

**DEPARTMENT OF THE TREASURY****31 CFR Part 33****DEPARTMENT OF HEALTH AND HUMAN SERVICES****Centers for Medicare & Medicaid Services****42 CFR Parts 435 and 600****Office of the Secretary****45 CFR Parts 153, 155, and 156****[CMS–9895–P]****RIN 0938–AV22****Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO–OP) Program; and Basic Health Program**

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

**ACTION:** Proposed rule.

**SUMMARY:** This proposed rule includes payment parameters and provisions related to the HHS-operated risk adjustment program, as well as 2025 user fee rates for issuers offering qualified health plans (QHPs) through Federally-facilitated Exchanges (FFE) and State-based Exchanges on the Federal platform (SBE-FPs). This proposed rule also includes proposed requirements related to the auto re-enrollment hierarchy; essential health benefits; failure to file and reconcile; non-standardized plan option limits and an exceptions process; standardized plan options; special enrollment periods (SEPs); direct enrollment (DE) entities; Insurance Affordability Program enrollment eligibility verification process; requirements for agents, brokers, web-brokers, and DE entities assisting Exchange consumers; network adequacy; public notice procedures for section 1332 waivers; prescription drug benefits; updates to the Consumer Operated and Oriented Plan (CO–OP) Program; State flexibility on the financial methodology used for Medicaid eligibility determinations for non-modified adjusted gross income (MAGI) populations; and State flexibility on the effective date of coverage in the Basic Health Program (BHP). A summary of this proposed rule

may be found at <https://www.regulations.gov/>.

**DATES:** To be assured consideration, comments must be received at one of the addresses provided below, by January 8, 2024.

**ADDRESSES:** In commenting, please refer to file code CMS–9895–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–9895–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–9895–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:**

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Joshua Paul, (301) 492–4347, Jackie Wilson, (301) 492–4286, or John Barfield, (301) 492–4433, for matters related to HHS-operated risk adjustment.

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

Marisa Beatley, (301) 492–4307, for matters related to the verification process related to eligibility for insurance affordability programs and current sources of income.

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

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

LeAnn Brodhead, (667) 290–8805, for matters related to the essential health benefits prescription drug benefit.

Carolyn Sabini, (667) 290–9750, for matters related to the essential health benefits benchmark plan policy.

Agata Pelka, (667) 290–9979, for matters related to mandates in addition to the essential health benefits.

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

Lina Rashid, (443) 902–2823, or Kimberly Koch (202) 381–6934, for matters related to section 1332 waivers.

Jacquelyn Rudich, (301) 492–5211, for matters related to netting of payments.

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Gene Coffey, (410) 786–2234, for matters related to Medicaid eligibility.

Arshdeep Dhanoa, (301) 492–4400, for matters related to incarceration verification for QHP eligibility and periodic data matching for dual and deceased enrollees.

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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 (ACA).<sup>1</sup> These proposals are

<sup>1</sup> The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this rulemaking, the two statutes are referred to collectively as the “Patient Protection and Affordable Care Act,” “Affordable Care Act,” or “ACA.”

published under the authority granted to the Secretary by the ACA and the Public Health Service (PHS) Act.<sup>2</sup> In this proposed rule, we propose changes related to some of the ACA provisions and parameters we previously implemented and propose to implement new provisions. We also propose a change to Medicaid financial eligibility provisions to provide States with greater flexibility to extend Medicaid eligibility to specific populations based on the State’s circumstances. Our goal with these proposals is providing quality, affordable coverage to consumers while minimizing administrative burden and ensuring program integrity. The changes proposed in this rule are also intended to help advance health equity and mitigate health disparities.

## 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 Public Health Service Act (PHS Act) to establish various reforms to the group and individual health insurance markets.

These provisions of the PHS Act were later augmented by other laws, including the ACA.

Subtitles A and C of title I of the ACA reorganized, amended, and added to the provisions of part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. The term “group health plan” includes both insured and self-insured group health plans.

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

Section 1301(a)(1)(B) of the ACA directs all issuers of qualified health plans (QHPs) to cover the essential health benefit (EHB) package described in section 1302(a) of the ACA, including coverage of the services described in section 1302(b) of the ACA, adherence to the cost-sharing limits described in section 1302(c) of the ACA, and meeting the Actuarial Value (AV) levels established in section 1302(d) of the ACA. Section 2707(a) of the PHS Act, which is effective for plan or policy years beginning on or after January 1, 2014, extends the requirement to cover the EHB package to non-grandfathered individual and small group health insurance coverage, irrespective of whether such coverage is offered through an Exchange. In addition,

<sup>2</sup> See sections 1311, 1312, 1313, 1321, 1332, and 1343 of the ACA and section 2792 of the PHS Act.

section 2707(b) of the PHS Act directs non-grandfathered group health plans to ensure that cost sharing under the plan does not exceed the limitations described in section 1302(c)(1) of the ACA.

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

Section 1311(c) of the ACA provides the Secretary the authority to issue regulations to establish criteria for the certification of QHPs. Section 1311(c)(1)(B) of the ACA requires, among the criteria for certification that the Secretary must establish by regulation, that QHPs ensure a sufficient choice of providers. Section 1311(e)(1) of the ACA grants the Exchange the authority to certify a health plan as a QHP if the health plan meets the Secretary’s requirements for certification issued under section 1311(c) of the ACA, and the Exchange determines that making the plan available through the Exchange is in the interests of qualified individuals and qualified employers in the State. Section 1311(c)(6)(C) of the ACA directs the Secretary of HHS to require an Exchange

to provide for special enrollment periods and section 1311(c)(6)(D) of the ACA directs the Secretary of HHS to require an Exchange to provide for a monthly enrollment period for Indians, as defined by section 4 of the Indian Health Care Improvement Act.

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

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

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

Section 1312(f)(1)(B) of the ACA provides that an individual shall not be treated as a qualified individual for enrollment in a QHP if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.

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

Section 1321(a) of the ACA provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs and other components of title I of the ACA,

including such other requirements as the Secretary determines appropriate. When operating an FFE under section 1321(c)(1) of the ACA, HHS has the authority under sections 1321(c)(1) and 1311(d)(5)(A) of the ACA to collect and spend user fees. Office of Management and Budget (OMB) Circular A–25 Revised establishes Federal policy regarding user fees and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the public.

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

Section 1322 of the ACA establishes the Consumer Operated and Oriented Plan (CO–OP) program, which is a loan program that funds the establishment of private, non-profit, consumer-operated, consumer-oriented health plan issuers of QHPs. The ACA requires, among other requirements, that substantially all of a CO–OP's activities consist of issuing QHPs in the individual and small group markets, and that a CO–OP be governed by a board of directors where a majority is elected by members covered by policies issued by the CO–OP.

Section 1331 of the ACA provides States with the option to operate a Basic Health Program (BHP).

Section 1332 of the ACA provides the Secretary of HHS and the Secretary of the Treasury (collectively, the Secretaries) with the discretion to approve a State's proposal to waive specific provisions of the ACA, provided the State's section 1332 waiver plan meets certain requirements. Section 1332(a)(4)(B) of the ACA requires the Secretaries to issue regulations regarding procedures for the application and approval of section 1332 waivers.

Section 1343 of the ACA establishes a permanent risk adjustment program to provide payments to health insurance issuers that attract higher-than-average risk populations, such as those with chronic conditions, funded by charges collected from those issuers that attract lower-than-average risk populations, thereby reducing incentives for issuers to avoid higher-risk enrollees. Section 1343(b) of the ACA provides that the Secretary, in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section.

Consistent with section 1321(c) of the ACA, the Secretary is responsible for operating the HHS risk adjustment program in any State that fails to do so.<sup>3</sup>

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

Section 1402 of the ACA provides for, among other things, reductions in cost sharing for EHB for qualified low- and moderate-income enrollees in silver level QHPs offered through the individual market Exchanges. This section also provides for reductions in cost sharing for Indians enrolled in QHPs at any metal level.

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

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

Section 1411(g) of the ACA allows the use of applicant information only for the limited 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 ACA directs the Secretary to establish, subject to minimum requirements, a streamlined enrollment process for enrollment in

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

QHPs and all insurance affordability programs.

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

Section 1902(r)(2)(A) of the Social Security Act (the Act), which permits States to apply less restrictive methodologies than cash assistance program methodologies in determining eligibility for certain eligibility groups.

#### 1. Premium Stabilization Programs

The premium stabilization programs refer to the HHS risk adjustment, risk corridors, and reinsurance programs established by the ACA.<sup>4</sup> 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 published 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

establish payment parameters in those programs.

- In the May 27, 2014 **Federal Register** (79 FR 30240), we announced the 2015 fiscal year sequestration rate for the 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 published 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.<sup>5</sup>

- 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 published 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 published in the March 23, 2012 (77 FR 17219) and the December 22, 2016 (81 FR 94058) editions of the **Federal Register**. In the rule, we set forth an additional explanation of the rationale supporting the use of Statewide average premium in the 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 published the 2021 Benefit Year Final HHS Risk Adjustment Model Coefficients on the CCIIO website.<sup>6</sup>

- 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 ICD–10 codes, approved the request from Alabama to reduce HHS risk adjustment transfers by 50

<sup>4</sup> See ACA section 1341 (transitional reinsurance program), ACA section 1342 (risk corridors program), and ACA section 1343 (HHS risk adjustment program).

<sup>5</sup> 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>.

<sup>6</sup> 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>.

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 September 2, 2020 **Federal Register** (85 FR 54820), we issued an interim final rule containing certain policy and regulatory revisions in response to the COVID–19 public health emergency (PHE), wherein we set forth HHS risk adjustment reporting requirements for issuers offering temporary premium credits in the 2020 benefit year.

