact. If finalized as proposed, this proposed policy to prohibit coverage of routine non-pediatric dental services as an EHB would be effective upon the effective date of the final rule, preventing any future premium impact from the former policy.

Consistent with our note in the 2025 Payment Notice final rule (89 FR 26409), which acknowledged that removing the prohibition on routine non-pediatric dental services as an EHB may increase costs for issuers who may need to expand their networks to cover these services, this policy may avoid cost increases for issuers that would have needed to expand their networks to cover these new required services, although issuers could have contracted with a dental vendor to administer the routine non-pediatric dental EHB if such a benefit was adopted by a State as an EHB. As we also noted in the 2025 Payment Notice final rule, the size of non-pediatric dental networks varies by State, therefore, some States would have been affected by the need to build a new network of dental providers (or contract with dental vendors) more than others.

Therefore, by reinstating the prohibition at § 156.115(d), this policy would avoid these potential network expansion costs.

While this proposed policy may limit potential premium increases for enrollees and cost increases for issuers related to network expansion, we acknowledge that this policy may impact long-term health outcomes and associated medical costs. As we explained in the proposed 2025 Payment Notice (88 FR 82597–98), oral health and overall health are inextricably linked; untreated oral health conditions can increase risk for and complicate the management of chronic conditions.[254] As we also noted in the 2025 Payment Notice final rule (89 FR 26348), improving access to non-pediatric dental services would reduce health care costs by yielding downstream savings in overall health care expenditures and reducing costly emergency room department visits for dental care. However, as we mentioned in preamble of this proposed rule, we clarify that this prohibition on including routine non-pediatric dental services as an EHB does not prevent States from addressing non-pediatric oral health and overall health outcomes—and associated medical costs—through alternative policy mechanisms. For example, as we mentioned earlier in this proposed rule, States could mandate coverage of routine non-pediatric dental services as a non-EHB and defray the cost associated with that benefit. We believe ensuring better alignment of the regulatory requirements at § 156.115(d) with section 1302(b)(2)(A) of the Affordable Care Act regarding the EHB typicality standard outweighs these other policy considerations.

We solicit comment on the impact of this proposal to revise § 156.115(d) to prohibit issuers from including routine non-pediatric dental services as an EHB and whether other impacts should be considered.

24. Multi-Year Terms for Catastrophic Plans To Improve Health (§§ 156.130 and 156.155)

Under current regulations, catastrophic plans, like all qualified health plans offered through the Exchanges, are limited to annual contract periods that require consumers to re-enroll each year during the open enrollment period. The proposed regulation would provide consumers who are eligible for catastrophic coverage with the potential of more predictable multi-year coverage arrangements, with a term of at least 2 years, compared to annual re-enrollment, though premiums and benefits may be adjusted during the contract term in accordance with applicable requirements. This could potentially reduce premium volatility and administrative burden while maintaining the EHB and consumer protections required under the Affordable Care Act. This proposal aims to enhance market stability for a segment of consumers who may benefit from longer-term coverage arrangements. The proposed regulation would be effective for plan years and policy years beginning on or after January 1, 2027.

We seek comments on issuer participation, State and State Exchange operational impacts, and market segmentation effects.

The proposed regulation is anticipated to deliver benefits for eligible consumers and participating issuers. Consumers who enroll in multi-year catastrophic plans could benefit from more predictable multi-year coverage, with a term of at least 2 years, arrangements, reduced need to navigate annual open enrollment periods, and decreased risk of coverage gaps due to missed enrollment deadlines. Additionally, the proposed regulation would permit catastrophic plans with terms of at least 2 years to utilize value-based insurance designs to offer preventive services before the deductible is satisfied, potentially enhancing access to care. Issuers offering multi-year catastrophic plans could experience reduced administrative burden associated with annual re-enrollment activities and lower operational expenses related to annual plan document preparation and filing. The extended contract periods could also promote continuous coverage among individuals. Nevertheless, there are potential unintended consequences associated with multi-year catastrophic plans such as a possible reduction in consumer flexibility to switch plans in response to changing health needs or life circumstances (for example, becoming eligible for employer sponsored coverage or relocating outside of the plans service area). Even though premiums may be adjusted during the contract term in accordance with applicable requirements, issuers may price plans conservatively to account for uncertainty, potentially resulting in higher initial premiums. Additionally, there is uncertainty about how multi-year catastrophic plans might affect risk selection, including whether healthier individuals would disproportionately select multi-year plans. We note that there is currently no available evidence on these potential effects and data that could help understand the potential unintended consequences.

Issuers could incur costs related to developing multi-year catastrophic plans, such as developing new pricing models. States and the Federal Government would face costs associated with reviewing and approving multi-year catastrophic plan filings. We seek comments on costs and data that could be used to quantify these impacts.

The availability of multi-year catastrophic plans could result in transfer effects impacting consumers, issuers, States, and the Federal Government, with the magnitude dependent on uptake rates. We seek comments on transfer effects, premium impacts, Federal PTC expenditures, and data that could be used to quantify these impacts.

Given that this would be a new option for consumers, there is uncertainty regarding consumer demand for multi-year catastrophic plans. There is also uncertainty regarding how premiums would be structured for multi-year catastrophic plans, including the methodology and frequency of adjustments (such as annual adjustments tied to inflation or other factors) permitted under applicable requirements. There would also be actuarial challenges for issuers in pricing coverage for periods up to 10 years, particularly in projecting medical cost trends and utilization patterns over extended timeframes. Additionally, there is uncertainty about how consumers locked into multi-year catastrophic plans would respond if their health status changed and what implications this might have for consumers. We seek comment on these uncertainties and request data that could help quantify the potential impacts of multi-year catastrophic plans on enrollment patterns, premium levels, and Federal expenditures.

25. Cost-Sharing for Bronze and Catastrophic Plans (§§ 156.136 and 156.155)

To address an issue that has arisen in the implementation of section 1302(c) through (e) of the Affordable Care Act, we propose adding new § 156.136 to change the permissible cost-sharing parameters for bronze plans and

[254] Kapila Y.L. (2021). Oral health's inextricable connection to systemic health: Special populations bring to bear multimodal relationships and factors connecting periodontal disease to systemic diseases and conditions. Periodontology 2000, 87(1), 11–16. *https://doi.org/10.1111/prd.12398*. Periodontal disease has been associated with diabetes, metabolic syndrome, obesity, eating disorders, liver disease, cardiovascular disease, Alzheimer disease, rheumatoid arthritis, adverse pregnancy outcomes, and cancer.

revisions to § 156.155(a)(3) for updated requirements for catastrophic plans.

We propose changes to the cost-sharing requirements at § 156.155(a)(3) for catastrophic plans in the individual market to address an irreconcilable conflict between section 1302(c) through (e) of the Affordable Care Act. Specifically, we propose to permit individual market bronze plans to exceed the maximum annual limitation on cost sharing (rounded down to the next lowest multiple of 50 dollars) in order to achieve an AV within the standard bronze *de minimis* variation at § 156.140(c), beginning with PY 2027. We propose to allow individual market issuers this option to offer one or more increased annual limitation on cost sharing plans only if they offer at least one bronze plan that meets the annual limitation on cost sharing (that is, does not have an increased annual limitation on cost sharing). We propose to require catastrophic plans to provide no benefits for any plan year (except as provided in § 156.155(a)(4), (b), and (c)) until an amount equal to 130 percent of the annual limitation on cost sharing is reached, beginning in PY 2027. If finalized, we expect that this would incentivize enrollment in catastrophic plans because issuers would be able to offer their catastrophic plans at lower premiums than they are currently able under the current annual limitation on cost sharing restriction. This, in turn, would raise the expected out-of-pocket costs by up to 30 percent for enrollees in catastrophic plans that incur health care costs in excess of the current annual limitation on cost sharing; enrollees in bronze plans could see them rise even higher. We also believe that this would provide consumers with additional choice of bronze plans, including the potential for plan designs with lower deductibles and lower premiums.

We seek comment on these proposed impact estimates and assumptions.

26. Discontinuation of Standardized Plan Options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv))

We propose to discontinue the full suite of standardized plan option policies effective beginning in PY 2027. Specifically, we propose to remove the following from our regulations: the definition of ''standardized options'' at § 155.20; all requirements pertaining to standardized plan options at § 156.201 (the requirements for FFE and SBE–FP QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one another at paragraph (c)); the authority to differentially display standardized plan options on *HealthCare.gov* at § 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv). Finally, we propose to cease the annual design and publication of these plans in the applicable Payment Notice for each plan year.

However, we recognize that some issuers and consumers may still find certain features of these plan designs valuable. This is why we are not proposing to require issuers to discontinue their existing standardized plan option offerings altogether. Instead, under this proposed approach, issuers would be permitted to choose whether to discontinue these offerings altogether or to continue offering them with either the same or modified cost sharing, while we simultaneously discontinue the differential display of these plans on *HealthCare.gov* and the DE pathways.

Under this proposed approach, if issuers wished to discontinue their standardized plan option offerings altogether, they would be permitted to do so, and enrollees in these plans would be crosswalked to a different plan in accordance with the crosswalk hierarchy at § 155.335(j). Additionally, if issuers wished to continue offering these standardized plan options with the same cost sharing, they would also be permitted to do so, and enrollees in these plans would continue to be auto-reenrolled in these plans from one plan year to the next. However, these plans would no longer be visually distinguished as standardized plan options on *HealthCare.gov* or the DE pathways. Finally, if issuers wished to continue offering these standardized plan options but also wished to modify these plans' cost sharing structures, they would be permitted to do so, but these issuers would continue to be subject to the requirements under the definition of ''plan'' at § 144.103 and to the uniform modification requirements at § 147.106.

In most scenarios where an issuer modifies the cost sharing structure of one of its standardized plan option offerings, the newly modified plan that was formerly the standardized plan option would be considered a new plan and would therefore require a new plan ID. In this scenario, enrollees would be crosswalked from the discontinued plan to another plan in accordance with the crosswalk hierarchy at § 155.335(j). These enrollees could be crosswalked into the newly modified plan that was formerly the standardized plan option, or an entirely different plan altogether, depending on the unique circumstances in each county.

However, under the definition of ''plan'' at § 144.103, a State may permit issuers to make greater changes to a plan's cost sharing while still permitting that plan to be considered the same plan—thus maintaining the same plan ID. Furthermore, pursuant to § 147.106(e)(3)(iv), as long as the variation in cost sharing is solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level (and other applicable requirements under § 147.106(e) are met), the modifications could be considered uniform (thus, a viable exception to guaranteed renewability).

In the scenario where an issuer modifies what was formerly a standardized plan option's cost sharing structure while maintaining the same plan ID, enrollees in the plan would be auto-reenrolled from one plan year to the next. In either case, whether the modification of a former standardized plan option's cost sharing results in that plan being considered the same or a different plan, enrollees would be crosswalked in accordance with the crosswalk hierarchy at § 155.335(j), and that plan would no longer be differentially displayed as a standardized plan option on *HealthCare.gov* or the DE pathways.

Adopting this approach would effectively remove the standardization component of this suite of policies while simultaneously minimizing the risk of disruption for consumers enrolled in and issuers of these plans. This approach would also ensure that issuers of these plans that wish to continue offering them would be able to do so at their discretion. If issuers did choose to continue offering these plans, either with the same or modified cost sharing structures, they would be able to continue utilizing existing benefit packages, provider networks, drug lists, and formularies, including those paired with standardized plan options for PY 2026. This would further minimize burden for these issuers.

In addition, we have assumed the responsibility for differentially displaying standardized plan options on *HealthCare.gov* in accordance with § 155.205(b)(1), meaning that FFE and SBE–FP issuers have not been subject to this burden since the requirement to offer standardized plan options as well as the differential display of these plans were reintroduced in PY 2023. Thus, discontinuing the differential display of these plans on *HealthCare.gov* would

not affect issuers or impose any additional burden in this regard.

However, we acknowledge that the discontinuation of the differential display requirements for the DE pathways at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv) would impose a degree of burden on approved web-broker and QHP issuer enrollment partners using a direct enrollment pathway to facilitate consumer enrollment through an FFE or SBE–FP, since these entities would be required to modify their own platforms in some manner. However, we anticipate that the burden of making these modifications would be minimal, as decommissioning existing functionalities (such as the differential display of standardized plan options, which would include the full suite of differential display features discussed in greater detail in the preamble to § 156.201 of this proposed rule) and reverting to the previous state of display would entail significantly lower burden than introducing novel features and functionalities.

Further, since differential display of standardized plan options on *HealthCare.gov* is operationally contingent on these plans having the required cost sharing parameters, and since we would no longer design and publish standardized plan options in the applicable Payment Notice for each plan year, no plans would technically meet the requirements to be considered standardized plan options, meaning no plans would be differentially display on *HealthCare.gov*—even if we made no changes to the current functionality. The same would be true for approved web-broker and QHP issuer enrollment partners using a direct enrollment pathway to facilitate consumer enrollment through an FFE or SBE–FP, meaning the discontinuation of the differential display features could occur even without disabling the existing functionality to differentially display standardized plan options on their respective platforms.

We refer readers to the preamble section for the proposal to discontinue standardized plan options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv)) for a detailed discussion of relevant literature we considered in our approach to this proposal.

We seek comment on these proposed impact estimates and assumptions.

27. Discontinuation of Non-Standardized Plan Option Limits and Exceptions (§ 156.202)

We propose to discontinue non-standardized plan option limits and exceptions at § 156.202. However, we recognize that some issuers and consumers may still find certain features of the chronic and high-cost condition plans that were originally offered through the non-standardized plan option limit exceptions process valuable. This is why we are not proposing to require issuers to discontinue these chronic and high-cost condition plans. Instead, under this proposal, issuers would be permitted to choose whether to discontinue the chronic and high-cost condition plans originally offered through the non-standardized plan option limit exceptions process altogether or continue offering them with either the same or modified cost sharing. Issuers would similarly be permitted to continue offering other non-standardized plan options not associated with the non-standardized plan option limit exceptions process.

Under this proposed approach, if issuers wished to discontinue the chronic and high-cost condition plans originally offered through the exceptions process (or other non-standardized plan options not associated with the non-standardized plan option limit exceptions process) altogether, they would be permitted to do so, and enrollees in these plans would be crosswalked to a different plan in accordance with the crosswalk hierarchy at § 155.335(j). Additionally, if issuers wished to continue offering the chronic and high-cost condition plans originally offered through the exceptions process (or other non-standardized plan options not associated with the non-standardized plan option limit exceptions process) with the same cost sharing structures, they would also be permitted to do so, and enrollees in these plans would continue to be auto-reenrolled in these plans from one plan year to the next. Finally, if issuers wished to continue offering the chronic and high-cost condition plans originally offered through the exceptions process (or other non-standardized plan options not associated with the non-standardized plan option limit exceptions process) but also wished to modify these plans' cost sharing structures, they would be permitted to do so, but these issuers would continue to be subject to the requirements under the definition of ''plan'' at § 144.103 and to the uniform modification requirements at § 147.106.

In most scenarios where an issuer modifies the cost sharing structure of one of its chronic and high-cost condition plans originally offered through the exceptions process (or other non-standardized plan options not associated with the non-standardized plan option limit exceptions process), the newly modified plan that was formerly the exceptions process plan (or other non-standardized plan options not associated with the non-standardized plan option limit exceptions process) would be considered a new plan and would therefore require a new plan ID. In this scenario, enrollees would be crosswalked from the discontinued plan to another plan in accordance with the crosswalk hierarchy at § 155.335(j). These enrollees could be crosswalked into the newly modified plan that was formerly the exceptions process plan, or an entirely different plan altogether, depending on the unique circumstances in each county.

However, under the definition of ''plan'' at § 144.103, a State may permit issuers to make greater changes to a plan's cost sharing while still permitting that plan to be considered the same plan—thus maintaining the same plan ID. Furthermore, pursuant to § 147.106(e)(3)(iv), as long as the variation in cost sharing is solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level (and other applicable requirements under 45 CFR 147.106(e) are met), the modifications could be considered uniform (thus, a viable exception to guaranteed renewability).

In the scenario where an issuer modifies what was formerly an exceptions process plan's (or other non-standardized plan options not associated with the non-standardized plan option limit exceptions process) cost sharing structure while maintaining the same plan ID, those enrolled in the plan would be auto-reenrolled from one plan year to the next. In either case, whether the modification of a former exceptions process plan's cost sharing results in that plan being considered the same or a different plan, enrollees would be crosswalked in accordance with the crosswalk hierarchy at § 155.335(j).

Ultimately, adopting this approach would substantially reduce regulatory complexity and the burden associated with the non-standardized plan option limit and the corresponding exceptions process while simultaneously minimizing the risk of disruption to consumers enrolled in and issuers of the chronic and high-cost condition plans originally offered through the exceptions process (or other non-standardized plan options not associated with the non-standardized plan option limit exceptions process). If issuers did choose to continue offering these plans, either with the same or modified cost sharing structures, they would be able to continue utilizing

existing benefit packages, provider networks, drug lists, and formularies, including those paired with what were formerly the exceptions process plans for PY 2026. This would further minimize burden for these issuers.

We refer readers to the preamble section for the proposal to discontinue standardized plan options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv)) for a detailed discussion of relevant literature we considered in our approach to the proposal to discontinue non-standardized plan option limits and exceptions.

We seek comment on these proposed impact estimates and assumptions.

28. Provider Access Standards for Network Plans (§ 155.1050 and § 156.230)

We propose at § 155.1050(d), for PY 2027 and beyond, to allow FFE States, including States that perform plan management, that elect to do so, to conduct provider access reviews for issuers' plans that use and do not use a provider network, provided that the State demonstrates it has sufficient authority and the technical capacity to conduct such reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program as described at proposed § 155.1050(d)(2) through (d)(4). HHS would continue to conduct network adequacy reviews consistent with § 156.230 for QHP issuers that use a provider network and provider access reviews for QHP issuers that do not use a provider network in FFE States that do not elect to conduct such reviews, or in FFE States that do not demonstrate they have sufficient authority and the technical capacity to conduct such reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program, as described at proposed § 155.1050(d)(2) through (d)(4). Under this proposal, we would continue to collect network adequacy data, including time and distance and appointment wait time data. We would continue collecting this data from all FFE issuers, either to use to conduct Federal network adequacy reviews in FFE States that do not elect to do so or do not demonstrate they have sufficient authority and the technical capacity to conduct these reviews by satisfying the criteria to be considered to have an Effective Provider Access Review Program as described at § 155.1050(d)(2) through (d)(4), or with a view to make it available in a standardized format to States that are determined to have an Effective Provider Access Review Program, to assist them in their network adequacy analysis.