- In the May 5, 2021 **Federal Register** (86 FR 24140) (part 2 of the 2022 Payment Notice), we finalized a subset of proposals from 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.<sup>7</sup>

- 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 adoption of the interacted HCC count specification for the adult and child models, along with modified enrollment duration factors for the adult model models, beginning with the 2023 benefit year.<sup>8</sup> 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. In addition, 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 also 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 repealed the State flexibility policy, including for prior participant States, and approved 50 percent reductions to HHS risk adjustment transfers for Alabama’s individual and small group markets. In addition, we finalized several 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 also announced the discontinuance of the Lifelong Permanent Condition List (LLPC) and Non-EDGE Claims (NEC) in HHS–RADV beginning with the 2022 benefit year.

## 2. Program Integrity

We have finalized program integrity standards related to the Exchanges and premium stabilization programs in two rules: the “first Program Integrity Rule” published in the August 30, 2013

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

In the April 27, 2023 **Federal Register** (88 FR 25740) (2024 Payment Notice), we finalized a policy to implement 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 documentation requirements for agents and brokers.

## 3. Market Rules

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

- In the April 8, 1997 **Federal Register** (62 FR 16894), HHS, with the Department of Labor and Department of the Treasury, published an interim final rule relating to the HIPAA health insurance reforms. In the February 27, 2013 **Federal Register** (78 FR 13406) (2014 Market Rules), we published the health insurance market rules.

- In the May 27, 2014 **Federal Register** (79 FR 30240) (2015 Market Standards Rule), we published the exchange and insurance market standards for 2015 and beyond.

- In the December 22, 2016 **Federal Register** (81 FR 94058), we provided additional guidance on guaranteed availability and guaranteed renewability.

- In the April 18, 2017 **Federal Register** (82 FR 18346) (Market Stabilization final rule), we further interpreted the guaranteed availability provision.

- In the April 17, 2018 **Federal Register** (83 FR 17058) (2019 Payment Notice), we clarified that certain exceptions to the special enrollment periods only apply to coverage offered outside of the Exchange in the individual market.

- In the June 19, 2020 **Federal Register** (85 FR 37160) (2020 section 1557 final rule), in which HHS discussed section 1557 of the ACA, HHS removed nondiscrimination protections based on gender identity and sexual orientation from the guaranteed availability regulation.

<sup>7</sup> See CMS. (2021, July 19). *2022 Benefit Year Final HHS Risk Adjustment Model Coefficients*. <https://www.cms.gov/files/document/updated-2022-benefit-year-final-hhs-risk-adjustment-model-coefficients-clean-version-508.pdf>.

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

- In part 2 of the 2022 Payment Notice, in the May 5, 2021 **Federal Register** (86 FR 24140), we made additional amendments to the guaranteed availability regulation regarding special enrollment periods and finalized new special enrollment periods related to untimely notice of triggering events, cessation of employer contributions or government subsidies to COBRA continuation coverage, and loss of APTC eligibility.

- In the September 27, 2021 **Federal Register** (86 FR 53412) (part 3 of the 2022 Payment Notice), which was published by HHS and the Department of the Treasury, we finalized additional amendments to the guaranteed availability regulations regarding special enrollment periods.

- In the May 6, 2022 **Federal Register** (87 FR 27208), we finalized a revision to our interpretation of the guaranteed availability requirement to prohibit issuers from applying a premium payment to an individual's or employer's past debt owed for coverage and refusing to effectuate enrollment in new coverage.

#### 4. Exchanges

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

In the August 17, 2011, **Federal Register** (76 FR 51201) we published a proposed rule regarding eligibility determinations, including the regulatory requirement to verify incarceration status. In the March 27, 2012, **Federal Register** (77 FR 18309) we finalized the regulatory requirement to verify incarceration attestation using an approved electronic data source that is current and accurate, and when attestations are not reasonably compatible with information in an approved data source, to resolve the inconsistency.

In the 2014 Payment Notice and the Amendments to the HHS Notice of

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

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

In an interim final rule, published in the May 11, 2016 **Federal Register** (81 FR 29146), we made amendments to the parameters of certain special enrollment periods (2016 Interim Final Rule). We finalized these in the 2018 Payment Notice, published in the December 22, 2016 **Federal Register** (81 FR 94058).

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

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

In the January 19, 2021 **Federal Register** (86 FR 6138) (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 published 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 special enrollment period verifications.

In the April 27, 2023 **Federal Register** (88 FR 25740) (2024 Payment Notice), we revised Exchange Blueprint approval timelines, lowered the user rate fee for QHPs, and amended re-enrollment hierarchies for enrollees. We also finalized policies to update standardized plan options, reduce the risk of plan choice overload by limiting the number of non-standardized plan options that issuers can offer, and ensure correct QHP information. In addition, to prevent gaps in coverage, we amended coverage effective date rules, lengthened the special enrollment period from 60 to 90 days to those who lose Medicaid coverage, and prohibited QHPs on the Federal platform from mid-year coverage terminations 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. To ensure provider network adequacy, we finalized provider network and ECP policies for QHPs.

#### 5. Essential Health Benefits

We established requirements relating to EHBs in the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule, which was published in the February 25, 2013 **Federal Register** (78 FR 12833) (EHB Rule). In the 2019 Payment Notice, published in the April 17, 2018 **Federal Register** (83 FR 16930), we added § 156.111 to provide States with additional options from which to select an EHB-benchmark plan for plan year (PY) 2020 and subsequent plan years. In the 2023 Payment Notice, published in the May 6, 2022 **Federal Register** (87 FR 27208), we revised § 156.111 to require States to notify HHS of the selection of a new EHB-benchmark plan by the first Wednesday in May of the year that is 2 years before the effective date of the new EHB-benchmark plan, otherwise the State's EHB-benchmark plan for the applicable plan year will be that State's EHB-benchmark plan applicable for the prior year. We displayed the Request for Information; Essential Health Benefits (EHB RFI), published in the December 2, 2022 **Federal Register** (87 FR 74097) to solicit public comment on a variety of topics related to the coverage of benefits in health plans subject to the EHB requirements of the ACA.

#### 6. State Innovation Waivers

In the March 14, 2011 **Federal Register** (76 FR 13553), HHS and the Department of the Treasury (collectively, the Departments)



published the “Application, Review, and Reporting Process for Waivers for State Innovation” proposed rule to implement section 1332(a)(4)(B) of the ACA.

In the February 27, 2012 **Federal Register** (77 FR 11700), the Departments published the “Application, Review, and Reporting Process for Waivers for State Innovation” final rule (2012 Final Rule).

In the October 24, 2018 **Federal Register** (83 FR 53575), the Departments issued the 2018 Guidance, which superseded the previous guidance published in the December 16, 2015 **Federal Register** (80 FR 78131) (2015 Guidance) and set forth requirements that States must meet for waivers, application review procedures, pass-through funding determinations, certain analytical requirements, and operational considerations.

In the November 6, 2020 **Federal Register** (85 FR 71142), the Departments issued an interim final rule (November 2020 IFC), which set forth flexibilities for waivers under section 1332 during the COVID-19 Public Health Emergency.

In the December 4, 2020 **Federal Register** (85 FR 78572), the Departments published the “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations” proposed rule (2022 Payment Notice proposed rule) which proposed to codify certain policies and interpretations of the 2018 Guidance.

In the January 19, 2021 **Federal Register** (86 FR 6138), the Departments published the “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations” final rule (part 1 of the 2022 Payment Notice) which codified many of the policies and interpretations of the 2018 Guidance.

In the September 27, 2021 **Federal Register** (86 FR 53412), part 3 of the 2022 Payment Notice, the Departments published the “Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond” final rule, which superseded and rescinded the policies and interpretations outlined in the 2018 Guidance and repealed the previous codification of the interpretations of statutory guidelines in part 1 of the 2022 Payment Notice. The Departments also

finalized flexibilities in the public notice requirements and post-award public participation requirements for section 1332 waivers under certain emergent situations and processes and procedures for amendments and extensions for approved waiver plans.

#### 7. Consumer Operated and Oriented Plans (CO-OPs)

In the December 13, 2011 **Federal Register** (76 FR 77392), we published the “Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program” final rule (2011 CO-OP Rule), which established the rules governing the CO-OP program to make loans to capitalize eligible prospective CO-OPs. In the May 11, 2016 **Federal Register** (81 FR 29146), we amended several CO-OP standards related to governance requirements to provide greater flexibility, and to facilitate private market transactions that would assist efforts of CO-OPs to arrange access to new sources of needed capital.

#### 8. Basic Health Program (BHP)

In the March 12, 2014, **Federal Register** (79 FR 14111), we published a final rule entitled “Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity,” implementing section 1331 of the ACA, which governs the establishment of BHPs.

#### 9. State Flexibility in the Use of Income and Resource Disregards in Medicaid Eligibility

In the January 19, 1993 **Federal Register** (58 FR 4929), we published a final rule with comment period entitled “Medicaid Program; Eligibility and Coverage Requirements,” in which we prescribed, at 42 CFR 435.601, the financial methodologies State Medicaid agencies must apply in determining eligibility for Medicaid, with options to apply less restrictive income and resource methodologies for the eligibility groups specified in section 1902(r)(2) of the Act.

In the August 22, 1994 **Federal Register** (59 FR 43052), we published a final rule entitled “Medicaid Program; Eligibility and Coverage Requirements,” in which we amended 42 CFR 435.601(f)(1) to delete cross-references to other regulatory provisions that had been removed from the CFR.