The preceding years of conducting reviews of QHP issuer provider network adequacy, including analyzing issuer submitted data and through discussions with States, issuers and other various interested parties around diverse market conditions, have demonstrated that a one-size-fits-all approach to provider network adequacy review is not satisfactory. For example, issuers have highlighted to us persistent challenges in locating and contracting with enough providers of various specialties (*e.g.,* allergy and immunology, behavioral health, gastroenterology) in remote or difficult to access areas of a State. States have brought to our attention various geographic constraints that impact QHP issuer's ability to satisfy time and distance requirements and have made arguments to assess based on time or distance individually rather than being required to meet a time and distance standard that may be insurmountable due to a topographical constraint such as a body of water or navigating roads in mountainous terrain. Partnerships with States performing plan management, that have elected to conduct their own network adequacy reviews, have highlighted for us how States may innovate in their approach to conducting network adequacy reviews in ways that are sensitive to conditions and capacity in the State. These are among the factors that have led us to revisit our previous approach to defer network adequacy reviews to States as we recognize that a State, with its more intimate knowledge of its own demographics, topographical considerations, and provider supply, is often best positioned to evaluate local provider networks and market conditions and can tailor network adequacy standards in a more nuanced way than the broader Federal Government requirements may. Thus, in recognition of the crucial role States have in developing and enforcing network adequacy standards and because we believe that States are often best positioned to evaluate local provider networks and market conditions, we propose at § 155.1050(d), for PY 2027 and beyond, to allow FFE States, including States that perform plan management, that elect to do so, to conduct provider access reviews for issuers' plans that use and do not use a provider network, provided that HHS determines the State has sufficient authority and the technical capacity to conduct the reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program as described at proposed § 155.1050(d)(2) through (d)(4). In addition, we would continue collecting network adequacy data from all FFE issuers, either to use to conduct Federal network adequacy reviews in FFE States that do not elect to do so, or do not demonstrate they have sufficient authority and the technical capacity to conduct these reviews by satisfying the criteria to be considered to have an Effective Provider Access Review Program as described at § 155.1050(d)(2) through (d)(4), or with a view to make it available in a standardized format to States that are determined to have an Effective Provider Access Review Program, to assist them in their network adequacy analysis.

We do not anticipate any additional costs to the Federal Government as part of this proposal. While HHS still intends to collect data from QHP issuers in States with Effective Provider Access Review Programs, there is the potential for cost savings at the Federal level related to network adequacy reviews during QHP certification if HHS shifts these responsibilities to States that elect to conduct their own reviews. However, this may increase costs in States if they do not already possess capability and resources necessary to conduct sufficient provider access reviews, as well as ensure compliance and appropriate consumer protections. For QHP issuers, this proposal may have reduced administrative costs and efficiency gains. While HHS would still collect network adequacy data from issuers in these States, issuers would not have to undergo network adequacy certification reviews at the Federal level which often requires additional reporting to HHS to address corrections in network adequacy required to meet Federal standards. Additionally, many QHP issuers already have State specific network adequacy requirements with which they must comply to operate plans in the State. Thus, redirecting network adequacy review activities to States, that issuers already need to report to, could streamline the efficiency of the QHP certification process and reduce burden for issuers. However, requiring issuers to submit network adequacy data on both the State and Federal levels could potentially duplicate efforts and increase costs for issuers, though the extent of any administrative burden is uncertain as States may have different data collection and submission requirements, and it is not yet known how FFE States would implement or may change network adequacy data collection as part of an Effective Provider Access Review

Program and if existing data collection processes already exist or need to be modified to support requirements under proposed § 155.1050(d).

Regarding Federalism implications of this proposal, the Affordable Care Act does not require States to establish and enforce network adequacy certification criteria and review programs for QHP issuers; if a State elects not to establish any of these programs or is not approved to do so, HHS must establish and operate the programs in that State. As part of this proposal, we would not require that States elect to conduct provider access certification reviews as part of an Effective Provider Access Review Program. Rather, we propose to allow States flexibility to conduct provider access certification reviews, should they choose, provided they have sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria in proposed § 155.1050(d)(2) through (d)(4).

We seek comment on these proposed impact estimates and assumptions.

29. Essential Community Provider Standards (§ 155.1051 and § 156.235)

ECP requirements under the General Standard at § 156.235(a)(2)(i) specify that a plan applying for QHP certification to be offered through a FFE must demonstrate in its QHP application that the issuer's provider network includes as participating providers at least a minimum percentage, as specified by HHS, of available ECPs in each plan's service area collectively across all ECP categories defined under § 156.235(a)(2)(ii)(B), and at least a minimum percentage of available ECPs in each plan's service area within certain individual ECP categories, as specified by HHS. Alternate Standard issuers must demonstrate similar minimum percentage requirements as described at § 156.235(b)(2)(i). For PY 2014, we set this minimum percentage at 20 percent and increased the minimum percentage to 30 percent for PY 2015. For QHP certification for PY 2018 and through the end of PY 2022, we returned to the percentage used in PY 2014, and to again consider the issuer to have satisfied the threshold requirement if the issuer contracted with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network. We increased the minimum percentage to 35 percent starting in PY 2023 and required issuers to separately meet 35 percent minimum percentage requirements within two standalone ECP categories, FQHCs and family planning providers, as finalized in the PY 2024 Payment Notice. In this proposed rule, we propose to consider medical QHP and SADP issuers to have satisfied minimum percentage requirements under § 156.235(a)(2)(i) and (b)(2)(i) if they contract with at least 20 percent of available ECPs in each plan's service area collectively across all ECP categories defined under § 156.235(a)(2)(ii)(B), they contract with at least 20 percent of available FQHCs that qualify as ECPs in each plan's service area, and they contract with at least 20 percent of available family planning providers that qualify as ECPs in the plan's service area (medical QHPs only) to participate in the plan's provider network. We believe reverting to the previous 20 percent minimum percentage that issuers were accustomed to for PY 2014 and PY 2018 through 2022 would result in minimal disruptions for issuers in adjusting to meet the threshold requirements based on previous analyses of ECP data that have identified that the majority of issuers exceed the minimum percentage requirement within their provider networks. For example, for PY 2026, the average threshold percentage for all FFE issuers, including issuers in States performing plan management, for the overall ECP requirement was 71 percent, for the family planning provider requirement was 85 percent, and for the FQHC requirement was 79 percent despite the minimum percentage being set at 35 percent. We believe that reducing the overall threshold requirement, FQHC threshold requirement, and family planning provider threshold requirement from 35 to 20 percent would minimally impact the majority of QHP issuers, while allowing issuers the opportunity and flexibility to build provider networks that comply with the ECP Standard under § 156.235.

We anticipate several potential impacts associated with these proposed changes to return minimum percentage requirements described under §§ 156.235(a)(2)(i) and (b)(2)(i) back to 20 percent. Less expansive requirements for network size would lead to both costs to consumers and cost savings to issuers. Costs could take the form of increased travel time and wait time for appointments or reductions in continuity of care for those patients whose providers have been removed from their insurance networks. Cost savings for issuers would be associated with reductions in administrative costs of arranging contracts, meeting higher QHP certification requirements for ECP Standards, and, if issuers focus their networks on relatively fewer providers to the extent possible, reductions in the cost of providing health care. Potential cost savings from reduced administrative burden for issuers may also be passed on to consumers through lower premium rates.

Additionally, we propose to modify the narrative justification requirement under §§ 156.235(a)(3) and 156.235(b) to make the language more consistent with current operations and data submission requirements for ECP certification reviews. As part of the narrative justification requirements, an issuer applying for QHP certification that is not meeting the ECP standard under § 156.235 has to include as part of its QHP application a written open-ended narrative describing how the issuer's provider network as currently designed would provide an adequate level of service for individuals residing in low-income zip codes or Health Professional Shortage Areas within the plan's service area, and how the issuer would strengthen the plan's provider network in future years. We have instituted multiple refinements and modernizations to the justification process over time, and recently in PY 2025, leveraged information technology to embed justification related information (for example, contract statuses) into the new ECP User Interface (UI) in the MPMS. In alignment with this modernization that now allows issuers to easily select and report the contract status of ECPs included within their networks or who are being recruited into their networks, we propose to modify §§ 156.235(a)(3) and 156.235(b) to instead designate that a network plan applying for QHP certification to be offered through a FFE must include as part of its QHP application the status of contract offers to qualified ECPs available in the network plan's service area. A network plan would not need to report on the status of contract offers for all available ECPs in the network plan's service area but should at least report on the status of contract offers for all ECPs which the issuer has either included in its network plan or offered a contract to be included in its network plan within each service area.

We believe these changes to the narrative justification requirements at §§ 156.235(a)(3) and 156.235(b) would not have meaningful impacts to issuers since these amendments would reflect current ECP data submission requirements that have been in place since PY 2025. Issuers would continue to upload ECP data into MPMS and complete required fields within the ECP UI, including selecting or importing

ECPs included within their networks and designating the status of their contract offers. Although this proposed language does not modify current requirements as part of ECP certification reviews, it would reflect modernizations to the ECP data collection process that have introduced significant program efficiencies that have improved data quality, and effectively reduced the time, resources, and administrative costs required by issuers to submit supporting justification documentation for meeting the ECP standard under § 156.235.

Furthermore, we propose at § 155.1051 to allow FFE States, including States performing plan management, to elect to perform their own State reviews of issuer-submitted ECP data provided the State demonstrates it has sufficient legal authority and the technical capacity to conduct these reviews by meeting the applicable criteria determined by HHS to be considered to have an Effective ECP Review Program under proposed § 155.1051. We propose that FFE States must ensure that a QHP with a provider network includes in its provider network a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the Exchange's network adequacy standards. In addition, we propose that FFE States must also ensure that a non-network plan applying for certification as a QHP to be offered through an FFE demonstrates that it provides reasonable and timely access to ECPs that accept the plan's benefit amount as payment in full to ensure that services will be accessible without unreasonable delay. We also propose that FFE States must have established ECP requirements that are set forth in State statute or regulation. And we propose that at a minimum, FFE States must demonstrate that these established ECP requirements are comparable to ECP requirements described under § 156.235 for issuers with a provider network and under proposed § 156.236 for issuers without a provider network to promote a sufficient number and geographic distribution of ECPs, but that those FFE States with alternative ECP requirements must demonstrate how those requirements would promote a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to ECPs. At proposed § 155.1051(e), we also set forth factors that HHS would consider in its review to determine if an FFE State has an Effective ECP Review Program. Additionally, we clarify that HHS would still be available to provide technical assistance and various resources to FFE States, including that we would continue collecting ECP data from FFE issuers in States with an Effective ECP Review Program with the goal of providing this data in a standardized format to FFE States that could inform additional assessments of access to ECPs across the State and assisting FFE States that may require additional support due to more limited resources.

We anticipate several potential impacts associated with these proposed changes to implement the Effective ECP Review Program provisions at proposed § 155.1051. First, while we believe that predominately collecting and reviewing ECP data on the Federal level as part of QHP certification for issuers across the FFE has helped ensure that issuers include a sufficient number and geographic distribution of ECPs within their networks, we believe providing FFE States more flexibility and authority to conduct their own ECP certification reviews may deliver quality improvements to the review process. We acknowledge that States possess unique knowledge on local and contextual factors, such as on market conditions, geographic constraints, and areas in the State with limited economic resources, provider shortages, workforce issues, and population demographics. FFE States may incorporate these various factors to tailor their ECP certification reviews and apply ECP certification results to more directly address State-specific challenges for consumers as it pertains to ECP access, which is more difficult to accomplish at the Federal level with a one-size-fits all approach for all States. In addition, continuing to leverage Federal infrastructure to collect ECP data from issuers in FFE States with an Effective ECP Review Program would create opportunities for a State-Federal partnership where HHS could provide data in a standardized format to States to inform their ECP certification reviews and provide support to FFE States that require additional assistance.

Additionally, we presume there are several cost related implications of this proposal. We do not anticipate any additional costs to the Federal Government as part of this proposal. While HHS still intends to collect data from QHP issuers in FFE States with Effective ECP Review Programs, there is still the potential for cost savings at the Federal level as it pertains to reviewing such ECP data during QHP certification and taking enforcement actions against QHP issuers after QHP certification as part of compliance if HHS shifts these responsibilities to FFE States that elect to conduct their own reviews of issuers as part of the Effective ECP Review Program. Though, in turn, this may increase costs among FFE States if they do not already possess the capability and resources to conduct complex, data-intensive ECP certification reviews and enforcement actions against issuers that neglect to meet ECP requirements. For QHP issuers, this proposal may have reduced administrative costs and efficiency gains. While HHS would still collect ECP data from issuers in these FFE States, issuers would not have to undergo intensive ECP certification reviews at the Federal level which often requires coordination with HHS to address corrections in ECP data until ECP requirements are met. Also, many QHP issuers already need to coordinate with FFE States to meet various requirements to operate plans in the State. Thus, redirecting ECP review activities to FFE States that issuers already need to coordinate with could further streamline the efficiency of the QHP certification process. However, requiring issuers to submit ECP data on both the State and Federal levels could potentially duplicate both effort and costs among issuers, but the extent of this administrative burden is uncertain as States likely have different data collection and submission requirements, and it is not yet known how FFE States will implement ECP data collection as part of the Effective ECP Review Program and if existing data collection processes already exist or need to be developed to support requirements under proposed § 155.1051.

Lastly, as it pertains to Federalism implications of this proposal, the Affordable Care Act does not require FFE States to establish and enforce ECP certification criteria and review programs for QHP issuers; if an FFE State elects not to establish any of these programs or is not approved to do so, HHS must establish and operate the programs in that State. As part of this proposal, we would not require that FFE States elect to conduct ECP certification reviews as part of the Effective ECP Review Program. Rather, we propose additional flexibilities to allow FFE States with the desire to conduct ECP certification reviews to have an opportunity to do so, provided they have sufficient authority and the technical capacity to conduct these reviews by meeting the applicable criteria in proposed § 155.1051. Thus, FFE States that elect to perform their ECP certification reviews and undergo

HHS' determination process for assessing if an FFE State has an Effective ECP Review Program would be willingly assuming this responsibility.

30. QHP Certification of Non-Network Plans (§ 156.236)

We propose a number of revisions to part 155 and part 156 to allow plans that do not use a network (non-network plans) to obtain QHP certification by demonstrating sufficient access to a broad range of providers in a manner consistent with sections 1311(c)(1)(B) and (C) of the Affordable Care Act. This proposal would not require States to approve non-network plans for sale nor would it require Exchanges to certify such plans. States that do not approve non-network plans as QHPs would see no impact under this proposal. The following impact analysis applies only to States that decide to approve such plans as QHPs.

Non-network plans may typically attract healthier enrollees who are generally more willing and able to engage in a sufficient number of price negotiations with providers to benefit from the value a non-network plan can provide. Conversely, individuals requiring frequent care may prefer enrolling in network plans to avoid the need to conduct price negotiations for a greater volume of needed care. This, in turn, naturally leads to favorable risk selection in non-network plans. Consequently, under this proposal, non-network plans should anticipate and budget for risk adjustment transfers in their premium calculations, at least to the extent that the issuers of such plans do not already have sufficient reserves at hand to be able to pay an expected high risk adjustment transfer amount.

This dynamic also means that non-network plans may tend to have lower premiums than network plans, so we would expect that they would tend to be among the least expensive plans in a particular area. This could affect premium tax credits to the extent that non-network plans are the lowest and/or second-lowest cost silver plan in that area.

We seek comment on these proposed impact estimates and assumptions.

31. Amendments To Strengthen HHS' Oversight of the Administration of the Advanced Payments of the Premium Tax Credit, Cost-Sharing Reductions, and User Fee Programs and Clarifying HHS' Compliance Review Authority (§ 156.480)

We propose to modify § 156.480 to clarify HHS' authority to audit or conduct a compliance review to assess issuers' compliance with requirements related to the APTC, CSR, and user fee programs. Specifically, we propose clarifying that under § 156.480(c), HHS or its designee may audit or conduct a compliance review to assess compliance with all requirements related to APTC, CSR, and user fee programs applicable to issuers offering a QHP in an Exchange. For consistency, we also propose to make conforming changes to § 156.480(c)(6) to provide that in instances where HHS enforces compliance with any requirements related to APTC, CSR, and user fee programs with respect to QHP issuers participating in State Exchanges or SBE–FPs, HHS may do so in accordance with § 156.805. We also propose clarifying that the compliance review authority in § 156.480(c) allows for compliance reviews as needed or on an annual basis.

We estimate that the audits that we would conduct under this authority would not impose additional costs beyond what is already accounted for in the audit review process (86 FR 24140, 24281). We estimate that we would conduct compliance reviews under this authority to address systemic issues for approximately 150 issuers each year. We estimate that it would take a business operations specialist 10 hours (at a rate of $44.41 per hour) to compile and submit data and other information necessary for a compliance review. We estimate it would take a compliance officer (at a rate of $40.86 per hour) 4 hours to review and sign off on the submission. The cost per issuer to develop and submit the compliance information would be approximately $607.54.

The total annual cost to issuers undergoing compliance reviews would be approximately $91,131 ($607.54 x 150 issuers) beginning in 2026. However, conducting compliance reviews on an as needed or annual basis if determined appropriate by HHS to assess issuer compliance with requirements related to the APTC programs may reduce the amount of APTC overpayments and result in HHS recouping those overpayments. Further, this additional information could assist issuers in correcting their data for APTC payments not received in advance of the three-year window, after which HHS only recoups overpayments.[255] While there would be some Federal costs to conduct the compliance reviews, we expect benefits of more accurate APTC reconciliation and payment adjustments to outweigh the costs.

We seek comment on these proposed impact estimates and assumptions.

32. Amendments to Factors Considered in Determining the Amount of Civil Money Penalties (CMPs) and HHS' Authority To Impose CMPs Against Issuers in State Exchanges or SBE–FPs (§ 156.805)

We propose to amend § 156.805 to reiterate what HHS considers when imposing CMPs as enforcement remedies against QHP issuers in Exchanges. Specifically, we propose to amend § 156.805(b) to provide that HHS, in determining the amount of CMPs, will identify the lawful purpose or purposes of the CMP.

We also propose to clarify the authority HHS has to impose CMPs against issuers in State Exchanges and SBE–FPs for identified violations. Specifically, we propose to amend § 156.805(f) to clarify that, when HHS' authority to enforce requirements in State Exchanges and SBE–FPs is triggered, HHS may impose CMPs against issuers in State Exchanges and SBE–FPs for violations of requirements applicable to the noncompliant actions described in § 156.805(a) that are applicable to issuers offering a QHP in a State Exchange or SBE–FP.

We do not believe that the proposed amendments would impose substantial additional costs to HHS beyond the costs that are already accounted for as part of the existing bases and process for imposing CMPs in the FFE, State Exchanges, and SBE–FPs. This is an existing policy that already applies broadly to those issuers participating on the Exchange and since this amendment does not independently add any new requirements for any issuer in an Exchange, we believe that the burden associated with it is already covered by existing requirements in § 156.805. Therefore, we do not believe there would be additional burden to issuers under this proposal. The burden associated with these requirements is the time and effort necessary to draft and submit audit reports that form the basis for subsequent CMP assessments. While these requirements do impose burdens, data collection requirements associated with imposing CMPs on QHP issuers in an Exchange are exempt from PRA requirements in accordance with 44 U.S.C. 3518(c)(1)(B)(ii), as effectuated

[255] Plan year data inaccuracies described to HHS or the State Exchange (as applicable) before the end of the 3-year period beginning at the end of the plan year are eligible for resolution and payment to the issuer of any confirmed APTC underpayments. Data inaccuracies identified after the 3-year period are not eligible for repayment to the issuer. However, should an issuer identify a payment error after the 3-year period, the issuer must notify HHS or the State Exchange (as applicable) and repay any overpayments. *See* 45 CFR 156.1210(c).

through 5 CFR 1320.4(a)(2), because this information would be collected during the conduct of an administrative action or investigation involving an agency against specific individuals or entities.

On balance, we anticipate that this proposal would streamline our compliance and enforcement processes and limit the administrative burden for evaluating Exchange standards and requirements applicable to issuers offering QHPs participating in Exchanges.

We seek comment on these proposed impact estimates and assumptions.

33. Amendments to the Administrative Review of QHP Issuer Sanctions (§§ 156.903 and 156.935)

We propose to amend to § 156.903 to provide that an ALJ presiding over an appeal of a sanction imposed in accordance with § 156.805 may issue subpoenas, upon his or her own motion or at the request of a party, if they are reasonably necessary for the full presentation of a case and to add procedures governing the process for issuing subpoenas. We also propose to amend § 156.935 to ensure that the discovery provisions set forth therein do not apply to appeals of proposed CMPs to be assessed under § 156.805 that result from violations identified in audits under § 156.480(c).

We do not believe that the proposed amendments would impose additional costs to HHS beyond what is currently accounted for in appeals to the DAB. The DAB's procedures include subpoena procedures which follow the procedures established by a program's regulations. We also do not believe the proposed amendments to exclude appeals of CMPs to be assessed under § 156.805 that result from violations identified in audits under § 156.480(c) from discovery would impose additional costs on HHS or issuers as both parties would be able to provide and obtain information during the audit and informal refutation process and obtain publicly available information that would help to develop a record for appeal.

We seek comment on these proposed impact estimates and assumptions.

34. Quality Improvement Strategy (§ 156.1130)

As discussed in section IV.U of this proposed rule, there is no information collection associated with this proposed policy and no changes were proposed to the QIS data collection requirements applicable to QHP issuers.

We seek comment on this proposed impact estimate and assumption.

35. Amendments to Netting Regulations To Include Netting of CMPs (§ 156.1215)

We propose to amend the payment and collections processes set forth at § 156.1215(b) to provide that any CMPs assessed against health insurance issuers for violations of any applicable Exchange standards and requirements or PHSA requirements applicable health insurance issuers, would be subject to netting as part of HHS' integrated monthly payment and collections cycle. We also propose to amend § 156.1215(c) to provide that any amount owed to the Federal Government by an issuer and its affiliates for unpaid CMP amounts, after HHS nets amounts owed by the Federal Government under these program affiliates, would be the basis for calculating the determination of the debt.

We do not believe that the proposed amendments would impose additional costs to HHS beyond costs that are already accounted for as part of the existing payment and collections process. The existing payment and collection process uses netting as one means to collect debts from health insurance issuers. The proposed amendments provide that HHS would utilize the existing process to collect unpaid amounts for CMPs assessed against issuers and their affiliates operating under the same tax identification number that are already subject to netting. This proposal also reduces the number of payments and charges flowing back and forth between HHS and issuers, allowing for more efficient collections.

Therefore, we anticipate this proposal would streamline the payments and collections processes and limit the administrative burden for operating our programs.

We seek comment on these proposed impact estimates and assumptions.

36. Regulatory Review Cost Estimation

Due to the uncertainty involved with accurately quantifying the number of entities that would review the rule, we assume that the mid-point between the total number of unique commenters on the 2026 Payment Notice proposed rule (269) and the number of page views on the **Federal Register** website during the comment period for that rule (15,824) would be the approximate number of reviewers (8,046) of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed last year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons, we thought that the mid-point of unique commenters and page views would be a fair estimate of the number of reviewers of this rule. We welcome any comments on the approach in estimating the number of entities which would review this proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate, we assume that each reviewer reads approximately 50 percent of the rule. We seek comments on this assumption.

Using the wage information from the BLS for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this final rule is $113.42 per hour, including overhead and fringe benefits.[256] Assuming an average reading speed of 250 words per minute, we estimate that it would take approximately 6.54 hours for the staff to review half of this proposed rule. For each entity that reviews the rule, the estimated cost is $741.77 (6.54 hours × $113.42). Therefore, we estimate that the total cost of reviewing this regulation is approximately $5,968,281.42 ($741.77 × 8,046 reviewers).

We seek comment on these estimates and assumptions.

37. Overall Impact of the Proposed Payment Notice Individual Provisions

In the regulatory impact analysis of this proposed rule, we include impact analyses and estimates for each proposal separately, as we intend for each provision to be severable from the rest. Please see section III.G for a more detailed discussion on the severability of the provisions of this rule. However, we anticipate that the provisions of this proposed rule, while severable, may work in concert with each other and affect many of the same individuals seeking coverage through the individual health insurance market. Therefore, the overall impact of this proposed rule would likely be less than the simple accumulation of the individual provisions' impact analyses. To the best of our ability, we provide overall impact estimates of these provisions with respect to enrollment, premiums, and APTC, that minimize the overlap of individuals affected.

The baseline starts with internal CMS data of enrollment by month, premiums, and APTCs, we summarize the data using average monthly amounts. These

[256] U.S. Bureau of Labor Statistics. (n.d.). Occupational Employment and Wage Statistics. Dep't. of Labor. *https://www.bls.gov/oes/current/oes_nat.htm.*

monthly averages are projected throughout the year using historical monthly patterns during a similar environment. For future years, the enrollment is trended by the projected growth in the under age 65 population. Spending amounts are trended using projected growth in NHEA less Medicare. While the expiration of enhanced subsidies is considered in baseline enrollment numbers, it is important to note effectuated enrollment numbers are unavailable at this time.

Based on the analysis presented thus far in this section, we expect average enrollment for 2027 to decrease between 1.2 and 2 million enrollees compared to baseline estimates. Many enrollees will lose coverage due to no longer being eligible for subsidies, and we believe it is likely that healthier enrollees are more likely to discontinue coverage. We have assumed a 2 percent increase in premiums in the scenario where 1.2 million enrollees leave the market and a 3 percent premium increase if 2.0 million enrollees exit the market.

These increases are offset by efforts to improve the health of the risk pool by removing opportunities for adverse selection with removal of an SEP for those under 150 percent FPL and with adding pre-enrollment SEP verification. With loss of enhanced subsidies and an increase in the member shared responsibility payment, an enrollment option always being available encourages healthier individuals to forgo coverage and wait until they are sick to enroll in an Affordable Care Act plan. These policies help mitigate that risk. We assume a 3percent premium reduction for removal of the under 150 percent FPL SEP and a 0.5 percent reduction for SEP verification in the 1.2 million enrollment scenario. We assume a 4 percent premium reduction for removal of the under 150 percent FPL SEP and a 0.8 percent reduction for SEP verification in the 2 million enrollment scenario. Overall, after accounting for these premium reductions, rates are expected to be 1.5 percent lower in the 1.2 million enrollment scenario and 1.8 percent lower in the 2 million enrollment scenario compared to the baseline scenario before normal premium trends.

For the 1.2 million enrollment scenario, premium trend is estimated to increase by 4.5 percent for 2027 and increase at 4 percent the following years. Premium trend is estimated to increase 6 percent for 2027 and 4.5 percent in the following years for the 2 million enrollment scenario. Starting with a 2026 premium PMPM of $736.36 and applying the adjustments mentioned above, we arrive at estimated premium PMPMs of $758.45 in the 1.2 million enrollment scenario and $767.29 in the 2 million enrollment scenario [736.36 * (1 + 0.045 + 0.02 − 0.03 − 0.005) = 758.45 and 736.36 * (1 + 0.06 + 0.03 − 0.04 − 0.008) = 767.29]. We assume APTC PMPMs will be approximately 88.5 percent of premium PMPMs, leading to projected 2027 APTC PMPMs of $671.23 for the 1.2 million enrollment scenario and $679.05 for the 2 million enrollment scenario (758.45 * 0.885 = 671.23 and 767.29 * 0.885 = 679.05).

Future enrollment is expected to shrink by 2.3 percent for 2028 as these policies continue to take full effect. We estimate modest enrollment increases of 0.3 percent for 2029 and 0.03 percent for 2030.

TABLE 26: Overall Enrollment and APTC Impacts – Lower Bound Estimates

1.2 Million Enrollment Decrease Scenario							
	Calendar Year	2026	2027	2028	2029	2030	2026-2030
Baseline	Total Enrollment (Millions)	17.710	17.729	16.484	16.527	16.532	84.981
	APTC Enrollment (Millions)	15.979	15.957	14.701	14.719	14.711	76.067
	Premium ($Billions)	156.491	162.599	156.873	164.414	172.577	812.954
	APTC ($Billions)	124.841	125.785	124.434	128.317	134.514	637.891
NBPP Rule	Total Enrollment (Millions)	17.710	16.529	16.149	16.191	16.196	82.775
	APTC Enrollment (Millions)	15.979	14.877	14.402	14.420	14.412	74.090
	Premium ($Billions)	156.491	150.436	152.855	159.382	165.813	784.978
	APTC ($Billions)	124.841	119.830	121.247	124.390	129.241	619.551
Changes	Total Enrollment (Millions)	0.000	-1.200	-0.335	-0.336	-0.336	-2.207
	APTC Enrollment (Millions)	0.000	-1.080	-0.299	-0.299	-0.299	-1.977
	Premium ($Billions)	0.000	-12.163	-4.017	-5.031	-6.764	-27.976
	APTC ($Billions)	0.000	-5.955	-3.187	-3.927	-5.272	-18.340

TABLE 27: Overall Enrollment and APTC Impacts – Upper Bound Estimates

2 Million Enrollment Decrease Scenario							
	Calendar Year	2026	2027	2028	2029	2030	2026-2030
Baseline	Total Enrollment (Millions)	17.710	17.729	16.484	16.527	16.532	84.981
	APTC Enrollment (Millions)	15.979	15.957	14.701	14.719	14.711	76.067
	Premium ($Billions)	156.491	162.599	156.873	164.414	172.577	812.954
	APTC ($Billions)	124.841	125.785	124.434	128.317	134.514	637.891
NBPP Rule	Total Enrollment (Millions)	17.710	15.729	15.367	15.407	15.412	79.626
	APTC Enrollment (Millions)	15.979	14.157	13.705	13.722	13.715	71.278
	Premium ($Billions)	156.491	144.823	147.859	154.914	161.940	766.027
	APTC ($Billions)	124.841	115.359	117.285	120.903	126.222	604.610
Changes	Total Enrollment (Millions)	0.000	-2.000	-1.117	-1.119	-1.120	-5.356
	APTC Enrollment (Millions)	0.000	-1.800	-0.996	-0.997	-0.996	-4.789
	Premium ($Billions)	0.000	-17.776	-9.013	-9.500	-10.638	-46.927
	APTC ($Billions)	0.000	-10.426	-7.149	-7.414	-8.292	-33.281

38. Regulatory Impact Considerations Regarding City of Columbus v. Kennedy

This proposed rule proposes updates to policies that were previously finalized with an earlier effective date in the 2025 Marketplace Integrity and Affordability final rule (90 FR 27074), including § 155.305(f)(4) Failure to File and Reconcile (FTR), § 155.320(c)(3)(iii) Income Verification when Data Sources Indicate Income Less than 100 Percent of the FPL, § 155.320(c)(5) Income Verification When Tax Data is Unavailable, and § 155.420(g) Pre-Enrollment Special Enrollment Period Verification. Although these policies were initially finalized in the 2025 Marketplace Integrity and Affordability final rule with a sunsetting at the end of PY 2026, they are currently stayed by the court.[257]

While we cannot postulate on active judicial proceedings, we have considered the regulatory impact if this stay was lifted and these provisions from the 2025 Marketplace Integrity and Affordability final rule became effective. If the stay is lifted in PY 2026, these provisions may become effective in PY 2026, but there still may be an operational delay in effectuating the policies. If the provisions become effective in PY 2026, the regulatory impacts that were estimated in the 2025 Marketplace Integrity and Affordability final rule would be in effect for PY 2026. From PY 2027, the ongoing regulatory impacts that are estimated in this proposed rule would be in effect. Any costs to sunset the provisions that were estimated in the 2025 Marketplace Integrity and Affordability final rule would be nullified if this proposed rule is finalized as proposed because the policies would continue beyond PY 2026. We do not anticipate additional impacts beyond what has been estimated in the 2025 Marketplace Integrity and Affordability final rule and this proposed rule. If the court stay is lifted after PY 2026 and this rule is finalized as proposed, we do not anticipate additional regulatory impacts from the court decision, as the policies in this proposed rule would be in effect, and we have estimated the regulatory impacts under the relevant provisions in this proposed rule.

Due to the uncertainties mentioned above, we are unable to further quantify the impact regarding the active court proceedings. We seek comment on these proposed estimates and assumptions.

D. Regulatory Alternatives Considered

CMS created a Frequently Asked Questions (FAQ) document to help address the issue of what is considered ''taking an action'' as it relates to regulatory requirements for creating documentation related to eligibility

[257] See *City of Columbus* v. *Kennedy,* 796 F. Supp. 3d at 170.

application review and consumer consent, as per § 155.220(j)(2)(ii)(A) and (j)(3)(iii)(A), respectively. However, adding this language solely to sub-regulatory guidance, such as an FAQ, would not provide HHS with the necessary enforcement authority when we are reviewing documentation submitted by agents/brokers related to documenting consumer eligibility application requirements and consent documentation. Therefore, it was determined that updating the regulations in § 155.220 was necessary.

When developing the proposal to expand the marketing regulations to improve our enforcement authority related to misleading marketing, we considered creating an FAQ document to notify agents, brokers, and web-brokers of certain prohibited behaviors related to marketing practices. However, adding this language solely to sub-regulatory guidance, such as an FAQ document, would not provide HHS with the necessary enforcement authority when we discover misleading marketing. Therefore, it was determined that updating the regulations in § 155.220 was necessary.

In developing the SEIPM policies contained in this proposed rule (§ 155.1600), we considered the lessons learned while implementing IPPTA. During IPPTA, HHS engaged with 19 State Exchanges to test measurement processes. We considered several data collection options and chose the primary option as that which provides the greatest amount of reliability and flexibility in providing the data that supports the payment decisions and calculations of APTC made by State Exchanges.

In regard to the proposed SEIPM, HHS considered several alternative approaches. For the implementation timeline, HHS considered alternative implementation timelines for SEIPM beyond the proposed January 1, 2027 effective date. Alternatives for extending the implementation timeline to 2028 or 2029 were considered as they would have provided HHS the window to evaluate all of the results from IPPTA as well as afford State Exchanges with additional preparation time. Delaying the implementation beyond 2027 would delay HHS' ability to meet PIIA requirements for comprehensive improper payment measurement across all APTC programs. The proposed January 2027 effective date balances the need for adequate State Exchange preparation time with Federal statutory obligations, particularly given the foundational framework established through the IPPTA with the large bulk of operational processes associated with collecting information from the State Exchanges being completed. IPPTA will continue through the end of 2026 and we will continue to assess lessons learned for incorporation into the SEIPM implementation.

For the data collection requirements, HHS evaluated alternate approaches that would have required more limited data submissions from State Exchanges. One alternative considered was limiting data collection to only basic enrollment and payment information, which would have reduced State Exchange burden but would not have provided sufficient detail to conduct comprehensive improper payment reviews that meet PIIA standards. For sampling methodology, HHS considered alternative approaches to the proposed stratified random sampling methodology. One alternative considered was using a simple random sampling approach without stratification, which would have been easier to implement but would have been less efficient in detecting errors and would have required larger sample sizes to achieve the same level of statistical precision. HHS also considered implementing a static sample size approach that would have applied the same sample size across all State Exchanges regardless of their APTC volume or operational characteristics. While this approach would have simplified program administration and ensured consistent measurement effort across all participating Exchanges, it would have resulted in imprecise estimates for smaller State Exchanges and inefficient resource allocation for larger Exchanges, failing to optimize statistical precision relative to program risk and Federal investment. HHS also evaluated implementing more prescriptive enforcement mechanisms with automatic penalties for noncompliance but determined that the proposed graduated enforcement approach with due process protections and opportunities for corrective action better supports the collaborative relationship necessary for successful program implementation while maintaining appropriate accountability for State Exchange compliance with Federal oversight requirements.

Finally, in considering the proposed SEIPM, we evaluated the option of publishing individual rates for each SBE, rather than an aggregate rate for all State Exchanges. Achieving an appropriate level of precision (that is, a margin of error less than +/− 5 percent) for such an approach, however, would require doubling the sample sizes used which would incur an additional $25 million Federal and $1.5 million State cost annually. Therefore, we did not adopt this approach.

In considering proposed modifications to the programmatic audit requirements under § 155.1200(c), HHS evaluated several alternatives. These included maintaining the existing audit requirement for State Exchanges that complete the SEIPM for a given benefit year, as well as allowing SEIPM to fully satisfy the audit requirement under § 155.1200. Maintaining the current audit requirement would have resulted in duplicative reviews and increased administrative burden for State Exchanges, while allowing SEIPM to replace the audit entirely would have reduced the comprehensiveness of oversight currently provided.

In developing this proposal to require issuers that make plan-level adjustments to account for unreimbursed CSRs to submit specified CSR data elements in the URRT and Actuarial Memorandum, HHS considered several alternative approaches. One alternative considered was to maintain the current policy as outlined in the 2025 Rate Filing Guidance, which would have continued to rely on reporting of CSR-related information in the Actuarial Memorandum without adding explicit URRT fields. However, this approach would not have achieved the policy goal of ensuring consistency and comparability across issuers and States in the reporting of CSR load methodologies and amounts. HHS also considered permitting issuers to use alternative or simplified methodologies for estimating CSR amounts paid on behalf of enrollees, leveraging existing internal calculations that may vary by issuer. While this approach could have reduced issuer burden, it would have resulted in inconsistent data and limited the ability of State and Federal regulators to assess whether CSR load adjustments are actuarially justified. Finally, HHS considered not requiring submission of CSR data at all, leaving such determinations entirely to State review processes. However, this would not have provided HHS and State regulators with standardized, plan-level information needed to ensure transparency and regulatory oversight of CSR loading practices. The proposed approach—requiring consistent data reporting through the URRT and Actuarial Memorandum using the standard methodology under § 156.430(c)(2)—balances the need for improved data comparability and regulatory oversight with the goal of minimizing additional issuer burden by leveraging existing data and familiar calculation methodologies.

We considered maintaining the vendor program, which would allow the opportunity for approved third-party vendors to facilitate agent and broker annual registration and training in addition to having the training and registration process available through the CMS Marketplace Learning Management System (MLMS), but determined the proposed benefits of terminating the vendor program outweighs the costs of maintaining the existing policy with both programs. As such, we did not consider other regulatory alternatives, as removing § 155.222, which would allow HHS to sunset the vendor program, would maintain agent and broker accessibility to training and registration while reducing costs.

We considered a range of regulatory alternatives for the proposal to discontinue the full suite of standardized plan options policies effective beginning in PY 2027. Under the current proposal, we propose to remove the following from our regulations: the definition of ''standardized option'' at § 155.20; all requirements pertaining to standardized plan options at § 156.201 (the requirements for FFE and SBE–FP QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one another at paragraph (c)); the differential display of standardized plan options on *HealthCare.gov* at § 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE–FP at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv), and non-standardized plan option limits and exceptions at § 156.202. Finally, we propose to cease the annual design and publication of these plans in the applicable Payment Notice rulemaking for each plan year.

That said, we considered several regulatory alternatives that could potentially allow us to achieve the same goals of simplifying the plan selection process and reducing burden without discontinuing this suite of policies in its entirety. In particular, we considered continuing to require issuers to offer standardized plan options but only at particular metal levels, such as the bronze and silver metal levels (instead of at every metal level at which they offer non-standardized plan options). We also considered requiring issuers to offer standardized plan options only in certain service areas in which they offer a certain number of non-standardized plan options. We also considered transitioning from requiring issuers to offer these standardized plan options to once more allowing issuers to voluntarily offer them—as was the approach with the previous iteration of the policy—while we continue to maintain the differential display of these plans on *HealthCare.gov* and the DE pathways. We also considered resuming a revised version of the meaningful difference standard, which was previously codified at § 156.298.