In the November 30, 2016 **Federal Register** (81 FR 86456), we published a final rule entitled “Medicaid and Children’s Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP,” in which we amended 42 CFR 435.601(b) to confirm that its provisions govern only individuals who are excepted from application of modified adjusted gross income financial methodologies (MAGI) in accordance with 42 CFR 435.603(j) (relating to “Eligibility Groups for which MAGI-based methods do not apply”). We also established in 42 CFR 435.601(d)(1) the authority for States to apply less restrictive methodologies for medically needy individuals whose income eligibility is determined under 42 CFR 435.831(b)(1) (including medically needy individuals whose eligibility is determined under MAGI-based methodologies that comply with certain rules relating to the financial responsibility of relatives and other individuals described in 42 CFR 435.602).

#### B. Summary of Major Provisions

The regulations outlined in this proposed rule would be codified in 31 CFR part 33, 42 CFR parts 435 and 600, and 45 CFR parts 153, 155, and 156.

##### 1. 31 CFR Part 33 and 45 CFR Part 155

This proposed rule would amend section 1332 Waivers for State Innovation (referred to throughout this proposed rule as section 1332 waivers) implementing regulations regarding State public notice and comment procedures. The Departments propose changes in 31 CFR part 33 and 45 CFR part 155 that would allow States the flexibility to hold a State public hearing or post-award forum in a virtual format (that is, one that uses telephonic, digital, and/or web-based platforms), or hybrid format (that is, one that provides for both in-person and virtual attendance), which would be considered as the equivalent of holding an in-person meeting. Specifically, the Departments propose changes to 31 CFR 33.112(c) and 45 CFR 155.1312(c) and 31 CFR 33.120(c) and 45 CFR 155.1320(c). The Departments propose that these changes go into effect upon finalization of this rule. Because these changes would relieve a regulatory restriction, the Departments anticipate that they would be made effective immediately upon publication of a final rule.

## 2. 42 CFR Part 435

We propose to amend 42 CFR 435.601(d) to remove paragraph (d)(4), which would provide States with greater flexibility to adopt income and/or resource disregards in determining Medicaid financial eligibility for individuals excepted from application of financial methodologies based on MAGI (“non-MAGI” methodologies). States are permitted to expand eligibility for individuals who are subject to non-MAGI methodologies by disregarding income and/or resources that would otherwise be required to be considered in the individual’s eligibility determination. However, under current rules, States must apply such income and/or resource disregards to all individuals within each Medicaid eligibility group. Removing paragraph (d)(4) would allow States, when considering expanding eligibility for non-MAGI individuals, to target disregards at discrete members of individuals within an eligibility group.

## 3. 42 CFR Part 600

We propose to amend 42 CFR 600.320(c) to allow States a third option when choosing the effective date of eligibility for BHP applicants. Under current rules, States have the option to choose between following: either the Medicaid rules at 42 CFR 435.915 or the Exchange rules at 45 CFR 155.420(b)(1). We propose to add an option to the effective date of coverage rules that would allow States to start coverage on the first day of the month following the date of application.

## 4. 45 CFR Part 153

In accordance with the OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2024, the HHS-operated risk adjustment program is subject to the fiscal year 2024 sequestration.<sup>9</sup> Therefore, the HHS-operated risk adjustment program will be sequestered at a rate of 5.7 percent for payments made from fiscal year 2024 resources (that is, funds collected during the 2024 fiscal year).

We propose to recalibrate the 2025 benefit year HHS risk adjustment models using the 2019, 2020, and 2021 benefit year enrollee-level EDGE data. For the 2025 benefit year, we propose to continue applying a market pricing adjustment to the plan liability associated with Hepatitis C drugs in the HHS risk adjustment models (see, for

example, 84 FR 17463 through 17466). We propose a modification to the adjustment for the receipt of CSRs in the HHS risk adjustment models to improve predictive accuracy for the American Indian and Alaska Native (AI/AN) subpopulation who are enrolled in zero and limited cost-sharing plans and to retain the other CSR adjustment factors in the HHS risk adjustment models. We also propose a risk adjustment user fee for the 2025 benefit year of \$0.20 per member per month (PMPM). Additionally, we propose that in certain cases we may require a corrective action plan to address an observation identified in an HHS risk adjustment audit.

## 5. 45 CFR Part 155

In part 155, we propose to amend § 155.105(b) to require that a State seeking to operate a State Exchange must first operate an SBE-FP for at least one plan year, including its open enrollment period. We believe this requirement would give States sufficient time to create, staff, and structure a State Exchange that could transition to operating its own platform and establish relationships with interested parties critical to a State Exchange’s success in operating a Navigator and consumer outreach program, assuming plan management responsibilities, and communicating effectively with consumers to support enrollment and avoid health care coverage gaps.

We propose to revise § 155.106(a)(2) as it pertains to Exchange Blueprint requirements for States transitioning to a State Exchange. Specifically, we propose to add that we may require that a State submitting a Blueprint Application seeking to operate a State Exchange provide upon request, supplemental documentation to HHS detailing the State’s implementation of its State Exchange functionality as laid out in the State Exchange Blueprint. This could include a State submitting detailed plans regarding its State Exchange consumer assistance programs and activities, such as information on its direct outreach plans. Further, we propose to require that a State applying to transition to a State Exchange must provide the public with a notice and copy of its State Exchange Blueprint Application, as well as conduct periodic public engagements whereby interested parties can learn about the status of a State’s transition to a State Exchange and provide input on that transition.

We propose to amend § 155.170(a)(2) to codify that benefits covered in a State’s EHB benchmark plan would not be 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. Under this proposal, there would be no obligation for the State to defray the cost of a State mandate enacted after December 31, 2011 that requires coverage of a benefit if that benefit is included in the State’s EHB-benchmark plan. Benefits that are covered in a State’s EHB-benchmark plan would not be considered in addition to EHB and would remain subject to the various rules applicable to the 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. We believe that this change would promote consumer protections and facilitate compliance with the defrayal requirement by making the identification of benefits in addition to EHB more intuitive.

At § 155.205(a), we propose to establish additional minimum standards for Exchange call center operations. Specifically, we propose to require that all Exchange call centers, other than those of SBE-FPs and Small Business Health Options Program (SHOP) Exchanges that do not provide for enrollment in SHOP coverage through an online SHOP enrollment platform, provide consumer access to a live call center representative during an Exchange’s published hours of operation to assist with submitting their QHP application. We believe speaking to a live representative would help troubleshoot consumer QHP application issues, provide in real time an opportunity for a live representative to explain QHP application terminology to a consumer, provide a live representative to ensure the consumer provides the most correct information to the QHP application—alleviating unnecessary follow-up, and provide greater overall consumer satisfaction.

We propose to amend § 155.205(b)(4) to require that an Exchange operate a centralized eligibility and enrollment platform on the Exchange’s website (or, for an SBE-FP, the Federal eligibility and enrollment platform) such that the Exchange allows for the submission of the single, streamlined application for enrollment in a QHP and insurance affordability programs through the Exchange’s website and performs eligibility determinations for all consumers based on submissions of the single, streamlined application. Further, we propose to amend § 155.302(a)(1) to clarify that the Exchange, through the centralized eligibility and enrollment platform operated on the Exchange’s

<sup>9</sup> OMB. (2023, March 13). OMB Report to the Congress on the BBEDCA 251A Sequestration for Fiscal Year 2024. [https://www.whitehouse.gov/wp-content/uploads/2023/03/BBEDCA\\_Sequestration\\_Report\\_and\\_Letter\\_3-13-2024.pdf](https://www.whitehouse.gov/wp-content/uploads/2023/03/BBEDCA_Sequestration_Report_and_Letter_3-13-2024.pdf).



website (or, for an SBE–FP, the Federal eligibility and enrollment platform), is the entity that is responsible for making all determinations regarding the eligibility for QHP coverage and insurance affordability programs regardless of whether an individual files an application for enrollment in a QHP on the Exchange's website (or, for SBE–FPs, on the Federal eligibility and enrollment platform), or on a website operated by a non-Exchange website allowed for under § 155.220 or § 155.221. We also clarify that only entities that an Exchange elects to contract with to operate its centralized eligibility and enrollment platform can perform this function on behalf of an Exchange, such that Exchanges would not be able to solely rely on non-Exchange entities, including a web-broker (defined at § 155.20) or other entities under § 155.220 or § 155.221, from making such eligibility determinations on behalf on the Exchanges.

We also propose to amend § 155.205(b)(5) to require that an Exchange operate a centralized eligibility and enrollment platform on the Exchange's website (or, for an SBE–FP, the Federal eligibility and enrollment platform) so that the Exchange (or, for an SBE–FP, the Federal eligibility and enrollment platform) meets the requirement under § 155.400(c) to maintain record of all effectuated enrollments in QHPs, including changes in effectuated QHP enrollments.

We propose to amend § 155.220(h) to specify that the HHS reconsideration entity is the CMS Administrator, who is a principal officer. This proposal would ensure agents, brokers, and web-brokers utilizing the FFEs and SBE–FPs can submit a request to the CMS Administrator to reconsider HHS' decision to terminate their Exchange agreement(s) for cause.

We propose 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, including in States with State Exchanges. We seek to ensure that certain current minimum Federal standards applicable in the FFEs and SBE–FPs, related to web-broker website display of standardized QHP comparative information, disclaimer language, information on eligibility for APTC/CSRs, operational readiness, and access by downstream agents and brokers, also apply to web-brokers in States with State Exchanges. We similarly propose to extend certain DE entity requirements applicable in the

FFEs and SBE–FPs related to marketing and display of QHPs, providing consumers with correct information and refraining from certain conduct, marketing of non-QHPs, website disclaimer language, and operational readiness to DE entities across all Exchanges, to newly apply to DE entities in States with State Exchanges. These proposals would help establish greater general uniformity with respect to these requirements for web-brokers and DE entities operating in the Exchanges and establish minimum Federal consumer protections in all States, regardless of the Exchange model.