However, based on our experience administering this suite of policies from PY 2023 through PY 2025, we have determined that this suite of policies has failed to meaningfully enhance the consumer experience, increase consumer understanding, and simplify the plan selection process—our originally articulated objectives. Furthermore, imposing these requirements has increased burden for both issuers and HHS (for example, by requiring issuers to create and submit certification applications for additional plans), impeded issuer innovation in plan design, unnecessarily constrained consumer choice, and caused significant market disruption.

Additionally, based on our experience administering the previous iteration of this suite of policies from PY 2017 through 2019 (when standardized plan options were voluntary and when there was no non-standardized plan option limit), we do not believe it would be an effective approach to once more revert to making it voluntary for issuers to offer these plans. This is primarily because when there was no requirement for issuers to offer these plans, few issuers chose to offer them, and fewer consumers chose to enroll in them.

Furthermore, we do not believe HHS is positioned to impose a ''one size fits all'' approach standardized plan option designs for an environment as heterogenous as the FFEs (such as in terms of consumer demographics, health care needs, and preferences). We refer readers to the preamble section for the proposal to discontinue standardized plan options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv)) for a detailed discussion of relevant literature we considered in our proposal to discontinue the full suite of standardized plan option limits policies.

Finally, given that we previously discontinued standardized plan options at a time when the individual market was considered to be at risk of destabilization, and given that there are a range of substantive changes in the present environment, we believe that now is not an appropriate time to once again add to that complexity.

We considered making the provisions requiring income verification when tax data is unavailable and income verification when trusted data sources indicate income less than 100 percent of the FPL optional for State Exchanges that demonstrate improper payment rates (that is, SEIPM) below the Federal rate (that is, FEIPM). Under the current proposal, we propose to impose these requirements on all Exchanges starting in PY 2027. We considered this regulatory alternative in light of the fact that some analysis [258] has shown that erroneous or improper enrollments are less widespread in State Exchanges than in Exchanges on the Federal platform and due to the significant annual administrative costs (that is, a combined $75 million annually) that would be incurred by States in implementing these provisions. Under this regulatory alternative these provisions would be optional for State Exchanges so long as they maintained a SEIPM below the FEIPM in any given year. If a State Exchange's SEIPM meets or exceeds the FEIPM in any year then, under this regulatory alternative, these integrity provisions would be imposed on that State Exchange in the subsequent year and would remain in effect unless the State Exchange demonstrated a SEIPM below the FEIPM for three subsequent consecutive years (at which point these provisions would revert to being optional for the State Exchange). While this approach could strike a balance between the need to safeguard program integrity and mitigate administrative costs, the SEIPM will not be fully implemented until at least PY 2029. Additionally, we note that implementation of this regulatory alternative would be administratively burdensome and would require a doubling of sample sizes (resulting in an additional $25 million Federal and $1.5 million State costs annually) to ensure a sufficiently precise margin of error. Since this regulatory alternative would significantly delay implementation of these vital program integrity measures, would impose additional administrative cost and complexity, and would fail to fully address known program integrity issues, it was determined that to impose these requirements on all Exchanges starting in PY 2027.

E. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small

[258] See, for example, Table 14 of the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability final rule.

entities, if a rule has a significant impact on a substantial number of small entities. The RFA generally defines a ''small entity'' as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. Individuals and States are not included in the definition of a ''small entity.''

1. Legislative and Regulatory Overview

Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) added a new title XXVII to the PHS Act to establish various reforms to the group and individual health insurance markets. These provisions of the PHS Act were later augmented by other laws, including the Affordable Care Act. Subtitles A and C of title I of the Affordable Care Act reorganized, amended, and added to the provisions of part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. The term ''group health plan'' includes both insured and self-insured group health plans. For summarized sections of the PHS Act and Affordable Care Act, please see section II.A of this proposed rule.

These proposed provisions revise current regulations, and HHS does not anticipate any duplication, overlap, or conflict with other rules and regulations associated with these rules.

2. Need for Regulatory Action and Objectives

For the purposes of the RFA, we believe the following provisions could impact smaller agent, broker, and web broker firms.

a. Mandating the HHS-Approved and -Created Consumer Consent Form—Eligibility Application Review and Documenting Receipt of Consumer Consent (§ 155.220(j))

We propose amendments to §§ 155.220(j)(2)(ii)(A) and (j)(2)(iii)(A) to require agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review requirements and consent documentation requirements. Our proposal would eliminate the current broad allowances for meeting these requirements. The language in the regulation would also be changed to clarify what types of actions constitute ''taking an action'' to meet the regulatory requirements. The goal of this policy is to reduce confusion among agents, brokers, and web-brokers on what constitutes compliant eligibility application review documentation and what constitutes compliant consumer consent by ensuring objective standards, which protects consumers ultimately. These proposals also greatly improve HHS' investigative abilities into agent, broker, and web-broker eligibility application review and consumer consent review by creating a clear and objective standard for all applications clearly outlining what HHS deems complaint. More information about this provision is available in section VI.C.8 of this proposed rule.

b. Misleading Marketing (§ 155.220(j)(3))

The proposed regulatory amendments would create a new standards of conduct section in § 155.220(j) describing marketing requirements. These requirements would list certain prohibited practices, provide HHS audit authority, and put agents, brokers, and web-brokers on notice that they are responsible for marketing created by their downstream entities. This proposal would allow HHS to increase its efforts to engage in compliance actions for misleading marketing by providing agents, brokers, and web-brokers notice of the types of activities that are prohibited, allowing HHS to review marketing materials for compliance, and ensure agents, brokers, and web-brokers are not able to push responsibility to third-parties. Creating a marketing standards of conduct section is necessary to protect consumers and maintain the integrity of the Exchanges. More information about this provision is available at section VI.C.9 of this proposed rule.

For the purposes of the RFA, we believe the following provisions could impact smaller insurers.

c. Submission of Rate Filing Justification (§ 154.215)

The proposed rule would require issuers to report actual CSR amounts paid in the Market Experience section (2 years prior, using the standard methodology), projected CSR amounts in the current filing year in the Projections section, and CSR load factors in a new dedicated line item, among other proposed requirements. Issuers would also be required to provide an explanation of how these data points were used to determine the CSR load as part of the Actuarial Memorandum.

The proposed provisions would primarily affect health insurance issuers offering qualified health plans in the individual market, Federal and State regulators in their review capacity, and indirectly, Marketplace enrollees who receive cost-sharing reductions. The enhanced CSR reporting would enable issuers to more accurately determine their CSR payment amounts and improve future projections for rate setting. This could result in more appropriate premium levels if current CSR load factors are inaccurate or unreasonable, enabling issuers to better calibrate their load factors to adequately cover actual CSR costs, potentially leading to more stable and accurate premium pricing over time. More information is available at section VI.C.3 of this proposed rule.

d. Amendments To Strengthen HHS' Oversight of the Administration of the Advanced Payments of the Premium Tax Credit, Cost-Sharing Reductions, and User Fee Programs and Clarifying HHS' Compliance Review Authority (§ 156.480)

We propose to modify § 156.480 to clarify HHS' authority to audit or conduct a compliance review to assess issuers' compliance with requirements related to the APTC, CSR, and user fee programs. Specifically, we propose clarifying that under § 156.480(c), HHS or its designee may audit or conduct a compliance review to assess compliance with all requirements related to APTC, CSR, and user fee programs applicable to issuers offering a QHP in an Exchange. For consistency, we also propose to make conforming changes to § 156.480(c)(6) to provide that in instances where HHS enforces compliance with any requirements related to APTC, CSR, and user fee programs with respect to QHP issuers participating in State Exchanges or SBE–FPs, HHS may do so in accordance with § 156.805. We also propose clarifying that the compliance review authority in § 156.480(c) allows for compliance reviews as needed or on an annual basis. More information about this provision is available at section VI.C.31 of this proposed rule.

3. Number of Affected Small Entities

For purposes of the RFA, we believe that health insurance issuers and group health plans would be classified under the North American Industry Classification System (NAICS) code 524114 (Direct Health and Medical Insurance Carriers) or possibly be classified in 621491 (HMO Medical Centers). Based on latest available Statistics of U.S. Businesses (SUSB) data, 1,071 and 146 total firms fall under NAIC codes 524114 and 621491,

respectively.[259] According to SBA size standards, entities with average annual receipts of $47 million or less would be considered small entities for NAICS code 524114 and $44.5 million or less for NAICS code 621491.[260] However, we believe that few, if any, insurance companies underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) fall below these size thresholds. Based on data from MLR annual report submissions for the 2023 MLR reporting year, approximately 84 out of 479 issuers of health insurance coverage nationwide had total premium revenue of $47 million or less.[261] Furthermore, it should be noted that approximately 80 percent of these small issuers belong to larger holding groups based on the MLR data, and many, if not all, of these small companies are likely to have non-health lines of business that result in their revenues exceeding $47 million.[262] Therefore, we assume approximately 20 percent, or 16, of the 84 potential small issuers are in fact small issuers for purposes of this analysis. We believe this is an overestimate, as many if not all of these small issuers are likely to have non-health lines of business that result in their revenues exceeding $47 million, but we use 16 small issuers for purposes of this analysis. We seek comment on these estimates.

For purposes of the RFA, the Departments consider agents, brokers, and web brokers classified under NAICS code 524210 (Insurance Agencies and Brokerages) that have annual receipts of $15 million or less to be small entities. According to the 2022 Statistics of U.S. Businesses data [263], there are 120,434 firms in the Insurance Agencies and Brokerages industry, of which 119,114, or approximately 99 percent, had annual receipts below the $15 million size standard. Nearly all agents, brokers, and web brokers affected by this proposed rule would therefore be small entities.[264]

4. Regulatory Impacts and Alternatives

For the purposes of this RFA, the costs per agent, broker, and web broker summarized in sections VI.C.8 and VI.C.9 are expected to be representative of the average costs that would be incurred by small agents, brokers, and web brokers to comply with the provisions in this proposed rule. We outline those proposed assumptions and estimates later in this section.

Regarding the costs related to requiring small agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form to meet the eligibility application review documentation requirements and the consumer consent documentation requirements, we estimate it would take approximately 10 minutes of time for an enrolling agent, broker or web-broker to meet eligibility application review documentation requirements and to obtain consumer, or their authorized representative, affirmation of their consent. Using the current adjusted hourly wage rate of $58.04 [265] for an insurance sales agent, each enrollment using the HHS-approved and -created consumer consent form would have approximately $9.87 (10 minutes, or 0.17 hours, at an hourly wage rate of $58.04) in additional cost associated with it based on the extra time commitment from these proposed policy changes. The total cost for small agents, brokers, and web-brokers would be contingent on the number of policies enrolled by each small firm, with the upper bound estimate being 9.8 million policies estimated for all agents, brokers, and web brokers regardless of firm size. Please see sections IV.C and VI.C.8 of this proposed rule for more information.

As stated in IV.D of this proposed rule, we do not anticipate many costs for the agents, brokers, or web-brokers we investigate for misleading marketing. We believe responding to HHS requests to provide confirmation they removed the ads and/or reviewed the marketing guidelines would not be overly time-consuming or burdensome. Our notifications to the agents, brokers, or web-brokers detail what response is required and provide hyperlinks to the noncompliant ad(s). We estimate it would take each agent, broker, or web-broker one hour to remove any noncompliant ad(s), and/or review the marketing guidelines, and respond to HHS via email. This estimate incorporates the potential of HHS asking these agents, brokers, and web-brokers to provide advertisements for HHS' review. Using the hourly wage rate for an insurance sales agent from Table 12 in section IV.A of this proposed rule ($58.04), the cost of responding to HHS would be $58.04 per response. The total cost for small agents, brokers, and web-brokers would be contingent on the number of responses from these smaller firms, with the upper bound estimate being 24 responses estimated for all agents, brokers, and web brokers regardless of firm size. Please see sections IV.D and VI.C.9 of this proposed rule for more information.

For the purposes of this RFA, the costs per issuer summarized in sections VI.C.3 and VI.C.31 of this proposed rule are expected to be representative of the average costs that would be incurred by small issuers to comply with the provisions in this proposed rule. We outline those proposed assumptions and estimates later in this section.

As discussed in section III.C of this proposed rule, this rule proposes to change the instructions for the URRT so that issuers would enter the actual amount of CSRs they paid for enrollees (2 years prior), the amount of CSRs they expect to provide to enrollees, and add a new field to gather the ''load amount.'' Issuers would incur ongoing burden to gather the three required values and enter them into the URRT in their appropriate places. The annual cost and burden per issuer to update and run the standard methodology calculations is $572,118 at 5,700 hours. The annual cost and burden per issuer to provide CSR related information in the URRT is $429.47 at 3.6 hours. The annual cost and burden per issuer to provide CSR calculation explanations in the Actuarial Memorandum is $1,718.27 at 14.2 hours. The total annual ongoing cost for 16 small issuers is $9,188,251.84 at 91,488 hours. We estimate that each issuer would incur an initial one-time cost of $1,114,236 at 11,400 burden hours in 2026 to develop and implement a claim-level re-adjudication process using the standard methodology set forth in § 156.430 to produce the required values, which totals $17,827,776 at 182,400 for 16 small issuers. Please see sections IV.B and VI.C.3 of this proposed rule for more information.

In regard to modifying § 156.480 to clarify HHS' authority to audit or conduct a compliance review to assess issuers' compliance with requirements

[259] United States Census Bureau. (April 2025). *2022 SUSB Annual Data Tables by Establishment Industry. https://www.census.gov/data/tables/2022/econ/susb/2022-susb-annual.html.*

[260] SBA. (n.d.). *Table of size standards. https://www.sba.gov/document/support—table-size-standards.*

[261] CMS. (n.d.). *Medical Loss Ratio Data and System Resources. https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.*

[262] Based on internal calculations. Source: CMS, Medical Loss Ratio Data and System Resources, available at: *https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.*

[263] U.S. Census Bureau (April 2025). *2022 SUSB Annual Data Tables by Establishment Industry, Data by Enterprise Receipts Size. https://www.census.gov/data/tables/2022/econ/susb/2022-susb-annual.html.*

[264] Previously, in 86 FR 51730, 51756, the Departments noted that a total of 55,541 agents and brokers work with issuers.

[265] *See* the U.S. Bureau of Labor Statistics (n.d.). Occupational Employment and Wage Statistics, May 2024 Occupation Profiles. Dep't. of Labor. *https://www.bls.gov/oes/current/oes_stru.htm.*

related to the APTC, CSR, and user fee programs, we estimate that the audits that we would conduct under this authority would not impose additional costs beyond what is already accounted for in the audit review process (86 FR 24140, 24281). We estimate that it would take a business operations specialist 10 hours (at a rate of $44.41 per hour) to compile and submit data and other information necessary for a compliance review. We estimate it would take a compliance officer (at a rate of $40.86 per hour) 4 hours to review and sign off on the submission. The cost per issuer to develop and submit the compliance information would be approximately $607.54. The total cost for small issuers is contingent on the number of small issuers selected for a compliance review each year (out of the 150 estimated regardless of firm size in section VI.C.31 of this proposed rule). Please see section VI.C.31 of this proposed rule for more information. We anticipate small issuers could be impacted by other provisions in this proposed rule. However, we are unable to quantify the impact of these changes on small issuers due to uncertainty regarding their market share, market participation, membership in larger holding groups, enrollment and risk mix, and APTC receipts. However, we anticipate that there would not be a significant change in revenue for issuers as a reduction in APTC payments would mean consumers would be responsible for the balance of the premium not covered by APTC. Yet, we also acknowledge that due to the reductions in enrollment anticipated to result from the policies in this proposed rule, including the potential reduction in APTC to consumers resulting in increased premiums and choose not to maintain coverage due to affordability constraints, issuers may experience a reduction in premium revenue. However, we anticipate this could be balanced by a reduction in claims experience, and we are unable to quantify this impact on small issuers due to uncertainty.

The data and conclusions presented in this section, along with the rest of the RIA, amount to our initial regulatory flexibility analysis under the RFA.

We seek comment on the proposed estimates and assumptions.

As discussed in section VI.C.36 of this proposed rule, we anticipate that entities such as issuers, including small issuers and agents/brokers, would face regulatory review costs as a result of needing to familiarize themselves with this proposed rule. The cost per entity to review this proposed rule is estimated to be $741.77. The total cost for 16 small issuers to review this rule is estimated to be $11,868.32. We anticipate that agents, brokers, and web brokers would also incur costs to review this proposed rule, however, we do not have reliable data on the number of agents, brokers, and web brokers that would review this rule and therefore do not estimate the total burden for these entities. We seek comment on the number of agents, brokers, and web brokers that may review this rule and the associated costs.

For regulatory alternatives considered regarding the provisions in this proposed rule, please see VI.D.

5. Impact on Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. While this proposed rule is not subject to section 1102 of the Act, we have determined that this rule would not affect small rural hospitals. Therefore, we anticipate this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

F. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2025, that threshold is approximately $187 million. Although we have not been able to quantify all costs, we expect that this proposed rule would not impose a mandate that would result in the expenditure by State, local, and Tribal Governments, in the aggregate, or by the private sector, of more than $187 million in any 1 year.

G. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications.

In compliance with the requirement of E.O. 13132 that agencies examine closely any policies that may have Federalism implications or limit the policy making discretion of the States, we have engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and attending conferences of the NAIC, and consulting with State insurance officials on an individual basis.

While developing this proposed rule, we attempted to balance the States' interests in regulating health insurance issuers with the need to ensure market stability. By doing so, we complied with the requirements of E.O. 13132.

Because States have flexibility in designing their Exchange and Exchange-related programs, State decisions would ultimately influence both administrative expenses and overall premiums. States are not required to establish an Exchange or risk adjustment program. For States that elected previously to operate an Exchange, those States had the opportunity to use funds under Exchange Planning and Establishment Grants to fund the development of data. Accordingly, some of the initial cost of creating programs was funded by Exchange Planning and Establishment Grants. After establishment, Exchanges must be financially self-sustaining, with revenue sources at the discretion of the State. Current State Exchanges charge user fees to issuers.

In our view, while this proposed rule will not impose substantial direct requirement costs on State and local governments, this regulation has Federalism implications due to potential direct effects on the distribution of power and responsibilities among the State and Federal Governments relating to determining standards relating to health insurance coverage that is offered in the individual and small group markets.

We have examined the federalism implications involved in proposing to revise § 155.170(a) to provide that any State-required benefits would be considered ''in addition to EHB'' (and thus not an EHB) if they are: required by a State action taking place after December 31, 2011; applicable to the small group and/or individual markets; specific to required care, treatment, or services; and not required by State action for purposes of compliance with Federal requirements. While developing this proposal, we considered our longstanding engagement with States regarding their benefit mandates and the operation and impact of the statutory defrayal requirement, including discussions with State insurance

officials over time about how State mandates affect affordability and Federal and State financial impacts. In developing this proposal, we sought to balance States' interests in regulating health insurance issuers with the need to promote market stability and affordability, and we believe this approach appropriately respects State authority while advancing the objectives of the Affordable Care Act. If finalized, we expect that there would be increased costs to any States that would have to defray the cost of benefits that would be considered ''in addition to EHB''.

In addition, we believe this proposed rule does have Federalism implications due to system and operation costs associated with requiring the four State Exchanges that process their own hardship exemptions to process the additional hardship exemptions expected due to the amendment to § 155.605(d)(1) in this proposed rule. However, the Federalism implications are mitigated as this proposed rule would not preempt state law, as it provides states with flexibility to either process hardship exemptions themselves or delegate this function to HHS under existing regulatory provisions at § 155.605(d), thereby avoiding any Federalism implications that would trigger the requirements of Executive Order 13132.

Additionally, in this proposed rule, HHS proposes new State flexibilities for provider access reviews and/or ECP certification reviews, which have federalism implications for FFE States, including States performing plan management. Specifically, CMS proposes that FFE States may elect to conduct their own provider access reviews and/or ECP certification reviews of issuers' plans, with or without a provider network, that apply for QHP certification to be offered through an FFE (including States that perform plan management), provided that CMS determines the State has sufficient authority and the technical capacity to conduct such reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program for provider access certification reviews, and/or an Effective ECP Review Program for ECP certification reviews. An FFE State would have the choice to elect to conduct their own provider access certification reviews, ECP certification reviews, or both reviews provided the FFE State satisfies the applicable criteria for each effective review program it wishes to administer. For additional detailed information on the federalism impacts of these proposals, please reference the discussions in sections VI.C.19 for Modification of Exchange Network Adequacy Standards, VI.C.28. for Provider Access Standards for Network Plans, and VI.C.29. Essential Community Provider Standards of this proposed rule.

Additionally, we believe this proposed rule also has Federalism implications for both policies related to income verification in cases where a consumer attests to an income at or above 100 percent of the FPL but the IRS returns data below 100 percent of the FPL as well as in cases where the IRS returns no income data for a household. Specifically, states will incur one-time implementation costs as well as annual operating costs for the policies, and, in the case of the Under 100 percent FPL policy, requiring State Exchanges to set continue the income verification when IRS returns data below 100 percent of the FPL but households attest to income at or above 100 percent of the FPL. However, this is mitigated by no longer requiring Exchanges to accept attestations in cases where the IRS returns no income for a household. Additionally, the Federalism implications are mitigated by the benefits to ensuring Marketplace stability, particularly through addressing continued potential fraud.

We also believe this proposed rule has Federalism implications for the amendment of the failure to file and reconcile policy at § 155.305(f)(4) in this proposed rule. Specifically, States will incur one-time implementation costs as well as annual operating costs for their failure to file and reconcile policies. Federalism implications are mitigated by the benefits to the Marketplace by removing unauthorized enrollments and lessening the potential for consumers to generate potentially large tax liabilities.

Executive Order 14192, entitled ''Unleashing Prosperity Through Deregulation'' was issued on January 31, 2025, and requires that ''any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations.'' This proposed rule, if finalized as proposed, is expected to be exempt from otherwise-applicable requirements under E.O. 14192, per footnote 1 of OMB's Accounting Methods.[266]

[266] See Accounting Methods under Executive Order 14192. *https://www.reginfo.gov/public/pdf/eo14192/Accounting_Methods_under_EO_14192.pdf.*

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on February 5, 2026.

List of Subjects

42 CFR Part 600

Administrative practice and procedure, Health care, Health insurance, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 150

Administrative practice and procedure, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interests, Consumer protection, Eligibility criteria, Exemptions, Grants administration, Grant programs—health, Health care, Health insurance, Health maintenance organizations (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Intergovernmental relations, Loan programs—health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, Technical assistance, Women and youth.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Brokers, Conflict of interests, Consumer protection, Grant programs—health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs—health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, and Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services and the Centers for Medicare & Medicaid Services propose to amend 42 CFR part 600 and 45 CFR subtitle A, subchapter B, as set forth below.

Title 42

PART 600—ADMINISTRATION, ELIGIBILITY, ESSENTIAL HEALTH BENEFITS, PERFORMANCE STANDARDS, SERVICE DELIVERY REQUIREMENTS, PREMIUM AND COST SHARING, ALLOTMENTS, AND RECONCILATION

■ 1. The authority citation for part 600 continues to read as follows:

Authority: Section 1331 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148, 124 Stat. 119), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111—152, 124 Stat. 1029).

■ 2. Section 600.5 is amended by adding the definition of ''Eligible noncitizen'' in alphabetical order as follows:

§ 600.5 Definitions and use of terms.

* * * * *

Eligible noncitizen has the meaning given in 45 CFR 155.20.

* * * * *

Title 45

PART 150—CMS ENFORCEMENT IN GROUP AND INDIVIDUAL INSURANCE MARKETS

■ 3. The authority citation for part 150 continues to read as follows:

Authority: 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92, as amended.

■ 4. Section 150.317 is amended by revising the introductory text to read as follows:

§ 150.317 Factors CMS uses to determine the amount of penalty.

In determining the amount of any civil money penalty, CMS will identify the lawful purpose or purposes of the penalty, and take into account the following factors as appropriate to the circumstances of the case:

* * * * *

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

■ 5. The authority citation for part 155 continues to read as follows:

Authority: 42 U.S.C. 18021–18024, 18031–18033, 18041–18042, 18051, 18054, 18071, and 18081–18083.

■ 6. Section 155.20 is amended by—

■ a. Adding the definition ''Eligible noncitizen'' in alphabetical order; and

■ b. Removing the definition ''Standardized option''.

The addition reads as follows:

§ 155.20 Definitions.

* * * * *

Eligible noncitizen means an ''eligible alien,'' as defined in 26 U.S.C. 36B(e)(2)(B).

* * * * *

§ 155.105 [Amended]

■ 7. Section 155.105 is amended by removing paragraph (b)(4).

■ 8. Section 155.106 is amended by revising paragraph (a)(2) to read as follows:

§ 155.106 Election to operate an Exchange after 2014.

(a) * * *

(2) Submit an Exchange Blueprint application for HHS approval at least 15 months prior to the date on which the Exchange proposes to begin open enrollment as a State Exchange.

(i) *Public notice.* Upon submission of an Exchange Blueprint application to operate a State Exchange, the State shall issue a public notice of its Exchange Blueprint application submission through its website and include a copy of the Exchange Blueprint application, a description of the Plan Year for which the State seeks to transition to a State Exchange, language indicating that the State is seeking approval from HHS to transition to a State Exchange, and information about when and where the State will conduct public engagements regarding the State's Exchange Blueprint application, as described in paragraph (a)(2)(ii) of this section.

(ii) *Public engagements.* After a State issues its public notice as described in paragraph (a)(2)(i) of this section and until HHS approves, or conditionally approves, the State's Exchange Blueprint application, a State must conduct at least one public engagement (such as a townhall meeting or public hearing) either in-person or virtually, regarding the State's Exchange Blueprint application progress, in a timeline and manner considered effective by the State and with HHS' concurrence. A State shall provide public notice of the public engagement. Such public engagement shall also provide interested parties the opportunity to learn about the State's progress in transitioning to a State Exchange and offer input on that transition. Following the initial public engagement described in this paragraph and until HHS approves or conditionally approves the State Exchange Blueprint application, a State shall conduct periodic public engagements, either in-person or virtually, in a timeframe and manner considered effective by the State.

* * * * *

■ 9. Section 155.170 is amended by revising paragraphs (a)(1) and (2) to read as follows:

§ 155.170 Additional required benefits.

(a) * * *

(1) A State may require a QHP to cover benefits in addition to the essential health benefits, which are any State-required benefits that are:

(i) Required by a State action taking place after December 31, 2011;

(ii) Applicable to the small group and/or individual markets;

(iii) Specific to required care, treatment, or services; and

(iv) Not required by State action for purposes of compliance with Federal requirements.

(2) A State must make payments in accordance with paragraph (b) of this section to defray the cost of any State-required benefits in addition to the EHB.

* * * * *

■ 10. Section 155.205 is amended by revising paragraphs (b)(1) introductory text, and (b)(4) and (5) to read as follows:

§ 155.205 Consumer assistance tools and programs of an Exchange.

* * * * *

(b) * * *

(1) Provides standardized comparative information on each available QHP and at a minimum includes:

* * * * *

(4)(i) Allows for an individual seeking coverage to submit an approved single streamlined eligibility application to the Exchange, in accordance with § 155.405(b), and allows for the Exchange to make all determinations of eligibility for enrollment in a QHP and insurance affordability programs, in accordance with subpart D of this part.

(ii) As an alternative to paragraph (4)(i) of this section, allows a non-Exchange web-broker entity to implement and operate a consumer website that allows an individual seeking coverage to submit an approved single streamlined eligibility application, in accordance with § 155.405(b), on the non-Exchange web-broker consumer website. Such non-Exchange web-broker websites must interface with the State Exchange to transmit eligibility application information such that the State Exchange may make determinations of eligibility for enrollment in a QHP and insurance affordability programs and communicate such eligibility determinations to applicants.

(iii) If the Exchange is a State-based Exchange on the Federal platform, directs an individual seeking coverage to submit a single streamlined eligibility

application through the Federal eligibility and enrollment platform.

(5)(i) Allows a qualified individual to select a QHP, and allows the Exchange to maintain records of all enrollments in the QHPs offered by the Exchange, in accordance with subpart E of this part.

(ii) As an alternative to paragraph (5)(i) of this section, a State Exchange may allow a non-Exchange web-broker entity to implement and operate a consumer website that allows an individual to select and enroll in a QHP on the web-broker's consumer website. Such non-Exchange web-broker websites must interface with the State Exchange to transmit individual QHP plan selection and enrollment information to the State Exchange so that the State Exchange is able to fulfil its requirement to maintain records of all enrollments in the QHPs offered by the State Exchange and meet all other applicable requirements under subpart E of this part.

(iii) If the Exchange is a State-based Exchange on the Federal platform, directs an individual seeking coverage to select a QHP through the Federal eligibility and enrollment platform.

* * * * *

■ 11. Section 155.220 is amended by—

■ a. Removing paragraph (c)(3)(i)(H);

■ b. Redesignating paragraphs (c)(3)(i)(I) through (M) as paragraphs (c)(3)(i)(H) through (L), respectively;

■ c. Revising paragraph (j)(2)(i);

■ d. Revising paragraph (j)(2)(ii)(A) introductory text;

■ e. Redesignating paragraph (j)(2)(ii)(A)*(2)* as paragraph (j)(2)(ii)(A)*(3)*;

■ f. Adding new paragraph (j)(2)(ii)(A)*(2);*

■ g. Revising paragraph (j)(2)(iii)(A);

■ h. Redesignating paragraph (j)(2)(iii)(C) as paragraph (j)(2)(iii)(D);

■ i. Adding new paragraph (j)(2)(iii)(C);

■ j. Redesignating paragraph (j)(3) as paragraph (j)(4); and

■ k. Adding new paragraph (j)(3).

The revisions and additions read as follows:

§ 155.220 Ability of States to permit agents and brokers and web-brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

* * * * *

(j) * * *

(2) * * *

(i) Provide consumers with correct information, without omission of material fact, regarding the Federally-facilitated Exchanges, QHPs offered through the Federally-facilitated Exchanges, and insurance affordability programs, and refrain from conduct that is misleading (including by having a direct enrollment website that HHS determines could mislead a consumer into believing they are visiting *HealthCare.gov*), coercive, or discriminates based on race, color, national origin, disability, age, or sex;

(ii) * * *

(A) Documenting that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or the consumer's authorized representative is effectuated by having the consumer or the consumer's authorized representative take an action to execute the HHS-approved and -created consumer consent form.

* * * * *

(2) The action the consumer or the consumer's authorized representative took to confirm the eligibility application information has been reviewed and confirmed to be accurate must be clear to HHS on the face of the documentation. This may include a hand-written or electronic written signature or initials, an email from the consumer, a recorded verbal conversation, or other means. A signature that is simply typed on the documentation or a filled-in check box does not clearly indicate the eligibility application information was reviewed and confirmed accurate by the consumer or the consumer's authorized representative.

* * * * *

(iii) * * *

(A) Obtaining and documenting the receipt of consent is effectuated by having the consumer or the consumer's authorized representative take an action to execute the HHS-approved and -created consumer consent form.

* * * * *

(C) The action the consumer or the consumer's authorized representative took to provide consent must be clear to HHS on the face of the documentation. This may include a hand-written or electronic written signature or initials, an email from the consumer, a recorded verbal conversation, or other means. A signature that is simply typed on the documentation or a filled-in check-box does not properly indicate consent was provided by the consumer or the consumer's authorized representative.

* * * * *

(3) Marketing Requirements. An individual or entity described in paragraph (j)(1) of this section must additionally:

(i) Comply with the standards of conduct under § 155.220(j)(2); and

(ii) Provide consumers with correct information, without omission of material fact, regarding the Federally-facilitated Exchanges, QHPs offered through the Federally-facilitated Exchanges, and insurance affordability programs, and refrain from marketing that is misleading, materially inaccurate, coercive, or discriminates based on race, color, national origin, disability, age, or sex.

(iii) Examples of prohibited misleading marketing practices agents, brokers, and web-brokers may not include in their marketing of FFE plans include, but are not limited to:

(A) Providing cash, monetary rebates, gift cards, travel vouchers, or cash equivalents as an inducement for enrollment or otherwise.

(B) Offering gifts to consumers, unless the gifts are of nominal value, are offered to similarly situated consumers without regard to whether or not the consumers enroll, and are not in the form of cash or cash equivalents.

(C) Falsely asserting or suggesting that consumers will always qualify for zero-dollar insurance/zero-dollar premiums.

(D) Falsely using identical or facsimiles of government or other official logos and notations.

(E) Miscommunicating enrollment timelines and deadlines.

(F) Misconstruing legislation, regulations, or Executive Orders, including listing fake or incorrect references or citations.

(G) Utilizing the image or likeness and/or utilize a quote from a notable figure, such as a celebrity or politician, in an advertisement claiming that figure has endorsed you or your agency when that endorsement is not truthful.

(iv) An individual or entity described in paragraph (j)(1) of this section must produce any marketing material upon request, within the specified timeframe HHS mandates, in response to monitoring, audit, and enforcement activities conducted consistent with paragraphs (c)(5), (g), (h), and (k) of this section.

(v) An individual or entity described in paragraph (j)(1) of this section is responsible to ensure that all marketing-related materials created, written, released, or otherwise produced by the individual or entity or on their behalf adhere to the requirements of § 155.220(j)(3)(ii)–(iii), and to make all such marketing-related materials available upon request in accordance with § 155.220(j)(3)(iv) of this section.

* * * * *

■ 12. Section 155.221 is amended by adding paragraph (k) to read as follows:

§ 155.221 Standards for direct enrollment entities and for third parties to perform audits of direct enrollment entities.

* * * * *

(k) *Direct Enrollment Option for a State Exchange.* Subject to HHS approval, and in lieu of the Exchange operating its own consumer-facing eligibility application and enrollment website, a State may elect for the State Exchange to select one or more web-brokers described in paragraph (a)(2) of this section to make available a non-Exchange online website to enroll qualified individuals in a QHP offered through the Exchange in the State in a manner that constitutes enrollment through the Exchange, as specified in paragraph (k) of this section. A newly transitioning or approved State Exchange that wishes to implement this option must submit an Exchange Blueprint, or a Blueprint revision, at least 15 months prior to the date on which the State Exchange pursuing this option proposes to begin open enrollment using this option, after which HHS would have up to 90 days to review and render a decision to approve or deny the Blueprint, and in accordance with § 155.105(b) and (e), and § 155.106(a). HHS will approve a State Exchange to make available a non-Exchange online website to enroll qualified individuals in a QHP offered through the Exchange, as described in this paragraph only if the State Exchange:

(1) Demonstrates to HHS operational readiness for the State Exchange to enroll qualified individuals in a QHP through approved direct enrollment entity websites in a manner that constitutes enrollment through the Exchange, including enabling individuals to apply for, and receive eligibility determinations for, QHP enrollment and advance payments of the premium tax credit and cost-sharing reductions, as well as receive assessments or determinations of Medicaid and CHIP eligibility from the Exchange as described in § 155.302, using the eligibility application described in § 155.405;

(2) Provides HHS with an implementation plan and timeline that details the key activities, milestones, and communication and outreach strategy to support the transition of enrollment operations to direct enrollment entities; and

(3) Demonstrates to HHS that a minimum of one direct enrollment entity selected by the State meets minimum Federal requirements to participate in the Federally-facilitated Exchange enhanced direct enrollment program, including requirements at §§ 155.220 and 155.221, particularly § 155.220(c)(3)(i)(A) and (D); displays detailed information for all available QHPs; meets accessibility requirements under § 155.205(c); and is capable of enrolling all consumers in the State, including those who present complex eligibility scenarios.

(i) If at any point there is no direct enrollment entity selected by the State that meets such minimum Federal requirements or possesses the capability to enroll all consumers in the State, as soon as practicable, the State Exchange must offer its consumer-facing website and ensure that it meets such requirements and possesses such capability.

(ii) [Reserved]

§ 155.222 [Removed]

■ 13. Remove § 155.222.

■ 14. Section 155.302 is amended by revising paragraph (a)(1) to read as follows:

§ 155.302 Options for conducting eligibility determinations.

(a) * * *

(1) Directly, through which the Exchange carries out all eligibility determinations for QHP coverage and related insurance affordability programs; or if the Exchange is a State-based Exchange on the Federal platform, through a Federal platform agreement under which HHS carries out eligibility determinations and other requirements contained within this subpart.

* * * * *

■ 15. Section 155.305 is amended by—

■ a. Revising paragraph (f)(1)(ii) introductory text;

■ b. Adding paragraph (f)(1)(ii)(C);

■ c. Removing and reserving paragraph (f)(2); and

■ d. Revising paragraph (f)(4).

The addition and revision read as follows:

§ 155.305 Eligibility Standards.

* * * * *

(f) * * *

(1) * * *

(ii) One or more applicants who is expected to be a member of the tax filer's family within the meaning of 26 CFR 1.36B–1(d) for the benefit year—

(A) * * *

(B) * * *

(C) He or she is a U.S. citizen, U.S. national, or an eligible noncitizen as defined in § 155.20.

* * * * *

(4) *Compliance with tax filing requirement.*

(i) APTC eligibility. (A) For plan year 2027, an Exchange must implement one of two policies where it may not determine a tax filer eligible for APTC if the tax filer and their spouse, if the tax filer is married, has either failed to file and reconcile for 1 year, as described in paragraph (f)(4)(ii)(A) (''1 tax year FTR policy'') or has failed to file and reconcile for 2 consecutive tax years, as described in paragraph (f)(4)(ii)(B) (''2 tax-year policy'') of this section. Exchanges must apply any such policy uniformly to all tax filers (and their spouses, if married).

(B) For plan year 2028 and beyond, an Exchange must implement a 1-tax year FTR policy described in paragraph (f)(4)(ii)(A) of this section.

(ii) *Failure to file and reconcile.* For purposes of paragraph (f)(4)(i) of this section:

(A) A tax filer and their spouse, if the tax filer is married, is considered to have failed to file and reconcile for 1 tax year if HHS notifies the Exchange as part of the process described in § 155.320(c)(3) that APTC payments were made on behalf of either the tax filer or the tax filer's spouse, if the tax is a married couple, for the most recent year for which tax data would be utilized for verification of household income and family size in accordance with § 155.320(c)(1)(i), and the tax filer or the tax filer's spouse did not comply with the requirement to file an income tax return for that year as required by 26 U.S.C. 6011, 6012, and in 26 CFR chapter I, and reconcile APTC for that period.

(B) A tax filer and their spouse, if the tax filer is married, is considered to have failed to file and reconcile for 2 tax years if HHS notifies the Exchange as part of the process described in § 155.320(c)(3) that APTC payments were made on behalf of either the tax filer or the tax filer's spouse, if the tax filer is a married couple, for the 2 most recent consecutive tax years for which tax data would be utilized for verification of household income and family size in accordance with § 155.320(c)(1)(i), and the tax filer or the tax filer's spouse did not comply with the requirement to file an income tax return for those years as required by 26 U.S.C. 6011, 6012, and in 26 CFR chapter I, and reconcile APTC for that period.