We propose to update regulations in § 155.221(b) to mandate *HealthCare.gov* changes be reflected on DE entity non-Exchange websites within a notice period set by HHS. We also propose requiring that DE entities make these display changes in a manner consistent with what is adopted by HHS for display on *HealthCare.gov* by meeting standards defined by HHS, unless HHS approves a deviation from those standards. This proposal would codify our existing practice of communicating important changes to the *HealthCare.gov* display to EDE entities, expand our existing change request processes to permit entities to request deviations from the required display changes, and require DE entities that do not participate in EDE to comply with these practices. Additionally, this proposal would also require that all display changes which affect the visual aspects of the website that users see and interact with must be prominently displayed on the non-Exchange website such that the changes are clear, noticeable, and understandable to consumers. Finally, this proposal would also require State Exchanges to require their DE entities to implement and prominently display changes adopted for display on the State Exchanges' websites on their non-Exchange websites for purposes of assisting consumers with DE in QHPs offered through the Exchange.

We propose in connection with the failure to file and reconcile process at § 155.305(f)(4) that Exchanges be required to send notices to tax filers for the first year in which they have been determined to have failed to reconcile APTC as an initial warning to inform and educate tax filers that they need to file and reconcile, or risk being determined ineligible for APTC if they fail to file and reconcile for a second consecutive year. Currently, the regulation does not describe notification procedures for tax filers who have failed to reconcile for 1 year. We propose to

require that all Exchanges be required to send informative notices at least annually to tax filers who have failed to reconcile.

We propose to amend § 155.315(e) to provide that all Exchanges can accept applicant incarceration status attestations without further verification, and Exchanges may verify applicant incarceration status using an HHS-approved verification data source. HHS would approve an alternative electronic data source for State Exchanges to use for incarceration verification if it provides data that are current and accurate, and if its use minimizes administrative costs and burdens.

We propose to reinterpret State Exchange and State Medicaid and Children's Health Insurance Program (CHIP) agency use of the Federal Data Services Hub to access and use the income data provided by the Verify Current Income (VCI) Hub service as a State Exchange or a State Medicaid and CHIP agency function because these State entities use this optional service to implement eligibility verification requirements applicable to them. More specifically, State Exchanges and State Medicaid and CHIP agencies have the option to use this information to verify a tax household's annual income attestation for Exchange QHP eligibility and the Medicaid applicant's current household income as required to make insurance affordability program eligibility determinations. We propose to amend § 155.320(c) to reflect this reinterpretation for the Exchanges but are not proposing to amend the Medicaid regulations as the Medicaid regulations already address Medicaid agency verification requirements and are not typically used to delineate Medicaid agency operations in this manner.

We propose to revise § 155.330(d) to require Exchanges to conduct periodic checks for deceased enrollees twice yearly and subsequently end deceased enrollees' QHP coverage. Additionally, we propose to revise § 155.330(d)(3) to grant the Secretary the authority to temporarily suspend the periodic data matching (PDM) requirement during certain situations (for example, a declared national public health emergency). These proposals would align § 155.330(d) with current Federal Exchange policy and operations, prevent overpayment of QHP premiums, and accurately capture household QHP eligibility based on household size.

We propose to amend § 155.335(j)(1) and (2) to require Exchanges to re-enroll individuals who are enrolled in catastrophic coverage, as defined in section 1302(e) of the ACA, into a new

QHP for the coming plan year. Incorporating these individuals enrolled in catastrophic coverage into the auto re-enrollment hierarchy rules at § 155.335(j) would help ensure continuity of coverage in cases where the issuer does not continue to offer a catastrophic plan for the new plan year, or these individuals are no longer eligible for enrollment in a catastrophic plan for the new year, and these individuals do not actively select a different QHP. We also propose to add a new paragraph (j)(5) to § 155.335 to establish that an Exchange may not newly auto re-enroll into catastrophic coverage an enrollee who is currently enrolled in coverage of a metal level as defined in section 1302(d) of the ACA. This change reflects our current practice for Exchanges on the Federal platform.

We propose to amend § 155.400(e)(2) to codify that the flexibility for issuers experiencing billing or enrollment problems due to high volume or technical errors is not limited to extensions of the binder payment.

We propose to amend § 155.410(e)(4)(ii) to revise parameters around the adoption of an alternative open enrollment period by a State Exchange. Specifically, we propose for benefit years beginning on or after January 1, 2025, State Exchanges must adopt an open enrollment period that begins on November 1 of the calendar year preceding the benefit year and ends no earlier than January 15 of the applicable benefit year, with the option to extend the open enrollment period beyond January 15 of the applicable benefit year. We believe this proposal would ensure consumers are not subjected to plan cost increases that they may not be notified about until after open enrollment ends, give Navigators, certified application counselors, and agents and brokers ample time to assist all interested applicants, provide State Exchanges with additional flexibility, reduce consumer confusion, and improve access to health coverage.

At § 155.420(b), we propose to align the effective dates of coverage after selecting a plan during certain special enrollment periods across all Exchanges, including State Exchanges. We would require all State Exchanges to provide coverage that is effective on the first day of the month following plan selection, if a consumer enrolls in a QHP during certain special enrollment periods. This proposal would prevent coverage gaps, particularly for consumers transitioning between different Exchanges or from other insurance coverage.

We propose to amend paragraph § 155.420(d)(16) to revise the parameters around the availability of a special enrollment period for APTC-eligible qualified individuals with a projected household income no greater than 150 percent of the Federal Poverty Level (FPL). Specifically, we are proposing to remove the limitation that this special enrollment period is only available during periods of time when APTC benefits are available such that the applicable taxpayers' applicable percentage is set to zero and that Exchanges have the option to permanently provide this special enrollment period. We believe this proposal would provide affordable coverage available to more uninsured people and additional enrollment opportunities to low-income consumers.

We propose to add § 155.430(b)(1)(iv)(D) to permit an enrollee to retroactively terminate the enrollee's enrollment in a QHP through an Exchange on the Federal platform when the enrollee enrolls in Medicare Parts A or B, and the termination date would be retroactively effective to the day before Medicare coverage begins. This proposal would allow consumers to avoid overlapping coverage and paying unnecessary premiums. State Exchanges would have the option of implementing this proposal, and we seek comment on whether this proposal should instead be mandatory for State Exchanges.

We propose to revise § 155.1050 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 the FFEs' network adequacy standards established for QHPs under § 156.230. We also propose that State Exchanges and SBE-FPs be required to conduct quantitative network adequacy reviews prior to certifying any plan as a QHP, consistent with the reviews conducted by the FFEs under § 156.230. We further propose to require State Exchanges and SBE-FPs to permit issuers that are unable to meet the specified network adequacy standards to participate in a justification process after submitting their initial network adequacy data to account for variances and potentially earn QHP certification. Finally, we propose to mandate that State Exchanges and SBE-FPs require all issuers seeking QHP certification to submit information to the State Exchange or SBE-FP about whether network providers offer telehealth services. These proposals would be effective for plan years beginning on or after January 1, 2025.

#### 6. 45 CFR part 156

In part 156, we propose user fee rates for the 2025 benefit year for all issuers participating on the Exchanges using the Federal platform. For the 2025 benefit year, we propose an FFE user fee rate of 2.2 percent of total monthly premiums and an SBE-FP user fee rate of 1.8 percent of total monthly premiums. We will issue the 2025 benefit year premium adjustment percentage index and related payment parameters in guidance, consistent with the policy finalized in part 2 of the 2022 Payment Notice.

For benefit years beginning on or after January 1, 2027, we propose three revisions to the standards for State selection of EHB-benchmark plans at § 156.111. First, we propose to consolidate the options for States to change EHB-benchmark plans at § 156.111(a) to reduce the burden on States to decide between three functionally identical choices. Second, we propose to revise the typicality standard at § 156.111(b)(2) so that, in demonstrating that a State's new EHB-benchmark plan provides a scope of benefits that is equal to the scope of benefits of a typical employer plan in the State, the scope of benefits of a typical employer plan in the State would be defined as any scope of benefits that is as or more generous than the scope of benefits in the State's least generous typical employer plan (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)), and as or less generous than the scope of benefits in the State's most generous typical employer plan (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)), among the typical employer plans currently defined at § 156.111(b)(2)(i)(A) and (B). We also propose to remove the generosity standard at § 156.111(b)(2)(ii) and to make a technical revision to the language regarding supplementation at § 156.111(b)(2)(i). Third, we propose to revise § 156.111(e)(3) to require States to submit a formulary drug list as part of their application to change EHB-benchmark plans only if the State is seeking to change their prescription drug EHB.

We propose to remove the regulatory prohibition at § 156.115(d) on issuers from including routine non-pediatric dental services as an EHB, which would provide States the option to add routine adult dental services as an EHB by updating their EHB-benchmark plans pursuant to § 156.111.

We propose to amend § 156.122 to codify that prescription drugs in excess of those covered by a State's EHB-benchmark plan are considered EHB. As a result, they would be subject to requirements including the annual limitation on cost sharing and the restriction on annual and lifetime dollar limits, consistent with § 156.130, unless the coverage of the drug is mandated by State action and is in addition to EHB pursuant to § 155.170, in which case the drug would not be considered EHB. In addition, for plan years beginning on or after January 1, 2026, we propose to amend § 156.122 to provide that the Pharmacy & Therapeutics (P&T) committee must include a consumer representative. We also seek comment on a possible future policy proposal to replace the United States Pharmacopeia (USP) Medicare Model Guidelines (MMG) with the USP Drug Classification system (DC) to classify the prescription drugs required to be covered as EHB under § 156.122(a)(1). In particular, we seek public comment to confirm or further expand our understanding of the risks and benefits associated with replacing the USP MMG with the USP DC in this context.