(iii) Notice Requirements. For purposes of paragraph (f)(4)(ii) of this section, the following notice requirements apply.

(A) An Exchange that implements a 2-tax year FTR policy as described in paragraph (f)(4)(ii)(B) of this section must:

(*1*) For tax filers failing to file and reconcile for 1 tax year as described in paragraph (f)(4)(ii)(A) of this section:

(*i*) Send a notification to the tax filer, consistent with the standards applicable to the protection of Federal Tax Information, that informs the tax filer

that the Exchange has determined that the tax filer or the tax filer's spouse, if the tax filer is married, has failed to file and reconcile, and educate the tax filer of the need to file and reconcile or risk being determined ineligible for APTC if they fail to file and reconcile for a second consecutive tax year; or

(*ii*) Send a notification to either the tax filer or their enrollee, that informs the tax filer or enrollee that they may be at risk of being determined ineligible for APTC in the future. These notices must educate tax filers or their enrollees on the requirement to file and reconcile, while not directly stating that the IRS indicates the tax filer or the tax filer's spouse, if the tax filer is married, has failed to file and reconcile.

(*2*) For tax filers failing to file and reconcile for 2 consecutive tax years as described in paragraph (f)(4)(ii)(B) of this section:

(*i*) Send a direct notification to the tax filer, consistent with the standards applicable to the protection of Federal Tax Information, that explicitly informs the tax filer that the Exchange has determined that the tax filer or the tax filer's spouse, if the tax filer is married, has failed to file their Federal income taxes and reconcile APTC, and educate the tax filer of the need to file and reconcile or risk being determined ineligible for APTC after 2 consecutive tax years of failing to file and reconcile; or

(*ii*) Send an indirect notification to either the tax filer or their enrollee, that informs the tax filer or enrollee that they may be at risk of being determined ineligible for APTC after 2 consecutive tax years of failing to file and reconcile. These notices must educate tax filers or their enrollees on the requirement to file and reconcile, while not directly stating that the Internal Revenue Service indicates the tax filer or the tax filer's spouse, if the tax filer is married, has failed to file and reconcile.

(B) An Exchange that implements 1-tax year FTR policy as described in paragraph (f)(4)(ii)(A) of this section must:

(1) Send a notification to the tax filer, consistent with the standards applicable to the protection of Federal Tax Information, that informs the tax filer that the Exchange has determined that the tax filer or the tax filer's spouse, if the tax filer is married, has failed to file and reconcile of the need to file and reconcile, and of the risk of being determined ineligible for APTC if they fail to file and reconcile immediately; or

(2) Send a notification to either the tax filer or their enrollee, that informs the tax filer or enrollee that they may be at risk of being determined ineligible for APTC in the future. These notices must educate tax filers or their enrollees on the requirement to file and reconcile, while not directly stating that the IRS indicates the tax filer or the tax filer's spouse, if the tax filer is married, has failed to file and reconcile.

* * * * *

■ 16. Section 155.320 is amended by—

■ a. Revising paragraphs (c)(3)(iii)(A) and (c)(3)(vi)(C)(2);

■ b. Removing the second occurrence of paragraph (c)(3)(viii);

■ c. Revising paragraphs (c)(3)(vii) and (viii);

■ d. Adding paragraph (c)(3)(ix); and

■ e. Removing paragraph (c)(5).

The revisions and addition read as follows:

§ 155.320 Verification process related to eligibility for insurance affordability programs.

* * * * *

(c) * * *

(3) * * *

(iii) * * *

(A) Except as specified in paragraphs (c)(3)(iii)(B), (C), and (D) of this section, if an applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, would qualify the tax payer as an applicable taxpayer under 26 CFR 1.36B–2(b) for the plan year for which coverage is requested and is more than a reasonable threshold above the annual household income computed in accordance with paragraph (c)(3)(ii)(A) of this section, the data described in paragraph (c)(3)(ii)(A) of this section indicates that projected annual household income is under 100 percent of the FPL, and the Exchange has not verified the applicant's MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section to be within the applicable Medicaid or CHIP MAGI-based income standard, the Exchange must proceed in accordance with § 155.315(f)(1) through (4). For the purposes of this paragraph, a reasonable threshold is established by the Exchange in guidance and approved by HHS, but must not be less than 10 percent, and can also include a threshold dollar amount.

* * * * *

(vi) * * *

(C) * * *

(2) If the data described in paragraph (c)(3)(vi)(A) of this section indicates that projected annual household income is under 100 percent of the FPL and the applicant's attestation to projected household income, as described in paragraph (c)(3)(ii)(B) of this section, would qualify the taxpayer as an applicable taxpayer according to 26 CFR 1.36B–2(b) for the plan year for which coverage is requested and is more than a reasonable threshold above the annual household income as computed using data sources described in paragraph (c)(3)(vi)(A) of this section, in which case the Exchange must follow the procedures specified in § 155.315(f)(1) through (4). The reasonable threshold used under this paragraph must be equal to the reasonable threshold established in accordance with paragraph (c)(3)(iii)(D) of this section.

* * * * *

(vii) *Definition of Household Income.* For the purposes of paragraph (c)(3) of this section, ''household income'' means household income as specified in 26 CFR 1.36B–1(e).

(viii) *Definition of Family Size.* For purposes of paragraph (c)(3) of this section, ''family size'' means family size as specified in section 26 CFR 1.36B–1(d).

(ix) Verification of Eligible Noncitizen Status. (A) Verification with the records of the Department of Homeland Security. For an applicant who has information or documentation of immigration status that can be verified through the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) program, and who attests to having an eligible noncitizen immigration status as defined at § 155.20, the Exchange must transmit information from the applicant or document to the Department of Homeland Security for verification.

(B) Inconsistencies and inability to verify information. For an applicant who attests to having an eligible noncitizen status as defined at § 155.20, and for whom the Exchange cannot verify such attestation through the Department of Homeland Security, the Exchange must follow the procedures specified in § 155.315(f)(1) through (4). The date on which the notice is received means 5 days after the date on the notice, unless the applicant demonstrates that he or she did not receive the notice within the 5 day period as described in § 155.315(b) (2).

(C) If, at the conclusion of the period specified in paragraph (c)(3)(ix)(B) of this section, the Exchange remains unable to verify the applicant's attestation, the Exchange must determine the applicant ineligible for advance payments of the premium tax credit and cost-sharing reductions, notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(g), and discontinue any advance payments of the premium tax credit and cost-sharing reductions in

accordance with the effective dates specified in § 155.330(f).

* * * * *

■ 17. Section 155.420 is amended by—
■ a. Removing paragraph (a)(4)(ii)(D);
■ b. Revising paragraph (a)(4)(iii) introductory text;
■ c. Removing paragraph (b)(2)(vii);
■ d. Revising paragraph (d)(13);
■ e. Removing paragraph (d)(16); and
■ f. Revising paragraph (g).

The revisions read as follows:

§ 155.420 Special enrollment periods.

(a) * * *

(4) * * *

(iii) For the other triggering events specified in paragraph (d) of this section, except for paragraphs (d)(2)(i), (d)(4), and (d)(6)(i) and (ii) of this section for becoming newly eligible or ineligible for CSRs, and paragraphs (d)(8), (9), (10), (12), and (14) of this section:

* * * * *

(d) * * *

(13) At the option of the Exchange, the qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in § 155.315.

* * * * *

(g) *Special enrollment period verification.* Beginning January 1, 2027, unless a request for modification is granted in accordance with § 155.315(h), Exchanges on the Federal platform must conduct pre-enrollment verification of new applicants' eligibility for special enrollment periods under this section. An Exchange meets this requirement if it verifies eligibility each plan year for the number of individuals newly enrolling in Exchange coverage through special enrollment periods that equals at least 75 percent of all special enrollments based on prior year enrollments. If the Exchange is unable to verify eligibility for individuals newly enrolling in Exchange coverage through a special enrollment period for which the Exchange requires verification, then such individuals are not eligible for enrollment through that special enrollment period. In accordance with § 155.505(b)(1)(iii), individuals have the right to appeal the eligibility determination.

■ 18. Section 155.605 is amended by—
■ a. Revising the end of paragraph (d)(1)(ii) to remove ''or'' and revising paragraph (d)(1)(iii) to add at the end ''; or''; and
■ b. Adding new paragraph (d)(1)(iv).

The addition reads as follows:

§ 155.605 Eligibility standards for exemptions.

(d) * * *

(1) * * *

(iv) The applicant, or their claiming tax filer in the case of a tax dependent, has a projected household income that does not qualify them as an applicable taxpayer according 26 CFR 1.36B–2(b) or does not qualify them for cost-sharing reductions according to 45 CFR 155.305(g)(1)(i)(C).

* * * * *

■ 19. Section 155.1050 is amended by—
■ a. Revising the section heading and paragraphs (a)(1) and (2); and
■ b. Adding paragraph (d).

The revisions and addition read as follows:

§ 155.1050 Establishment of Exchange provider access standards.

(a) * * *

(1) A Federally-facilitated Exchange or a State on the Federally-facilitated Exchanges with an Effective Provider Access Review Program (as defined in paragraph (d) of this section) must ensure that each QHP provides sufficient access to providers in a manner that meets the standards specified in § 156.230(a)(1)(ii) and (iii) for network plans, or § 156.236(a) for non-network plans, as applicable.

(2) State Exchanges and State-based Exchanges on the Federal Platform must ensure that each QHP provides sufficient access to providers in a manner that meets applicable standards specified in § 156.230(a)(1)(ii) and (iii) for network plans, or § 156.236(a) for non-network plans, as applicable.

* * * * *

(d) *Effective Provider Access Review Program.* (1) FFE States may elect to conduct their own provider access certification reviews of issuers' plans, with or without a provider network, applying for certification as a QHP to be offered through a Federally-facilitated Exchange provided that the State has demonstrated sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program under paragraphs (d)(2) through (d)(4) of this section. This option applies to Federally-facilitated Exchange States, including States performing plan management. If States do not satisfy the criteria established under paragraphs (d)(2) through (d)(4) of this section, CMS will continue to perform reviews of QHP issuer provider access in those States consistent with requirements listed at § 156.230(a)(1), (a)(2), and (a)(3) for network plans and § 156.236 for non-network plans.

(2) FFE States with an Effective Provider Access Review Program must ensure that a QHP issuer that uses a network of providers ensures that the in-network providers, as available to all enrollees, include essential community providers (ECPs) in accordance with § 156.235, and maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay. The QHP issuer's provider network consisting of in-network providers, as available to all enrollees, must be consistent with the rules for network plans of section 2702(c) of the PHS Act.

(3) FFE States with an Effective Provider Access Review Program must ensure that a QHP issuer that does not use a network of providers (a non-network plan) provides access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full, including ECPs and providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay.

(4) A State operating on the Federally-facilitated Exchanges that elects to conduct its own provider access reviews has an Effective Provider Access Review Program if it meets the following requirements:

(i) The FFE State has established provider access standards that are set forth in State statute or regulation, which are consistent with provider access standards as set forth in § 156.230(a)(1)(ii) and (iii), and reports to CMS whether the State has delegated authority to some entity other than the State Department of Insurance to perform any or all provider access review activities.

(ii) The FFE State's provider access review process includes reporting systems for State required provider access metrics and documentation of methodology and the State provides descriptions of all data collection systems, resources, templates, and methodologies used by the State, or the State's delegated entity to collect and review provider access data; and the State receives from issuers data and documentation in connection with provider access standards that are sufficient to conduct the examination.

(iii) The FFE State's provider access review process includes procedures to ensure full and ongoing compliance

with State provider access standards and enforcement frameworks applicable to issuers that fail to meet provider access standards so that those issuers come into compliance with State provider access standards, including standardized processes to assess efforts the issuer is pursuing to come into compliance with State provider access standards and implementing any justification and exception processes for issuers that have not yet or cannot meet provider access requirements.

(iv) The FFE State establishes and maintains clear procedures and timeline requirements for regular provider access reviews, including processes that ensure reviews occur prior to each plan year's QHP certification cycle.

(v) The FFE State has a process for monitoring and addressing consumer-related provider access complaints to ensure sufficient access to providers consistent with section 1311(c)(1)(B) of the Affordable Care Act and as set forth in State statute.

(vi) The FFE State has a process to collect and review information capable of demonstrating whether non-network plans provide access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full.

(5) CMS will determine whether a State has an Effective Provider Access Review Program based on information available to CMS that demonstrates whether the program meets the criteria described in paragraph (d)(4) of this section.

(6) CMS may grant an exception to the requirements in paragraph (d) of this section if it determines that making such an exception is in the interests of qualified individuals in the State or States in which such Exchange operates.

(7) CMS will notify the FFE State electing to conduct provider access certification reviews of its decision in writing whether the State is determined to have an Effective Provider Access Review Program and can therefore conduct its own provider access certification reviews. CMS reserves the right to evaluate at any time whether, and to what extent, a FFE State's circumstances have changed such that it has begun to or has ceased to satisfy the criteria established by CMS under this section. Such evaluations may result in CMS assuming provider access review responsibilities or transitioning such responsibilities back to the State.

* * * * *

■ 20. Part 155 is amended by adding § 155.1051 to subpart K to read as follows:

§ 155.1051 Effective Essential Community Provider Review Program.

(a) FFE States may elect to conduct their own ECP certification reviews of issuers' plans with or without a provider network applying for certification as a QHP to be offered through a Federally-facilitated Exchange provided that the State demonstrates it has sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective Essential Community Provider Review Program under this section. This option applies to all FFE States, including States performing plan management. An FFE State must demonstrate it meets applicable criteria established under paragraphs (b) through (c) of this section for both network plans and non-network plans, and the sufficient authority and technical capacity to conduct reviews of such plans (as assessed by CMS under § 155.1051(e)), to be considered to have an Effective Essential Community Provider Review Program, if they decide to certify such plans. If FFE States do not satisfy the criteria established by CMS under paragraphs (b) through (e) of this section or do not elect to conduct such reviews, then CMS will continue to perform ECP certification reviews consistent with § 156.235 for network plans and § 156.236 for non-network plans.

(b) FFE States with an Effective ECP Review Program must ensure that a QHP issuer with a provider network includes in their provider network a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the Exchange's network adequacy standards. FFE States with an Effective ECP Review Program must also ensure that a non-network plan applying for certification to be offered as a QHP through a Federally-facilitated Exchange demonstrates that it provides reasonable and timely access to ECPs that accept the plan's benefit amount as payment in full to ensure that services will be accessible without unreasonable delay.

(c) FFE States with an Effective ECP Review Program must have established ECP requirements that are set forth in State statute or regulation. FFE States must demonstrate that these established ECP requirements ensure that plans meet all the following requirements that promote a sufficient number and geographic distribution of ECPs:

(1) The minimum percentage requirements under § 156.235(a)(2)(i) for network plans, and under § 156.236(b)(1) for non-network plans.

(2) The Indian health care provider requirement under § 156.235(a)(2)(ii)(A) for network plans and under § 156.236(b)(3) for non-network plans.

(3) The category per county requirements, including for each of the eight ECP category types under § 156.235(a)(2)(ii)(B) for network plans and under § 156.236(b)(2) for non-network plans.

(d) FFE States with an Effective ECP Review Program that have alternative ECP requirements compared to those described under paragraph (c)(1) through (3) of this section must demonstrate how their requirements would continue to promote a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to ECPs, and an adequate level of service for low-income enrollees or individuals residing in Health Professional Shortage Areas.

(e) CMS will consider all the following factors in its review to determine if a FFE State has an Effective ECP Review Program:

(1) The State's legal authority to review whether plans applying for QHP certification meet ECP requirements, including relevant State regulations and statutes.

(2) Evidence that the State's requirements are consistent with ECP requirements under paragraph (c)(1) through (3) of this section that promote a sufficient number and geographic distribution of ECPs, or the State provides a rationale to describe how its alternative requirements promote a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to ECPs.

(3) A description of the State's definition of an ECP, if different from the definition under § 156.235(c), including relevant categories and eligibility criteria that the State uses to determine whether a facility qualifies as an ECP.

(4) Whether the State utilizes the Federal ECP List or has a process it uses to identify qualified ECPs that may be included within a network plan's provider network.

(5) Whether the State utilizes the Federal ECP List or has a process it uses to identify qualified ECPs that may accept a non-network plan's benefit amount as payment in full.

(6) A description of data collection systems, resources, templates, or methodologies used by the State to collect and review ECP data.

(7) Whether the State generally collects information from QHP issuers regarding the status of contract offers for network plans or offers of benefit amounts as payment in full to an ECP for non-network plans.

(8) Whether the State has delegated authority to some other entity other than the State Department of Insurance to perform any or all ECP review activities.

(9) Whether the State has compliance reviews, follow-up procedures, and enforcement frameworks applicable to issuers that demonstrate inadequate networks of ECPs or inadequate access to ECPs that accept benefit amounts as payment in full, so that those issuers come into compliance with State ECP requirements, including standardized processes to assess efforts the issuer is pursuing to come into compliance with State ECP requirements and any justification and exception processes for issuers that have not yet or cannot meet ECP requirements.

(10) Whether the State has a process for monitoring and addressing consumer-related complaints regarding access to ECPs to ensure sufficient access to ECPs consistent with section 1311(c)(1)(C) of the Affordable Care Act and set forth in State statute.

(f) CMS will notify the FFE State electing to conduct ECP certification reviews of its decision in writing whether the State is determined to have an Effective ECP Review Program and can therefore conduct its own ECP certification reviews. CMS reserves the right to evaluate at any time whether, and to what extent, an FFE State's circumstances have changed such that it has begun to or has ceased to satisfy the criteria established by CMS under this section, and consequently no longer has an Effective ECP Review Program.

■ 21. Section 155.1200 is amended by revising paragraph (d) introductory text and adding paragraph (e) to read as follows:

§ 155.1200 General program integrity and oversight requirements.

* * * * *

(d) *External audit standard.* The State Exchange must ensure that independent audits of State Exchange financial activities and program activities under paragraph (c) of this section address the following requirements, unless a State Exchange is satisfying certain programmatic audit requirements for a given benefit year, as identified by HHS in sub-regulatory guidance, under paragraph (e) of this section:

* * * * *

(e) *State Exchange Improper Payment Measurement (SEIPM) program.* For a given benefit year, a State Exchange may satisfy certain requirements of the independent external programmatic audit, particularly the review of compliance with subparts D and E, as identified by HHS in sub-regulatory guidance, as outlined in paragraph (d), by completing the SEIPM process established through 45 CFR part 155, subpart Q.

* * * * *

■ 22. Part 155 is amended by adding subparts Q to read as follows:

Subpart Q—State Exchange Improper Payment Measurement (SEIPM)

Sec.

155.1600 Purpose and scope.
155.1605 Effective date and implementation.
155.1610 Definitions.
155.1615 Information submission.
155.1620 Sampling procedures.
155.1625 Determining payment errors.
155.1630 Difference Resolution and appeal process.
155.1635 Corrective action plan (CAP).
155.1640 SEIPM preparation phase.
155.1645 Minimizing potential duplicate audit requirements.
155.1650 Failure to comply.

§ 155.1600 Purpose and scope.

(a) This subpart sets forth the requirements of the State Exchange Improper Payment Measurement (SEIPM) program. SEIPM is an initiative through which HHS will measure improper payments of advance payment of the premium tax credit (APTC) that are administered by State Exchanges, as described in more detail in § 155.1610. HHS will use the SEIPM program results to produce an estimate of improper payments of APTC aggregated across State Exchanges.

(b) Unless otherwise specified by HHS, all State Exchanges must submit information on an annual basis that is necessary to support the SEIPM processes.