For PY 2025, we propose to follow the approach finalized in the 2024 Payment Notice concerning standardized plan option metal levels, and to otherwise maintain continuity with our approach to standardized plan options finalized in the 2023 and 2024 Payment Notices.<sup>10</sup> We propose to make only minor updates to the plan designs for PY 2025 to ensure these plans have AVs within the permissible *de minimis* range for each metal level. Our proposed updates to plan designs for PY 2025 are detailed in § 156.201 of the preamble of this proposed rule, specifically in Tables 12 and 13.

In the 2024 Payment Notice (88 FR 25858), we announced our intent to propose an exceptions process that would allow issuers to offer non-standardized plan options in excess of the limit of two per product network type, metal level, inclusion of dental and vision benefit coverage, and service area for PY 2025 and subsequent years. We propose an exceptions process at § 156.202 that would allow issuers to offer more than two non-standardized plan options per product network type,

metal level, inclusion of dental and vision benefit coverage, and service area for PY 2025 and subsequent plan years, if the issuer can demonstrate that these additional non-standardized plans have specific design features that would substantially benefit consumers with chronic and high-cost conditions.

We propose a new regulatory provision that would permit us to allow a CO-OP loan recipient to voluntarily terminate its loan agreement with us and cease to constitute a qualified non-profit health insurance issuer (QNHI), for the purpose of pursuing innovative business plans that are not otherwise consistent with the governance requirements and business standards applicable to a CO-OP borrower. Under the proposed new regulatory provision, we would be able to consider a request by a CO-OP to voluntarily terminate its loan agreement for reasons other than financial viability, provided all outstanding CO-OP loans issued to the loan recipient are repaid in full prior to termination, and we believe granting the request would meaningfully enhance consumer access to quality, affordable, member-focused, non-profit health care options in affected markets.

We propose conforming amendments to the payment and collections process set forth at § 156.1215 to align with the policies and regulations proposed in the Federal Independent Dispute Resolution Operations proposed rule (88 FR 75744). This proposal would provide that administrative fees for utilizing the No Surprises Act Federal independent dispute resolution (IDR) process for health insurance issuers that participate in financial programs under the ACA would be subject to netting as part of HHS' integrated monthly payment and collections cycle. Additionally, we propose to amend § 156.1215 to provide that any amount owed to the Federal government by an issuer and its affiliates for unpaid administrative fees due to the Federal government from these issuers and their affiliates for utilizing the Federal IDR process in accordance with § 149.510(d)(2), after HHS nets amounts owed by the Federal government under these programs, would be the basis for calculating a debt owed to the Federal government.

### III. Provisions of the Proposed Regulations

#### A. 31 CFR part 33 and 45 CFR Part 155—Section 1332 Waivers

##### 1. Background

Section 1332 of the ACA permits States to apply for a section 1332 waiver to pursue innovative strategies for providing their residents with access to

higher value, more affordable health insurance coverage. To allow for greater flexibility in communicating with the public, we are proposing updates to the public hearing process requirements for section 1332 waivers.

Under section 1332(b) of the ACA, the Secretary of HHS and the Secretary of the Treasury (collectively, the Secretaries) may exercise their discretion to approve a request for a section 1332 waiver only if the Secretaries determine that the proposal for the section 1332 waiver meets the following four requirements, referred to as the statutory guardrails: (1) the proposal will provide coverage that is at least as comprehensive as coverage defined in section 1302(b) of the ACA and offered through Exchanges established under title I of the ACA, as certified by the Office of the Actuary of CMS, based on sufficient data from the State and from comparable States about their experience with programs created by the ACA and the provisions of the ACA that would be waived; (2) the proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the State's residents as would be provided under title I of the ACA; (3) the proposal will provide coverage to at least a comparable number of the State's residents as would be provided under title I of the ACA; and (4) the proposal will not increase the Federal deficit. The Secretaries retain their discretionary authority to deny requested section 1332 waivers when appropriate given consideration of the application, as a whole, even if a proposal for a section 1332 waiver meets the four statutory guardrails.

The Departments are responsible for monitoring an approved section 1332 waiver's compliance with the statutory guardrails and for conducting evaluations to determine the impact of the section 1332 waiver. Specifically, section 1332(a)(4)(B)(v) of the ACA requires the Secretaries to promulgate regulations that provide for a process for the periodic evaluation of approved section 1332 waivers. The Secretaries must also promulgate regulations that provide for a process under which States with approved section 1332 waivers submit to the Secretaries periodic reports concerning the implementation of the State's waiver program.<sup>11</sup>

<sup>10</sup> This includes continuation of the differential display of standardized plan options on [HealthCare.gov](https://www.healthcare.gov) and enforcement of the standardized plan options display requirements for approved web-brokers and QHP issuers using a direct enrollment pathway to facilitate enrollment through an FFE or SBE-FP— including both the Classic Direct Enrollment (Classic DE) and Enhanced Direct Enrollment (EDE) Pathways.

<sup>11</sup> See ACA section 1332(a)(4)(B)(iv).

2. Proposed Amendments to Normal Public Notice Requirements (31 CFR 33.112, 31 CFR 33.120, 45 CFR 155.1312, and 45 CFR 155.1320)

Sections 1332(a)(4)(B)(i) and (iii) of the ACA provide that the Secretaries shall promulgate regulations that provide for a process for public notice and comment at the State level, including public hearings, and a process for providing public notice and comment at the Federal level after the section 1332 waiver application is received by the Secretaries, respectively, that are both sufficient to ensure a meaningful level of public input. Current regulations at 31 CFR 33.112 and 45 CFR 155.1312 specify State public notice and comment period and participation requirements for proposed section 1332 waiver requests, and 31 CFR 33.116(b) and 45 CFR 155.1316(b) specify the public notice and comment period and approval requirements under the accompanying Federal process.

In the November 2020 interim final rule (85 FR 71142), the Departments revised regulations to set forth flexibilities in the public notice requirements and post-award public participation requirements for section 1332 waivers during the COVID-19 PHE. In the September 2021 final rule (86 FR 53502), the Departments extended those changes beyond the COVID-19 PHE to allow similar flexibilities in the event of future natural disasters; PHEs; or other emergent situations that threaten consumers' access to health insurance coverage, consumers' access to health care, or human life. Currently, in such an event, States may submit a request to the Departments to modify, in part, the State public notice requirements specified in 31 CFR 33.112(a)(1), (b), (c), and (d) and 45 CFR 155.1312(a)(1), (b), (c), and (d), and the Federal public notice requirement specified in 31 CFR 33.116(b) and 45 CFR 155.1316(b), pursuant to 31 CFR 33.118(a) and 45 CFR 155.1318(a).

The criteria to request a modification from the normal public notice requirements during an emergent situation are set forth in 31 CFR 33.118(b)(1) through (5) and 45 CFR 155.1318(b)(1) through (5). Pursuant to 31 CFR 33.118(b)(3) and 45 CFR 155.1318(b)(3), the State's request to modify normal public notice procedures is required to include: the justification for the requested modification from the State public notice procedures as it relates to the emergent situation and the alternative public notice procedures, including public hearings, that it proposes to implement at the State level

and that are designed to provide the greatest opportunity for and level of meaningful public input from impacted interested parties that is practicable given the emergent circumstances motivating the State's request for a modification.

Since the finalization of the flexibilities in 31 CFR 33.118(b)(1) through (5) and 45 CFR 155.1318(b)(1) through (5), almost all States with approved section 1332 waivers ("section 1332 waiver States") submitted requests that were granted by the Departments to conduct their annual post-award forums virtually instead of in-person during the COVID-19 PHE to reduce the risk of transmission of COVID-19. Similarly, during the COVID-19 PHE, States submitting new section 1332 waiver applications, waiver extension requests, or waiver amendment requests also requested to host their State public hearings virtually and these requests were also granted by the Departments. However, with the recent expiration of the Federal COVID-19 PHE<sup>12</sup> (and many State COVID-19 PHEs)<sup>13</sup> and in line with the requirements of 31 CFR 33.120(c) and 45 CFR 155.1320(c) and 31 CFR 33.112(c) and 45 CFR 155.1312(c), the Departments have ceased granting States' requests to hold public hearings or post-award forums virtually instead of in-person on the basis of the Federal COVID-19 PHE.

Upon review and consideration of the lessons learned during the COVID-19 PHE, the Departments have determined that some current provisions regarding normal State public notice procedures are outdated given the increased accessibility that technology has provided for virtual and telephonic meetings. States have shared that their residents benefitted from the States' opportunity to host public hearings and post-award forums virtually, and that they would like to continue doing so to facilitate attendance. States have also reported to the Departments that hosting meetings virtually during the COVID-19 PHE did not decrease the amount or

quality of meaningful input received. States' experience during this time demonstrated that interested parties were able to virtually attend meetings and submit public comments verbally or in-writing, and States did not report any significant issues relating to virtual platforms that impeded public attendance or participation. States continued to share with the Departments summaries of their post-award forums, as well as all public comments received and actions taken in response to concerns or comments, in accordance with section 1332 waiver annual reporting requirements. In States' new waiver applications, waiver extension requests, and waiver amendment requests, States also shared with the Departments summaries of virtually conducted hearings from their State public comment periods and addressed public comments or concerns received.

Beyond mitigating the spread of COVID-19, information shared by section 1332 waiver States has demonstrated that the opportunity to host post-award forums and public hearings on virtual platforms facilitated comparable or higher levels of public attendance when compared to previously held in-person meetings. For example, at Maryland's annual post-award forums held in 2019 (in-person) and 2020–2022 (virtual), the State saw comparable participation across the years from interested parties. Minnesota also reported comparable attendance at its post-award forums across the years: 4 attendees in 2018 (in-person), 1 in 2019 (in-person), 4 in 2020 (virtual), 9 in 2021 (virtual),<sup>14</sup> and 2 in 2022 (virtual). Likewise, Wisconsin had 6 attendees at its post-award forum in 2019 (in-person), 24 in 2020 (virtual),<sup>15</sup> 11 in 2021 (virtual), and 7 in 2022 (virtual). Wisconsin noted that using a virtual format has allowed individuals who would otherwise not be able to attend in-person to view the State's presentation and that this has proven to be a convenient means for individuals to attend the forum.

States that began waiver implementation after the start of the COVID-19 PHE have also reported successfully hosting virtual post-award forums. For example, Colorado conducted its first post-award forum entirely virtually in 2020 and reported

<sup>12</sup> The Federal COVID-19 PHE ended on May 11, 2023. <https://www.hhs.gov/about/news/2023/05/09/fact-sheet-end-of-the-covid-19-public-health-emergency.html#:~:text=That%20means%20with%20the%20COVID,the%20expiration%20of%20the%20PHE.>

<sup>13</sup> For example, in Alaska the State's PHE ended on July 1, 2022 (<https://health.alaska.gov/PHE/Pages/default.aspx>); in Colorado the Disaster Recovery Order ended on April 27, 2023 (<https://hcpf.colorado.gov/covid-19-phe-planning>); in Georgia the State of Emergency ended on May 11, 2023 (<https://dph.georgia.gov/press-releases/2023-05-11/dph-news-release-end-public-health-emergency-declaration>); and in Rhode Island the State's COVID-19 Disaster Emergency ended on May 11, 2023 (<https://governor.ri.gov/executive-orders/executive-order-23-05>).

<sup>14</sup> Note that this post-award hearing was also a hearing for the State's waiver extension application, which likely increased attendance.

<sup>15</sup> Note that attendance was relatively higher in 2020 likely due to the forum following the State's first full year of implementing its reinsurance program.

79 attendees.<sup>16</sup> Pennsylvania had 2 attendees at its first post-award forum in 2021 (virtual) and 4 in 2022 (virtual). Pennsylvania noted that due to the expansiveness of the State's geography, there has historically been low in-person attendance, as observed at its in-person public hearings in 2019 for its waiver application, where no members of the public attended the first meeting, and two members of the public attended the second meeting.

States submitting new waiver applications, waiver extension requests, or waiver amendment requests during the COVID-19 PHE also reported successfully conducting their public hearings on virtual platforms. For example, in January 2022, Alaska held a combined post-award forum and State public hearing for its waiver extension application both in-person and with a telephonic option, which 3 members of the public attended either in-person or virtually. In April 2022, Washington held two State public hearings virtually, in which 9 representatives from organizations attended and shared public comments.

There are other Federal programs and agencies that permitted a virtual option in place of in-person public hearings prior to the COVID-19 PHE or that have more recently amended their policies for public input to continue virtual and telephonic options that were first implemented during the COVID-19 PHE. For example, States that are applying for Medicaid section 1115 demonstrations are permitted to use telephonic and web-based conference capabilities for public meetings. In fact, per 42 CFR 431.408(a)(3), a State must use telephonic and/or web conference capabilities for at least one of the two required public hearings to ensure statewide accessibility to the public hearing, unless it can document it has afforded the public throughout the State the opportunity to provide comment, such as holding the two public hearings in geographically distinct areas of the State.

As another example, during the COVID-19 PHE, the Internal Revenue Service (IRS) began holding public hearings on notices of proposed rulemaking telephonically instead of in-person. Following the end of the Federal COVID-19 PHE, the IRS recently announced that, for proposed regulations published in the **Federal Register** after May 11, 2023,<sup>17</sup> public

hearings would be conducted in-person but that a telephonic option would remain available for those who prefer to attend or testify by telephone.

The Departments considered whether to propose requiring States to hold at least one of the required public hearings for waiver applications in-person. However, as explained above, States have successfully hosted post-award forums and public hearings for section 1332 waiver applications virtually to allow for meaningful public input over the last several years. Furthermore, by allowing States the ability to hold all of their meetings virtually, States may better allow for input across different geographies, communities, and populations. We also considered proposing the standard under section 1115 demonstrations where one hearing is required to be done virtually. However, given the successful hosting of virtual meetings with public participation by States for section 1332 waivers, it does not seem necessary to continue to require in-person meetings to solicit public input on section 1332 waivers.

The Departments believe that by allowing States the opportunity to hold post-award forums and public hearings virtually and through digital platforms, States would be able to continue facilitating attendance and participation from interested parties and the public to provide meaningful input. As such, the Departments are of the view that updating the State public notice procedures would enhance public participation in the section 1332 waiver review and monitoring process. This approach would help remove barriers to participation and increase opportunities for engagement in policymaking for communities and local partners who may face barriers to in-person participation (for example, those in rural areas). This approach is also consistent with Executive Order 14094, Executive Order on Modernizing Regulatory Review, as it would proactively engage interested or affected parties, including members of underserved communities, and promote best practices for information accessibility and engagement with interested or affected parties through the use of alternative platforms and media for engaging the public.<sup>18</sup> Further, this approach may improve States' ability to understand and eliminate barriers experienced by underserved or under-

represented communities, and identify opportunities to advance health equity, while diminishing administrative burden related to the integration of in-person and virtual formats.

Therefore, we propose that a virtual (that is, one that uses telephonic, digital, and/or web-based platforms) or hybrid (that is, one that provides for both in-person and virtual attendance) public hearing or forum be considered as the equivalent of holding an in-person meeting. In the 2012 final rule (77 FR 11700), the Departments noted that as set forth in 31 CFR 33.112(c)(1) and 45 CFR 155.1312(c)(1), a State must hold at least two public hearings in distinct locations. Under the proposal in this rule to modify the normal public notice procedures, States would still need to hold at least two public hearings in distinct locations. For example, the Departments clarify that under this rule's proposal to allow flexibility to host these meetings virtually, a State would not be permitted to count a public hearing in which there is simultaneously an in-person location and virtual platform as two hearings (or two locations). Instead, one virtual or hybrid meeting would still count as one public hearing, and two virtual or hybrid meetings would count as two public hearings.

To codify these new proposed policies, we propose to amend 31 CFR 33.112(c) and 45 CFR 155.1312(c) and 31 CFR 33.120(c) and 45 CFR 155.1320(c). More specifically, the Departments propose to amend 31 CFR 33.112(c) and 45 CFR 155.1312(c) to permit States to conduct public hearings in a virtual (that is, one that uses telephonic, digital, and/or web-based platforms) or hybrid (that is, one that provides for both in-person and virtual attendance) format in lieu of conducting an in-person meeting. The Departments also propose to amend 31 CFR 33.120(c) and 45 CFR 155.1320(c) to provide that for a State's annual post-award forum, the public forum shall be conducted in an in-person, virtual (that is, one that uses telephonic, digital, and/or web-based platforms), or hybrid (that is, one that provides for both in-person and virtual attendance) format. The Departments propose that these changes go into effect upon finalization of this rule. Because these changes would relieve a regulatory restriction, the Departments anticipate that they would be made effective immediately upon publication of a final rule.

This proposal is limited to allowing flexibility to host required meetings virtually. States would be required to continue to abide all other public notice requirements, including public notice

<sup>16</sup> Note that this post-award forum was also a hearing for the State's waiver extension application, which likely increased attendance.

<sup>17</sup> Internal Revenue Service, Public Hearings on Proposed Regulations to Be Conducted in Person

with Telephone Options Available, Announcement 2023-16. Accessed at <https://www.irs.gov/pub/irs-drop/a-23-16.pdf>.

<sup>18</sup> 88 FR 21879. <https://www.govinfo.gov/content/pkg/FR-2023-04-11/pdf/2023-07760.pdf>.

procedural requirements for waiver applications, waiver extension and waiver amendment requests, and post-award forums. For example, States would still be required to have a process to consult and collaborate with Federally-recognized tribes,<sup>19</sup> as applicable, as well as take reasonable steps to provide meaningful access for individuals with limited English proficiency and appropriate steps to ensure effective access for and communication with individuals with disabilities, including accessibility of information and communication technology.<sup>20</sup> States should recognize that virtual meetings may present additional accessibility challenges for people with communications and mobility disabilities, as well as to those who lack broadband access. Complying with the requirement to ensure effective communication may entail providing American Sign Language interpretation and real-time captioning and ensuring that the virtual platform is interoperable with assistive technology for those with mobility difficulties.

Finally, the Departments clarify that under this proposal, States should have a process by which members of the public can request in-person meetings for the annual post-award forum or State public hearings on waiver applications, waiver extension requests, or waiver amendments requests, and that States should accommodate those requests whenever possible. In addition, States with approved section 1332 waivers and States seeking approval for proposed waivers would continue to have flexibility to submit requests to the Departments during emergent situations to modify certain public participation requirements as set forth in 31 CFR 33.118(b)(1) through (5) and 45 CFR 155.1318(b)(1) through (5).

The Departments seek comment on these proposals.