(c) HHS will publish in the Agency Financial Report an estimate of improper payments that is aggregated across all State Exchanges.

§ 155.1605 Applicability date and implementation.

(a) *Applicability date.* The requirements of this subpart are applicable beginning January 1, 2027.

§ 155.1610 Definitions.

As used in this subpart—

Annual Program Schedule means the document issued by HHS to each State Exchange that prescribes the dates for which key program milestones must be met for each SEIPM Cycle.

Administrative Appeal means the process by which a State Exchange may request HHS to review and reconsider a Difference Resolution Decision. The appeal is the second and last level for a State Exchange to contest findings of error or improper payment as it relates to APTC.

Administrative Appeal decision means the HHS final appeal decision resulting from a State Exchange's request for an appeal of one or more error or improper payment findings in a Sampled Unit Assessment Package.

Corrective action plan (*CAP*) means the plan a State Exchange develops in order to correct errors resulting in improper payments of APTC identified through SEIPM.

Difference Resolution means the process by which a State Exchange may initially request HHS to reconsider one or more errors or improper payment findings documented in a Sampled Unit Assessment Package. The Difference Resolution is the first level of appeal.

Difference Resolution Decision means the HHS decision resulting from a State Exchange's request for a difference resolution or an appeal of any Sampled Unit Assessment Package.

Error means a finding by HHS that a State Exchange did not correctly apply a requirement of subparts D and E of this part related to:

(1) Eligibility for and enrollment in a Qualified Health Plan (QHP);

(2) Eligibility for APTC, and calculated amount of APTC;

(3) Redeterminations of eligibility during a plan year;

(4) Eligibility redeterminations for purposes of re-enrollment.

Measurement Year means the calendar year in which the processes described in § 155.1625 are initiated. The Measurement Year immediately follows the Plan Year and is the second year of the SEIPM Cycle.

Reporting Year means the calendar year in which HHS reports the improper payment rate for State Exchanges as required under § 155.1625(c), following completion of the measurement processes for the applicable Plan Year. The Reporting Year immediately follows the Measurement Year and is the last year of the SEIPM Cycle.

Sampled Unit Assessment Package means the collection of findings and supporting documentation that HHS prepares in order to record errors at the tax household level using the process described § 155.1625.

State Exchange Improper Payment Measurement or SEIPM means the process for determining estimated improper payments of APTC that are administered by State Exchanges as required under the Payment Integrity Information Act of 2019, which includes

a review of a State Exchange's APTC-related determinations regarding:

(1) Eligibility for and enrollment in a QHP;

(2) Eligibility for APTC, and calculated amount of APTC;

(3) Redeterminations of eligibility during a Plan Year;

(4) Annual eligibility redeterminations.

SEIPM Cycle means the 3-year period consisting of the Plan Year, Measurement Year, and Reporting Year, during which the improper payment measurement process occurs for the Plan Year that is subject to review.

Tax household means the applicant, the applicant's spouse if the applicant is married and files a joint return, and all individuals who are dependents of the applicant or spouse as defined in 26 U.S.C. 152.

§ 155.1615 Information submission

(a) HHS will issue an Annual Program Schedule to each State Exchange no later than January 5th of the Measurement Year. The Annual Program Schedule will specify the deadlines for all information submissions required under this section.

(b) On an annual basis, each State Exchange must submit or make available to HHS the following information:

(1) *Program documentation.* Policy, operational and technical documentation concerning business rules and APTC calculations that pertain to consumer eligibility and enrollment processes of the State Exchange as well as information that describes the data system architecture of the State Exchange such as entity relationship diagrams and data dictionaries.

(2) *Universe.* For the Plan Year being reviewed, a listing of the population of tax households that have associated QHP enrollments and payments of APTC. For each tax household within the universe, the State Exchange must submit the following information:

(i) Exchange assigned policy identifier;

(ii) Tax household grouping identifier;

(iii) SSN inconsistency indicator;

(iv) Citizenship inconsistency indicator;

(v) Lawful presence inconsistency indicator;

(vi) Annual income inconsistency indicator;

(vii) Non-employer sponsored minimum essential coverage inconsistency indicator;

(viii) Employer sponsored minimum essential coverage inconsistency indicator;

(ix) Incarceration inconsistency indicator;

(x) Residency inconsistency indicator;

(xi) Number of tax household members; and

(xii) APTC amount paid over the duration of the benefit year.

(3) *Tax household Data.* For each of the sampled tax households and in a format specified by HHS:

(i) Information pertaining to the calculation of the APTC benefits paid that includes monthly enrollment premium amounts, monthly APTC payment amounts, monthly Second Lowest Cost Silver Plan Premium amounts, and the amount of each monthly premium that is attributable to essential health benefits.

(ii) Information relevant to enrollment that includes dates and amounts of effectuation payments, premium payment amount, and policy start and end dates.

(iii) Information relevant to the determination of eligibility for a special enrollment period (where applicable), which would include (where applicable) information collected by the State Exchange about consumer attestations and representations regarding special enrollment period eligibility criteria, copies of documentary evidence submitted by applicants, electronic verification information, and timing information.

(iv) Information about the timing of QHP certification or approval, the coverage area of the associated QHP, and the timing of any QHP decertification or suppression.

(v) To the extent applicable, for each person who is included in the APTC payment calculation:

(A) Information collected by the State Exchange about consumer attestations regarding QHP and APTC eligibility factors and demographic information relevant to initial QHP enrollment and eligibility.

(B) APTC eligibility and payment determinations which includes evidence of required data verifications, the electronic sources consulted, the timing of required verifications, and the results of the verification.

(C) Information relevant to QHP and APTC manual eligibility verifications and the resolution of electronic verification inconsistencies, which would include copies of documentary evidence submitted by QHP enrollees, the timing of submissions, the timing of adjudication, and information about good faith extensions.

(D) Information relevant to QHP and APTC eligibility redeterminations such as information about automatic annual redeterminations, the timing and results of periodic examinations of data sources, and policy or application changes initiated by the consumer and resultant electronic or manual eligibility verifications.

(vi) Any consumer submitted documents that were used to establish new or continued eligibility for enrollment in a QHP and APTC.

§ 155.1620 Sampling procedures.

(a) *Sample size.* At the beginning of each SEIPM cycle, HHS will calculate a sample size in aggregate across all State Exchanges.

(1) *Statistical Methodology.* The sample size will be calculated to estimate an improper payment rate.

(2) *State-specific sample sizes.* HHS will develop sample sizes specific for each State Exchange. HHS may take into consideration the following factors in determining each State Exchange's sample size for the current SEIPM cycle:

(i) Overall APTC expenditures associated with the State Exchange.

(ii) State-level precision goals for the current SEIPM cycle.

(iii) The improper payment rate from the State Exchange's previous SEIPM cycle.

(3) *Sample size parameters.* HHS will establish minimum and maximum sample sizes to ensure statistical validity while maintaining operational feasibility across State Exchanges of varying sizes.

(b) *Sample selection procedures.* On an annual basis, HHS will select samples of tax households from the data provided by each State Exchange as described in § 155.1615(b)(2).

(c) *State Exchange coordination and notification.*

(1) *Sampled records notification.* Following receipt of the universe data from State Exchanges as described in § 155.1615(b)(2), HHS will notify each State Exchange of the specific records selected for review. This notification will include:

(i) The total number of sampled tax households selected for the State Exchange.

(ii) A unique identifier for each sampled tax household.

(iii) Any specific instructions or requirements that HHS determines are needed to facilitate HHS' review of the sampled records.

(2) *Timing of sampled records notification.* HHS will provide the sampled records notification described in paragraph (c)(1) of this section no later than 60 days after receipt of complete universe data from all State Exchanges.

(3) *Extension of sampling notification timeline.*

(i) HHS may extend the 60-day timeline specified in paragraph (c)(2) of this section if:

(A) Technical issues prevent completion of the sampling process within the standard timeframe;

(B) Data quality issues require additional coordination with State Exchanges before sampling can be completed; or

(C) Other circumstances beyond HHS's control necessitate additional time to ensure accurate sampling methodology.

(ii) If HHS determines an extension is necessary, HHS will:

(A) Notify all affected State Exchanges in writing of the extension and the revised notification date;

(B) Provide the reason for the extension; and

(C) Confirm the impact, if any, on subsequent SEIPM cycle timelines.

§ 155.1625 Determining payment errors.

(a) *Review of records and error identification.* (1) *Systematic review process.* For each sampled record, HHS will conduct a comprehensive review of all information provided by the State Exchange using standardized review criteria.

(2) *Data sources.* HHS will conduct reviews using the tax household information provided under § 155.1615(b)(3), supplemented by any relevant consumer-submitted documents that were gathered by the State Exchange as part of the enrollment and eligibility process and provided to HHS.

(3) *Error identification.* The review will identify whether the State Exchange made any errors related to the following resulting in improper payments of APTC:

(i) Enrolling or re-enrolling a consumer into a QHP for which APTC was paid.

(ii) Consumer eligibility for APTC being paid on the consumer's behalf.

(iii) Calculating the APTC amount that was paid on the consumer's behalf.

(iv) Taking required actions upon changes to a consumer's status that would affect their APTC-related eligibility or payment amount.

(4) *Review standards and criteria.* HHS will apply consistent review standards based on the APTC-related determination requirements established in subparts D and E of this part, and other applicable provisions of this part.

(b) *Error evaluation.* HHS will evaluate each error to determine an improper payment amount. For each error identified, HHS will:

(1) Calculate the correct APTC amount based on the requirements of section 36B of the Internal Revenue Code and applicable implementing regulations.

(2) Determine an improper payment amount.

(3) Document the error and improper payment amount within a Sampled Unit Assessment Package and provide the Sampled Unit Assessment Package to the State Exchange.

(4) Extrapolate the identified improper payments from the sample to estimate the total improper payment amount for the State Exchange's entire universe of APTC payments, using statistically valid methodologies that comply with OMB guidance on improper payment estimation.

(c) *Reporting.* HHS will report annually in the Agency Financial Report, which is made available to the public:

(1) The estimated aggregate improper payment rate for Federal and State Exchanges combined.

(2) The estimated aggregate improper payment rate for State Exchanges, and;

(3) HHS will provide to each State Exchange a report that documents the State-specific improper payment rate and error analysis.

§ 155.1630 Difference Resolution and appeal process.

(a) *Difference Resolution.*

(1) The State Exchange may make a written Difference Resolution request to HHS within 30 days after the issuance of the Sampled Unit Assessment Package to dispute HHS' error and improper payment findings.

(2) Upon receipt of a Difference Resolution request, HHS will do the following:

(i) Engage with the State Exchange in a collaborative process to examine the disputed findings and any additional documentation provided by the State Exchange.

(ii) Evaluate the disputed findings by applying the same protocol used in the original review while considering whether the State Exchange's position is supported by the existing or newly provided evidence.

(iii) Prepare the Difference Resolution Decision.

(3) The Difference Resolution Decision will be communicated to the State Exchange within 90 days of receipt of the written request for a Difference Resolution. The Difference Resolution Decision will include a summary of the analysis and rationale that informed the decision.

(b) *Administrative Appeal.*

(1) To dispute a Difference Resolution Decision, the State Exchange may make a written request for an administrative appeal within 15 business days after the issuance of the Difference Resolution Decision.

(i) The State Exchange may not submit new evidence; it may use evidence that was previously submitted during Difference Resolution.

(ii) The State Exchange may provide additional context regarding information that was submitted during Difference Resolution.

(2) Upon receipt of an appeal request, HHS will do the following:

(i) Assign the appeal request to one or more administrative appeal reviewers who were not involved in the original review;

(ii) Conduct a comprehensive review of the disputed findings using the administrative record established during the Difference Resolution process;

(iii) Independently evaluate the disputed findings by applying the same protocol used in the original review while considering whether the State Exchange's position is supported by the evidence; and

(iv) Prepare an appeal decision for the completed review based on a preponderance of the evidence.

(3) HHS will issue the appeal decision within 90 days of receipt of the written request for appeal. The appeal decision will include a summary of the analysis and rationale that informed the decision.

(c) *Difference Resolution and administrative appeal submission requirements.* All Difference Resolution and appeal requests must be filed in a form and manner specified by HHS and contain the following:

(1) A clear statement of the specific finding(s) being challenged.

(2) All factual and legal bases for filing the request.

(3) Evidence directly related to the finding(s), which may include:

(i) Clarifying information regarding data interpretation.

(ii) Legal citations supporting the State Exchange's position.

(d) *Timing of Difference Resolution and Administrative Appeal decisions.*

(1) For Difference Resolution Requests or administrative appeals resolved in favor of the State Exchange during the current SEIPM cycle:

(i) HHS will adjust the affected improper payment rate calculations for the SEIPM cycle.

(ii) Updated aggregate rates will be reflected in current cycle reporting.

(2) For Difference Resolution Requests or administrative appeals resolved in favor of the State Exchange after completion of the SEIPM cycle:

(i) If Difference Resolution or administrative appeal decisions result

in material changes to aggregate rates, HHS will publish amended aggregate improper payment rates in subsequent Agency Financial Reports or other appropriate public reporting mechanisms as well as notify affected State Exchanges of any amendments to previously published rates.

(ii) If HHS determines, at its discretion, that the Difference Resolution or administrative appeal decisions do not result in material changes to aggregate rates, no action will be taken to publish amended aggregated improper payment rates or notify affected State Exchanges.

(e) *Good cause exception.* For good cause, HHS may extend the timelines for accepting a Difference Resolution request or administrative appeal request or for issuing a Difference Resolution Decision or Administrative Appeal Decision. The failure of HHS to timely issue a Difference Resolution or Administrative Appeal decision does not indicate an acceptance of the State Exchange's position and is not a basis to decide in favor of the State Exchange.

§ 155.1635 Corrective action plan (CAP).

(a) *CAP.* HHS may require the State Exchange to develop and submit a proposed CAP to correct errors resulting in improper payments.

(b) *Development of proposed CAP.* A State Exchange's proposed CAP must address errors that are included in the State Exchange improper payment report described in § 155.1625(c)(2) and must be developed in accordance with HHS requirements.

(1) In developing a proposed CAP, the State Exchange must conduct an error analysis such as reviewing causes, characteristics, and frequency of errors that are associated with improper payments. The State Exchange must review the findings of the analysis to determine the causes of the errors included in the State Exchange improper payment rate, if any, and to identify the root causes of the resulting improper payments.

(i) If a State Exchange has a pending Difference Resolution request or administrative appeal and HHS requests a CAP, HHS may provide a new timeline for CAP submission after the Difference Resolution or Administrative Appeal Decision and calculation of the final improper payment rate.

(2) The State Exchange must determine the corrective actions to be implemented to correct causes of the errors included in the State Exchange improper payment rate and to prevent them from occurring again.

(3) The proposed CAP must include measurable milestones, accountability mechanisms, regular monitoring and validation of progress, documentation of implemented corrective actions, and regular status updates. The CAP must include all the following for each identified error:

(i) The specific corrective action.

(ii) Status of the corrective action.

(iii) Scheduled or actual implementation date of the corrective action.

(iv) Key personnel responsible for implementing each corrective action.

(iv) A plan for monitoring the effectiveness of the corrective action.

(c) *Implementation and evaluation of CAP.* A State Exchange must develop an implementation schedule for its CAP, implement the plan in accordance with that schedule, and regularly evaluate whether the initiatives are effective at reducing or eliminating error causes. The State Exchange must provide updates on CAP implementation progress in a manner and frequency specified by HHS, but at least annually.

(d) *Failures in the CAP process.* If a State Exchange does not submit a CAP when one has been required, submits an incomplete CAP that does not address all the required parts of a CAP as specified in paragraph (b)(3) of this section, fails to follow the implementation schedule referenced in paragraph (c), or submits a CAP that is otherwise unacceptable following technical assistance from HHS, HHS may take actions consistent with § 155.1650.

§ 155.1640 SEIPM preparation phase.

(a) Any State Exchange in its first year of operation must participate in a 1-year SEIPM preparation phase prior to participating in SEIPM in the subsequent year.

(b) To satisfy the requirements of the SEIPM preparation phase, a State Exchange must:

(1) Complete the information submission requirements in § 155.1615(b)(1) and (3) using information from the most current Plan Year for a sample size not to exceed 10 unique tax households that address scenarios specified by HHS.

(2) Undergo the review procedures in § 155.1625(a) and (b).

(3) Participate in technical assistance activities provided by HHS, which may include:

(i) Training on SEIPM requirements and procedures;

(ii) System readiness assessments;

(iii) Data quality validation exercises; and

(iv) Process improvement recommendations.

(c) At the beginning of each calendar year, HHS will provide any State Exchange that meets either of the conditions in paragraphs (a)(1) and (2) of this section with a schedule that spans a 12-month period that specifies when the requirements of this section must be completed.

§ 155.1645 Minimizing potential duplicate audit requirements.

HHS will minimize potential duplicate requirements of the annual independent external programmatic audit described at § 155.1200(c) and (d) and SEIPM, such that, as determined by HHS, a State Exchange may be deemed to satisfy certain requirements of § 155.1200(c) and (d), particularly the review of compliance with subparts D and E, as identified in HHS sub-regulatory guidance, for a particular plan year by successfully completing the SEIPM process.

§ 155.1650 Failure to comply.

(a) *General principle.* For purposes of improper payment measurement under this subpart, HHS will classify APTC payments as improper when a State Exchange fails to provide adequate documentation demonstrating that such payments were made in accordance with applicable Federal requirements.

(b) *Determination of substantial noncompliance.* HHS will determine that a State Exchange has failed to substantially comply with this subpart if the State Exchange:

(1) Fails to submit required data or documentation within the timelines specified in the Annual Program Schedule.

(2) Submits data or documentation that is incomplete, inaccurate, or in a format that would reasonably prevent effective review.

(3) Fails to implement the CAP process as set out in § 155.1635(d).

(4) A pattern, that is more than five instances during a SEIPM cycle, of non-response within 30 calendar days to HHS requests for clarification or additional information.

(c) *Notice and opportunity to cure.* Before implementing measures under paragraph (d) of this section, HHS will:

(1) Provide written notice to the State Exchange specifying the nature of the noncompliance and the potential consequences.

(2) Allow the State Exchange a reasonable opportunity, not less than 30 days, to cure the noncompliance or demonstrate that compliance has been achieved.

(d) *Remedial measures.* If a State Exchange fails to substantially comply with the data collection requirements, the CAP provisions contained in this subpart, or HHS requests for

clarification or additional information, and HHS finds that such failures undermine or prohibit HHS's efficient administration of Exchange improper payment measurement activities, HHS may implement measures or procedures for:

(1) Enhanced monitoring and reporting.

(2) Mandatory implementation of specific operational procedures or controls.

(3) On-site visits to State Exchange facilities to assess operational procedures, data systems, and compliance with program requirements.

(e) *Escalation procedures.* If a State Exchange continues to fail to comply after implementation of initial remedial measures under paragraph (d) of this section, HHS may initiate proceedings to revoke the State Exchange's authority to operate in accordance with applicable law.

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

■ 23. The authority citation for part 156 continues to read as follows:

Authority: 42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, and 26 U.S.C. 36B.

■ 24. Section 156.80 is amended by revising the heading of paragraph (d) and paragraph (d)(2)(ii) to read as follows:

§ 156.80 Single risk pool.

* * * * *

(d) *Index rate.*

* * * * *

(2) * * *

* * * * *

(ii) The plan's provider network, delivery system characteristics, utilization management practices, and for catastrophic plans with terms of multiple consecutive years, the length of the entire term, to account for such plans' benefit characteristics, such as their deductible and maximum out-of-pocket cost structure.