#### B. 42 CFR Parts 435 and 600

##### 1. Increase State Flexibility in the Use of Income and Resource Disregards for Non-MAGI Populations (42 CFR 435.601)

We propose to provide States with greater flexibility to adopt income and/or resource disregards in determining financial eligibility under section 1902(r)(2) of the Act for individuals excepted from application of financial methodologies based on modified adjusted gross income (“MAGI-based methodologies”).

Section 1902(r)(2) of the Act requires that States, in determining Medicaid financial eligibility, apply a methodology that may be less restrictive, but which may not be more restrictive, than in the case of individuals seeking eligibility on the basis of being 65 years old or older, having blindness or a disability, under the supplemental security income (SSI) program. In the case for other individuals, the methodology may be less restrictive, but may not be more restrictive than the methodology applied to determine eligibility “under the State plan most closely categorically related.” For the latter populations, prior to the enactment of the ACA, the aid to families with dependent child AFDC program methodologies were generally used (42 CFR 435.601(a), (b), and (d)(2)(ii)). However, section 2002(a) of the ACA amended section 1902(e) of the Act which, at paragraph (14)(A), requires that, notwithstanding section 1902(r)(2) of the Act (or any other provision of title XIX of the Act), States use MAGI-based methodologies in determining individuals’ Medicaid eligibility unless the individual is excepted from such methodologies under section 1902(e)(14)(D) of the Act.<sup>21</sup> Implemented in our regulations at 42 CFR 435.603(j), these exceptions include, but are not limited to, individuals who are age 65 years old or older; have blindness or a disability; are being evaluated for coverage as medically needy; or request need for coverage of long-term services and supports (LTSS). This means, for example, that in determining financial eligibility for an optional eligibility group in which being at least 65 years old is a requirement, SSI-based methodologies (as the most closely related cash assistance program) and not MAGI-based methodologies apply, and States must apply a methodology no more restrictive than the methodology

of the SSI program. Similarly, in determining eligibility for a medically needy group of parents and caretaker relatives, States must apply a methodology no more restrictive than the methodology of the former AFDC program.<sup>22</sup>

Importantly, for any group to which SSI, AFDC, or MAGI-like methodologies apply, States may utilize the authority under section 1902(r)(2)(A) of the Act to apply a “less restrictive” methodology; that is, they may elect to *disregard* income and/or resources that would otherwise be countable under the relevant methodology. For example, under SSI methodologies, \$20 of an individual’s otherwise countable monthly income is disregarded in determining income eligibility. A State Medicaid agency, using the authority under section 1902(r)(2)(A) of the Act, could adopt an additional monthly income disregard of \$100 for an eligibility group to which SSI methodologies apply.<sup>23</sup>

In 1993, we implemented the less-restrictive methodology authority in section 1902(r)(2)(A) of the Act at 42 CFR 435.601(d)(4) (58 FR 4908–01, 4929–4930 (January 19, 1993)). We confirmed in the regulation the eligibility groups to which States may apply less restrictive methodologies, which include: optional categorically needy groups described in section 1902(a)(10)(A)(ii) of the Act; medically needy groups described in section 1902(a)(10)(C) of the Act; the mandatory group serving individuals 65 years old or older; who have blindness or disabilities in States that have exercised the option in section 1902(f) of the Act to apply more restrictive criteria to these populations than SSI (so-called “section 209(b) States”); and Qualified Medicare Beneficiaries described in sections

<sup>22</sup> Because the AFDC program no longer exists, we have permitted States, where AFDC methodologies otherwise apply, to use MAGI-like methodologies instead of AFDC methodologies in determining eligibility for the medically needy. 42 CFR 435.831(b)(1)(ii). Disregards under section 1902(r)(2)(A) of the Act may be applied to individuals whose eligibility is determined using these “MAGI-like” methodologies. For a discussion of MAGI-like methodologies, see 81 FR 86382, 86415–86418 (November 30, 2016). We have proposed that States have the option to apply MAGI-like methodologies in all circumstances in which AFDC methodologies otherwise apply. 87 FR 54842.

<sup>23</sup> Section 1902(r)(2) of the Act does not limit the amount of an income or a resource disregard. States could, for example, disregard all countable income and/or resources for an eligibility under the authority of section 1902(r)(2) of the Act. Under 42 CFR 435.1007(e), the Federal financial participation (FFP)-related income limits are applied after application of cash assistance income deductions and any disregards in the State plan authorized under section 1902(r)(2) of the Act.

<sup>19</sup> See 31 CFR 33.112(a)(2) and 45 CFR 155.1312(a)(2).

<sup>20</sup> See Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d, 45 CFR part 80), Section 1557 of the ACA (42 U.S.C. 18116), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794, 45 CFR part 84), and Title II of the Americans with Disabilities Act (42 U.S.C. 1213 *et seq.*, 28 CFR part 35). The HHS Office for Civil Rights enforces applicable Federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, sex, age, or disability, as well as laws protecting the exercise of conscience and religious freedom, including the Religious Freedom Restoration Act (Pub. L. 103–141) (42 U.S.C. 2000bb through 2000bb–4).

<sup>21</sup> MAGI-based methodologies are the rules described in section 36B(d)(2)(B) of the U.S. Internal Revenue Code.



1902(a)(10)(E) and 1905(p) of the Act. Additionally, the current regulation requires that any less restrictive methodologies elected by a State must be “comparable for all persons within each category of assistance within an eligibility group.” As further explained in 42 CFR 435.601(d)(4): “For example, if the agency chooses to apply less restrictive income or resource methodology to an eligibility group of aged individuals, it must apply that methodology to all aged individuals within the selected group.”

In 2001, we issued guidance on the use of less restrictive methodologies by States (“Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources Questions and Answers,” May 11, 2001 (May 2001 guidance)). As explained in the May 2001 guidance, an “eligibility group” under section 1902(a)(10)(A)(ii) of the Act for purposes of less restrictive methodologies is created by applying the eligibility requirements described in any of the clauses of section 1902(a)(10)(A)(ii) of the Act (for example, section 1902(a)(10)(A)(ii)(I) of the Act) to one of the categorical populations described in section 1905(a) of the Act (for example, individuals under the age of 21, or at the option of a State, under the age of 20, 19, or 18, as described in section 1905(a)(i) of the Act).

For example, a State could elect to apply the eligibility criteria described in section 1902(a)(10)(A)(ii)(V) of the Act (relating to individuals in medical institutions for at least 30 consecutive days whose incomes do not exceed 300 percent of the SSI Federal benefit rate) to individuals 65 years old or older (the population described in section 1905(a)(iii) of the Act). A State similarly could apply the eligibility criteria described in section 1902(a)(10)(A)(ii)(V) of the Act to other categorical populations described in section 1905(a) of the Act, such as individuals who have blindness or disabilities (section 1905(a)(vii) of the Act) or individuals under age 21 (section 1905(a)(i) of the Act). As explained in the May 2001 guidance, the election of the optional eligibility category at section 1902(a)(10)(A)(ii)(V) of the Act and a population in section 1905(a) of the Act (for example, individuals 65 years old or older) forms a singular *eligibility group*.<sup>24</sup>

Thus, consistent with 42 CFR 435.601(d)(4), if a State that covers an eligibility group of individuals 65 years old and older who have been in a medical institution for at least 30 consecutive days wants to adopt a resource disregard of \$5,000 of otherwise countable resources, the State must apply the disregard to all 65 and older individuals who are seeking coverage under the group; the State could not target the disregard at only certain 65 and older individuals seeking eligibility in the group, for example individuals age 65 and older with a diagnosed cognitive impairment.

Section 1902(r)(2)(A) of the Act does not expressly impose, and we did not identify a specific legal rationale in the proposed or final rule requiring, the “comparability” mandate that we incorporated into 42 CFR 435.601(d)(4). 54 FR 39421, 39433 (September 26, 1989); 58 FR 4908, 4919 (January 19, 1993). Section 1902 of the Act contains two separate provisions which are commonly referred to as “comparability” rules: section 1902(a)(10)(B) of the Act, which requires that the amount, duration, and scope of the medical assistance available to any categorically needy individuals must not be less than the medical assistance available to any other categorically needy individuals (subject to express exceptions in the statute); and section 1902(a)(17) of the Act, which requires that eligibility standards, subject to certain exceptions, must be “comparable for all groups.”

Upon further analysis, we conclude that neither section 1902(a)(10)(B) of the Act nor section 1902(a)(17) of the Act requires that a State adopting a less restrictive methodology for a given eligibility group apply such methodology to all individuals seeking coverage under the group. First, a State’s use of a less restrictive methodology for an eligibility group would never alter the amount, duration, and scope of medical assistance available within the group, which means the comparability mandate in section 1902(a)(10)(B) of the Act would never be implicated by a less restrictive methodology. Second, the comparability mandate in section 1902(a)(17) of the Act refers to *standards*, not *methodologies*, which are different terms and which we have in the past expressly defined differently. “Standard” refers to the dollar level that a person’s income or resources cannot

exceed to qualify for Medicaid; “methodology” refers to the rules for determining what sources and amounts of income and resources will be counted in determining whether a person’s income exceeds the income and resource standard. 54 FR 39421–01, 39430 (September 26, 1989). Thus, we conclude that the incorporation of a comparability mandate into 42 CFR 435.601(d)(4) was a policy choice that was not mandated by Federal law.