* * * * *

■ 25. Section 156.115 is amended by—

■ a. Redesignating paragraphs (a)(2) through (a)(6) as paragraphs (a)(3) through (a)(7);

■ b. Adding new paragraph (a)(2); and

■ c. Revising paragraph (d).

The addition and revision read as follows:

§ 156.115 Provision of EHB.

(a) * * *

(2) Are required by a State action taking place on or before December 31, 2011.

* * * * *

(d) For plan years beginning before January 1, 2026, an issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB. For plan years beginning on any day in calendar year 2026, an issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, non-medically necessary orthodontia, or specified sex-trait modification procedures (as defined at § 156.400) as EHB. For plan years beginning on or after January 1, 2027, an issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, non-medically necessary orthodontia, or specified sex-trait modification procedures (as defined at § 156.400) as EHB.

* * * * *

■ 26. Section 156.130 is amended by—

■ a. Revising paragraph (a)(2);

■ b. Redesignating paragraphs (c) through (h) as paragraphs (d) through (i); and

■ c. Adding new paragraph (c).

The revision and addition read as follows:

§ 156.130 Cost-sharing requirements.

(a) * * *

(2) Except as permitted in § 156.136, for a plan year beginning in a calendar year after 2014, cost sharing may not exceed the following:

* * * * *

(c) *Special rule for catastrophic plans with consecutive multi-year terms.* In the case of a catastrophic plan with a consecutive multi-year term, the annual limitation on cost sharing for the initial plan year of the contract may apply on an annual basis, or on average over the life of the contract.

* * * * *

■ 27. Part 156 is amended by adding § 156.136 to subpart B to read as follows:

§ 156.136 Expanded cost-sharing parameters.

For plan years beginning on or after January 1, 2027, if an issuer offers a bronze plan (as defined at § 156.140(b)(1)) in the individual market that complies with the cost-sharing requirements at § 156.130 and the levels of coverage requirements at § 156.140, it may also offer, within the same service area, bronze plans that utilize a cost-sharing design that exceeds the maximum annual limitation on cost sharing at § 156.130 by amounts in increments of 50 dollars in order to achieve an AV within the standard bronze de minimis variation at § 156.140(c), calculated as described in § 156.135 of this subpart.

■ 28. Section 156.155 is amended by—

■ a. Revising paragraphs (a)(1) and (3); and

■ b. Adding paragraph (a)(6).

The revisions and addition read as follows:

§ 156.155 Enrollment in catastrophic plans.

(a) * * *

(1) Meets all applicable requirements for health insurance coverage in the individual market other than as permitted under paragraph (a)(6) of this section or as required under § 156.80 (including but not limited to those requirements described in parts 147 and 148 of this subchapter), and is offered only in the individual market.

* * * * *

(3)(i) For plan years beginning before January 1, 2027, provides coverage of the essential health benefits under section 1302(b) of the Affordable Care Act, except that the plan provides no benefits for any plan year (except as provided in paragraphs (a)(4), (b), and (c) of this section) until the annual limitation on cost sharing in section 1302(c)(1) of the Affordable Care Act is reached.

(ii) For plan years beginning on or after January 1, 2027, provides coverage of the essential health benefits under section 1302(b) of the Affordable Care Act, except that the plan provides no benefits for any plan year (except as provided in paragraphs (a)(4), (b), and (c) of this section) until an amount equal to 130 percent of the annual limitation on cost sharing in section 1302(c)(1) of the Affordable Care Act, rounded down to the next lowest multiple of 50 dollars, is reached.

* * * * *

(6) Has a plan term of either 1 year, or of multiple consecutive years not to exceed 10 years. Such a plan with a plan term of at least 2 consecutive years may utilize value-based insurance designs to provide benefits for preventive services under section 2713 of the Public Health Service Act beyond those specified in section 2713(a)(1)-(5) prior to the enrollee's satisfaction of the plan's deductible and prior to satisfying

the plan's annual limitation on cost sharing.

* * * * *

§ 156.201 [Removed]

■ 29. Remove § 156.201.

§ 156.202 [Removed]

■ 30. Remove § 156.202.

■ 31. Section 156.230 is amended by revising the section heading, paragraphs (a)(1) introductory text, (a)(2)(i) introductory text, (a)(2)(ii), and (a)(3) and (4) to read as follows:

§ 156.230 Provider access standards for network plans.

(a) * * *

(1) A QHP that uses a network of providers must ensure that the provider network consisting of in-network providers, as available to all enrollees, meets the following standards:

* * * * *

(2) * * *

(i) *Standards.* A QHP issuer in a Federally-facilitated Exchange in a State that CMS has not determined to have an Effective Provider Access Review Program as described in § 155.1050(d) must comply with the requirement in paragraph (a)(1)(ii) of this section by:

* * * * *

(ii) *Justification.* If a plan applying for QHP certification to be offered through a Federally-facilitated Exchange in a State that CMS has not determined to have an Effective Provider Access Review Program as described in § 155.1050(d) does not satisfy the network adequacy standards described in paragraphs (a)(2)(i)(A) and (B) of this section, the issuer must include as part of its QHP application a justification describing how the plan's provider network provides an adequate level of service for enrollees and how the plan's provider network will be strengthened and brought closer to compliance with the network adequacy standards prior to the start of the plan year. The issuer must provide information as requested by the FFE to support this justification.

(3) When CMS is conducting provider access reviews under paragraph (a)(2)(i)(A) and (B) of this section, the Federally-facilitated Exchange may grant an exception to the requirements in paragraphs (a)(2)(i)(A) and (B) of this section if the Exchange determines that making such health plan available through such Exchange is in the interests of qualified individuals in the State or States in which such Exchange operates.

(4) A limited exception to the requirement described under *paragraph (a)(1)* of this section is available to stand-alone dental plans issuers that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers; this exception is not available to medical QHP issuers. Under this exception, an area is considered ''prohibitively difficult'' for the stand-alone dental plan issuer to establish a network of dental providers based on attestations from State departments of insurance in States with at least 80 percent of counties classified as Counties with Extreme Access Considerations (CEAC) that at least one of the following factors exists in the area of concern: a significant shortage of dental providers, a significant number of dental providers unwilling to contract with Exchange issuers, or significant geographic limitations impacting consumer access to dental providers.

* * * * *

■ 32. Section 156.235 is amended by revising the section heading, and paragraphs (a)(1), (a)(2) introductory text, (a)(2)(i), (a)(2)(ii) introductory text, (a)(3), (a)(5), and (b) to read as follows:

§ 156.235 Essential community provider standards for network plans.

(a) * * *

(1) A QHP issuer that uses a provider network consisting of in-network providers must ensure that the provider network of each of its QHPs includes a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the Exchange's network adequacy standards.

(2) A network plan applying for QHP certification to be offered through a Federally-facilitated Exchange has a sufficient number and geographic distribution of ECPs if it demonstrates in its QHP application that—

(i) The QHP issuer's provider network includes as participating providers at least a minimum percentage, as specified by HHS, of available ECPs in each network plan's service area collectively across all ECP categories defined under paragraph (a)(2)(ii)(B) of this section, and at least a minimum percentage of available ECPs in each network plan's service area within certain individual ECP categories, as specified by HHS. Multiple providers at a single location will count as a single ECP toward both the available ECPs in the network plan's service area and the issuer's satisfaction of the ECP participation standard. For network plans that use tiered networks, to count toward the issuer's satisfaction of the ECP standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. For network plans with two network tiers (for example, participating providers and preferred providers), such as many preferred provider organizations (PPOs), where cost-sharing is lower for preferred providers, only preferred providers will be counted towards ECP standards; and

(ii) The issuer of the network plan offers contracts to—

* * * * *

(3) A network plan applying for QHP certification to be offered through a Federally-facilitated Exchange must include as part of its QHP application the status of contract offers to qualified ECPs available in the network plan's service area. A network plan does not need to report on the status of contract offers for all available ECPs in the network plan's service area, but must at least report on the status of contract offers for all ECPs which the issuer has either included in its network plan or offered a contract to be included in its network plan within each service area.

* * * * *

(5) A network plan that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section.

(b) *Alternate ECP standard.*

(1) A network plan described in paragraph (a)(5) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities, to ensure reasonable and timely access for low-income individuals or individuals residing in Health Professional Shortage Areas within the network plan's service area, in accordance with the Exchange's network adequacy standards.

(2) A network plan described in paragraph (a)(5) of this section applying for QHP certification to be offered through a Federally-facilitated Exchange has a sufficient number and geographic distribution of employed or contracted providers if it demonstrates in its QHP application that—

(i) The number of its providers that are located in Health Professional Shortage Areas or five-digit zip codes in which 30 percent or more of the population falls below 200 percent of the Federal poverty level satisfies a minimum percentage, specified by HHS,

of available ECPs in each network plan's service area collectively across all ECP categories defined under paragraph (a)(2)(ii)(B) of this section, and at least a minimum percentage of available ECPs in each network plan's service area within certain individual ECP categories, as specified by HHS. Multiple providers at a single location will count as a single ECP toward both the available ECPs in the network plan's service area and the issuer's satisfaction of the ECP participation standard. For network plans that use tiered networks, to count toward the issuer's satisfaction of the ECP standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. For network plans with two network tiers (for example, participating providers and preferred providers), such as many PPOs, where cost sharing is lower for preferred providers, only preferred providers would be counted towards ECP standards; and

(ii) The issuer's integrated delivery system provides all of the categories of services provided by entities in each of the ECP categories in each county in the network plan's service area as outlined in the general ECP standard, or otherwise offers a contract to at least one ECP outside of the issuer's integrated delivery system per ECP category in each county in the network plan's service area that can provide those services to low-income, medically underserved individuals.

(3) A network plan applying for QHP certification to be offered through a Federally-facilitated Exchange must include as part of its QHP application the status of contract offers to qualified ECPs available in the network plan's service area. A network plan does not need to report on the status of contract offers for all available ECPs in the network plan's service area, but must at least report on the status of contract offers for all ECPs which the issuer has either included in its network plan or offered a contract to be included in its network plan within each service area.

* * * * *

■ 33. Part 156 is amended by adding § 156.236 to subpart C to read as follows:

§ 156.236 Provider access and essential community providers standards for non-network plans.

(a) A QHP that does not use a network of providers (a non-network plan) must ensure access to a range of providers that accept the non-network plan's benefit amount as payment in full, including essential community providers (ECPs) and providers that specialize in mental health and substance use disorder services, to ensure that services will be accessible without unreasonable delay. A non-network plan does not provide access to a range of providers in this manner by simply providing some benefit amount for covered services rendered by any provider without providing the Exchange any other contextual information.

(b) A non-network plan applying for QHP certification to be offered as a QHP through a Federally-facilitated Exchange must submit the following information to the Federally-facilitated Exchange for a determination that it provides access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full, and reasonable and timely access to ECPs that accept the plan's benefit amount as payment in full:

(1) The non-network plan's assessed percentage of providers in each plan's service area that accepts the plan's benefit amount as payment in full; and for ECPs, whether the non-network plan meets at least a minimum percentage, as specified by HHS, of available ECPs that accept the plan's benefit amount as payment in full in each plan's service area collectively across all ECP categories defined under § 156.235(a)(2)(ii)(B), and at least a minimum percentage of available ECPs that accept the plan's benefit amount as payment in full in each plan's service area within certain individual ECP categories, as specified by HHS;

(2) For ECPs, whether the non-network plan offers the benefit amount as payment in full to at least one ECP in each of the eight (8) ECP categories per county in the plan's service area described in § 156.235(a)(2)(ii)(B);

(3) For ECPs, whether the non-network plan offers the benefit amount as payment in full to all available Indian health care providers in the plan's service area;

(4) The non-network plan's strategy for conducting continuous outreach to available providers (including ECPs) in a particular area to determine whether they would accept the plan's benefit amount as payment in full;

(5) The non-network plan's strategy for making benefit amounts available publicly to the public, including plan enrollees, potential enrollees, and providers (including ECPs), in an easily accessible and understandable format;

(6) The non-network plan's methodology for determining benefit amounts;

(7) The non-network plan's strategy for providing consumer-friendly and public information about potential balance billing scenarios and expected out-of-pocket costs, including historical data on actual out-of-pocket costs incurred by its enrollees while accessing providers (including ECPs) in the area;

(8) The availability of an exceptions process under the non-network plan for enrollees who cannot find providers (including ECPs) willing to accept the benefit amount as payment in full; and

(9) The non-network plan's strategy for providing adequate customer service or online provider directory assistance resources to assist plan enrollees and potential enrollees in finding providers (including ECPs) in their area who will accept the plan's benefit amount as payment in full.

§ 156.265 [Amended]

■ 34. Section 156.265 is amended by removing paragraph (b)(3)(iv).

■ 35. Section 156.275 is amended by revising paragraphs (a)(1)(viii) and (c)(2)(iv) to read as follows:

§ 156.275 Accreditation of QHP issuers.

(a) * * *

(1) * * *

(viii) Provider access; and

* * * * *

(c) * * *

(2) * * *

(iv) *Provider access.* The provider access standards for accreditation used by the recognized accrediting entities must, at a minimum, be consistent with the general requirements for network plans codified in § 156.230(a)(2) and (3) and the general requirements for non-network plans codified in § 156.236(a).

* * * * *

■ 36. Section 156.480 is amended by revising paragraph (c) introductory text and paragraph (c)(6) to read as follows:

§ 156.480 Oversight of the administration of the advance payments of the premium tax credit, cost-sharing reductions, and user fee programs.

* * * * *

(c) *Audits and compliance reviews.* HHS or its designee may audit or conduct a compliance review of an issuer offering a QHP through an Exchange to assess its compliance with the applicable requirements related to administration of the advance payments of the premium tax credit, cost-sharing reductions, and user fee programs. Compliance reviews conducted under this section will follow the standards set forth in § 156.715.

* * * * *

(6) *Circumstances requiring HHS enforcement.* If HHS determines that the State Exchange or State-based Exchange on the Federal platform is not enforcing or fails to substantially enforce compliance with the applicable

requirements related to administration of the advance payments of the premium tax credit, cost-sharing reductions, and user fee programs, then HHS may do so and may pursue the imposition of civil money penalties as specified in § 156.805 for noncompliance by QHP issuers participating in the State Exchange or State-based Exchange on the Federal platform.

■ 37. Section 156.800 is amended by revising paragraph (b) to read as follows:

§ 156.800 Available remedies; Scope.

* * * * *

(b) *Scope.* Sanctions under subpart I are applicable for noncompliance with QHP issuer participation standards and other standards applicable to issuers offering QHPs in a Federally-facilitated Exchange. Sanctions under paragraph (a)(1) of this section are also applicable for noncompliance by QHP issuers participating in State Exchanges and State-based Exchanges on the Federal platform when HHS is responsible for enforcement of any of the requirements applicable to the actions identified in § 156.805(a) that are applicable to issuers offering a QHP in a State Exchange or State-based Exchange on the Federal platform.

* * * * *

■ 38. Section 156.805 is amended by revising paragraphs (b) introductory text and (f) to read as follows:

§ 156.805 Bases and process for imposing civil money penalties in Federally-facilitated Exchanges.

* * * * *

(b) *Factors in determining the amount of civil money penalties assessed.* In determining the amount of civil money penalties, HHS will identify the lawful purpose or purposes of the civil money penalty, and take into account the following factors as appropriate to the circumstances of the case:

* * * * *

(f) *Circumstances requiring HHS enforcement in State Exchanges and State-based Exchanges on the Federal platform.* (1) HHS will enforce the requirements applicable to the actions identified in paragraph (a) of this section that are applicable to issuers offering a QHP in a State Exchange or State-based Exchange on the Federal platform, if the State with enforcement authority over such Exchange notifies HHS that it is not enforcing these requirements or if HHS makes a determination using the process set forth at 45 CFR 150.201, *et seq.* that such State is failing to substantially enforce these requirements.

(2) If HHS is responsible under paragraph (f)(1) of this section for enforcement of the requirements applicable to the actions identified in paragraph (a) of this section that are applicable to issuers offering a QHP in a State Exchange or State-based Exchange on the Federal platform, HHS may impose civil money penalties on an issuer in such Exchange, in accordance with the bases and process for imposing civil money penalties set forth in this section.

■ 39. Section 156.810 is amended by revising paragraph (a)(8) to read as follows:

§ 156.810 Bases and process for decertification of a QHP offered by an issuer through a Federally-facilitated Exchange.

(a) * * *

(8) The QHP issuer substantially fails to meet the requirements under § 156.230 related to provider access standards for network plans, § 156.235 related to essential community provider access standards for network plans, or § 156.236 related to provider access and essential community providers standards for non-network plans, as applicable;

* * * * *

■ 40. Section 156.903 is amended by adding paragraph (d) to read as follows:

§ 156.903 Scope of Administrative Law Judge's (ALJ) authority.

* * * * *

(d) The ALJ, upon his or her own motion or at the request of a party, may issue subpoenas if they are reasonably necessary for the full presentation of a case.

(1) The party must file a written request for a subpoena with the ALJ at least 5 calendar days before the date set for the hearing.

(2) The request must:

(i) Identify the witnesses or documents to be produced;

(ii) Describe their addresses or location with sufficient particularity to permit them to be found; and

(iii) Specify the pertinent facts the party expects to establish by the witnesses or documents, and indicate why those facts could not be established without use of a subpoena.

(3) Subpoenas are issued in the name of the Secretary.

■ 41. Section 156.935 is amended by adding paragraph (f) to read as follows:

§ 156.935 Discovery.

* * * * *

(f) This section does not apply to appeals of civil money penalties imposed under § 156.805 for violations identified during audits or compliance reviews conducted in accordance with § 156.480(c).

■ 42. Section 156.1215 is amended by revising paragraphs (b) and (c) to read as follows:

§ 156.1215 Payment and collections processes.

* * * * *

(b) *Netting of payments and charges for later years.* As part of its payment and collections process, HHS may net payments owed to issuers and their affiliates operating under the same tax identification number against amounts due to the Federal Government from the issuers and their affiliates under the same taxpayer identification number for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, payment of Federally facilitated Exchange user fees, payment of State Exchanges utilizing the Federal platform user fees, HHS risk adjustment, reinsurance, and risk corridors payments and charges, administrative fees for utilizing the Federal Independent Dispute Resolution process in accordance with § 149.510(d)(2) of this subchapter, and civil money penalties assessed for violations of any applicable Exchange standards and requirements or Public Health Service Act standards and requirements applicable to issuers.

(c) *Determination of debt.* Any amount owed to the Federal Government by an issuer and its affiliates for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, Federally-facilitated Exchange user fees, including any fees for State-based Exchanges utilizing the Federal platform, HHS risk adjustment, reinsurance, risk corridors, unpaid administrative fees for utilizing the Federal Independent Dispute Resolution process in accordance with § 149.510(d)(2), and civil money penalties assessed for violations of any applicable Exchange standards and requirements or Public Health Service Act standards and requirements applicable to issuers, after HHS nets amounts owed by the Federal Government under these programs, is a determination of a debt.

■ 43. Section 156.1220 is amended by revising paragraph (b)(1) as follow:

§ 156.1220 Administrative appeals.

* * * * *

(b) * * *

(1) *Manner and timing for request.* A request for an informal hearing must be made in writing and filed with HHS

within 30 calendar days of the date of the reconsideration decision under paragraph (a)(6) of this section. If the last day of this period is not a business day, the request for an informal hearing must be made in writing and filed by the next applicable business day.

* * * * *

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

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