In addition, section 3(b) of the Sustaining Excellence in Medicaid Act (Pub. L. 116–39, enacted in 2019) directed that nothing in section 1902(a)(17) of the Act should be construed as prohibiting a State from adopting income or resource disregards under section 1902(r)(2) of the Act exclusively for people who need home and community-based services (HCBS) authorized under various authorities. In other words, section 3(b) of the Sustaining Excellence in Medicaid Act confirmed that, at least with regard to the use of section 1902(r)(2)-related authority to target income and/or resource disregards at people who need HCBS, the comparability mandate in section 1902(a)(17) of the Act does not impose a bar. We believe that this provides further support for the view that the comparability mandate in section 1902(a)(17) of the Act should not be considered to require comparability in the use of less restrictive methodologies under section 1902(r)(2)(A) of the Act.<sup>25</sup>

Over the years, a number of States also have sought to target income and/or resource disregards to other populations within an eligibility group without applying the disregard to all, including, for example, individuals with disabilities who have accumulated resources through saving their earned income. Under this example, the eligibility group serving individuals with disabilities who have earned income has comparatively higher resource standard than other eligibility groups with a resource standard to allow these individuals to save their earned income. When these individuals stop working and must qualify in a separate eligibility group to maintain their Medicaid, most typically one with a much lower resource standard, they may be faced with the choice of forgoing Medicaid coverage or exhausting the savings they were effectively incentivized to accumulate in their

<sup>24</sup> As also explained in the May 2001 guidance, medically needy groups are created in the same manner; for example, a State that has adopted the medically needy category in section 1902(a)(10)(C) of the Act (that is, the medically needy) and elects to include the population described in section 1905(a)(ii) of the Act (parents and caretaker

relatives) forms a singular medically needy group. Section 1902(a)(10)(C) of the Act requires that States that select the medically needy category must adopt a medically needy group for children under 18 and a medically needy group for pregnant individuals.

<sup>25</sup> For further information, see CMS State Medicaid Director Letter 21–004, “State Flexibilities to Determine Financial Eligibility for Individuals in Need of Home and Community-Based Services.” [https://www.medicaid.gov/sites/default/files/2021-12/smd21004\\_0.pdf](https://www.medicaid.gov/sites/default/files/2021-12/smd21004_0.pdf).

original eligibility group in order to retain their Medicaid eligibility. States cannot address this predicament without effectively increasing the resource standard for everyone in the new group because States currently cannot, consistent with the comparability mandate in 42 CFR 435.601(d)(4), target a resource disregard at applicants for a particular eligibility group based on their previous eligibility in a separate group.

For these reasons, we are proposing to eliminate paragraph (d)(4) from 42 CFR 435.601, which would allow States to target income and/or resource disregards at discrete subpopulations in the same eligibility group, provided the subpopulation is reasonable and does not violate other Federal statutes (for example, it does not discriminate based on race, gender, sexual orientation or disability). We believe this would increase State flexibility and provide States more options to extend eligibility to specific populations based on the State's circumstances. As noted above, this proposed regulatory change would not be applicable to eligibility groups to which MAGI-based financial methodologies apply but could be applied to most non-MAGI eligibility groups. In enacting the Sustaining Excellence in Medicaid Act, Congress recognized that the ability to target income and resource disregards at people who need HCBS provides States a critical tool in their efforts to "rebalance" their LTSS programs and move institutionalized individuals to community-based care. We similarly believe that more broadly eliminating the comparability rule in the use of income and/or resource disregards would enable States to achieve targeted expansions of coverage that best meet their needs, in contrast to the all-or-nothing approach that is effectively required by the current regulation.

It is possible that, in eliminating the comparability rule from 42 CFR 435.601(d), a State might narrow an existing disregard that is broadly available to an eligibility group to discrete members of the group. However, CMS has not received inquiries from States on the feasibility of such an approach to the same extent that we have received questions from States on whether they may use income and/or resource disregards to expand eligibility in a targeted manner. CMS believes that, in the absence of a comparability rule in 42 CFR 435.601(d), States would on the whole utilize disregard-related authority to expand eligibility instead of contracting it.

Consistent with 42 CFR 435.601(f)(2), under the proposed revisions to 42 CFR 435.601(d), States would continue to be required to submit a State plan amendment describing any new less restrictive methodologies the State seeks to apply and the groups to which it seeks to apply such methodologies. We also confirm that eliminating paragraph (d)(4) from 42 CFR 435.601 would not mean that States would be required to target any new income or resource disregards or modify any existing ones. The proposed change simply provides States with additional flexibility to do so.

We propose to amend 42 CFR 435.601 to: eliminate the current language of paragraph (d)(4); and redesignate the current paragraph (d)(5) as paragraph (d)(4). We seek comment on our proposal.

## 2. Changes to the Basic Health Program Regulations (42 CFR 600.320)

Section 1331 of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted March 30, 2010), provides States with the option to operate a Basic Health Program (BHP). In the States that elect to operate a BHP, the State's BHP makes affordable health benefits coverage available for lawfully present individuals under age 65 with household incomes between 133 and 200 percent of the Federal poverty level (FPL) (or in the case of a lawfully present non-citizen, ineligible for Medicaid or the Children's Health Insurance Program (CHIP) due to immigration status, with household incomes between zero and 200 percent of the FPL) who are not eligible for Medicaid, CHIP, or other minimum essential coverage. As of the date of this proposed rule, only New York and Minnesota have implemented a BHP.

Under current 42 CFR 600.320(c), States must establish a uniform method of determining the effective date of eligibility for enrollment in a standard health plan following either the Medicaid process at 42 CFR 435.915 exclusive of § 435.915(a) or the Exchange standards at 45 CFR 155.420(b)(1).

Under the Medicaid rules at § 435.915, the effective date of an individual's eligibility is also the effective date of coverage. Under the Exchange rules at 45 CFR 155.420(b)(1), an individual must first be determined to be a qualified individual (that is, eligible to enroll in a QHP through an Exchange). After that determination is made, the individual can make a plan selection. The Exchange coverage

effective date is then determined based on when the qualified individual selects their plan. If the plan selection is made between the first and fifteenth day of the month, coverage will be effective the first day of the month following the plan selection month. If the plan selection is made between the sixteenth and the last day of the month, coverage will be effective the first day of the second month following the plan selection month.

In States selecting the Medicaid process at 42 CFR 435.915 exclusive of § 435.915(a), eligibility for enrollment in a standard health plan in the BHP can be effective on either the date the application was submitted or the first day of the month of such month. In States selecting the Exchange standards at 45 CFR 155.420(b)(1), an individual is eligible to enroll in a standard health plan in the BHP on the first day of the month following the month of application if that individual is found eligible to enroll in a standard health plan between the first and the fifteenth of such month. Furthermore, under the Exchange standards if an individual is found eligible to enroll in a standard health plan between the sixteenth and the last day of any month, the individual will have an eligibility effective date of the first day of the second following month. A State operating a BHP may require an eligible individual to select a plan and/or pay a premium prior to the coverage.

Although the current BHP regulation provides States with some flexibility in establishing an effective eligibility date, it does not permit a State to select a standard in which all applicants who meet all requirements are eligible to enroll in a standard health plan in the BHP effective the first day of the month following the month of application or eligibility determination regardless of when they apply or are found eligible to enroll in a standard health plan in the BHP. As an example, to help to illustrate this point, if an individual applied on July 7, Medicaid rules would allow a BHP to determine an individual eligible for enrollment in a standard health plan on July 1 or July 7. If an individual applied on July 7 and was determined BHP-eligible on July 15, in a State that follows Exchange rules, the individual would be eligible for enrollment in a standard health plan on August 1. If the individual was determined BHP-eligible on July 23 in a State that follows Exchange rules, the individual would be eligible for enrollment in a standard health plan on September 1; the State could not choose to have coverage start on August 1, regardless of the date of application.

Even in a State with real-time eligibility determinations, if the State follows Exchange rules and the application is on July 23, the individual would be eligible for enrollment in a standard health plan on September 1.

We believe eligible individuals should have access to coverage as soon as is feasible. Since the BHP and Exchange standards were first established, HHS has taken steps to provide further flexibility for States to reduce barriers to enrollment and eliminate coverage gaps. Additionally, system improvements have provided faster and more accurate eligibility determinations. For example, in practice, all special enrollment periods on the FFEs now allow coverage to start at the beginning of the month after the qualifying individual's triggering event regardless of the plan selection date.

While the Medicaid process at 42 CFR 435.915, exclusive of § 435.915(a), allows for a State operating a BHP to have the earliest possible effective date for its enrollees, we understand that some States may have operational or regulatory constraints that do not allow them to follow the Medicaid process, but may be able to implement an effective date for all eligible applicants the first day of the month after the month in which the eligibility determination is made, regardless of which day of the month such determination occurs.

Therefore, we propose to revise § 600.320(c) to add a third option at paragraph (c)(iii) that would allow a State operating a BHP to follow an effective date of eligibility for all enrollees on the first day of the month following the month in which BHP eligibility is determined. Because States can require individuals to pay their first month's premium prior to enrolling in a standard health plan, § 600.320(c)(iii) also reflects this State option. Under § 600.320(c)(i), States will continue to have the option to follow the Exchange standards at 45 CFR 155.420(b)(1) and under § 600.320(c)(ii), a State may follow Medicaid standards at 42 CFR 435.915 exclusive of § 435.915(a).

We considered an alternative option of whether to instead allow a State to establish its own uniform effective date policy, outside of following the three

options in this proposed rule, subject to CMS approval and as long as it is no later than the first day of the second month following the date that an individual has been determined BHP-eligible. This alternative option, however, may cause delays in coverage even further. We seek comment on the proposed additional option for determining the effective date of eligibility for enrollment in a standard health plan as well as the alternative option.

#### *C. 45 CFR Part 153—Standards Related to Reinsurance, Risk Corridors, and HHS Risk Adjustment*

In subparts A, D, G, and H of part 153, we established standards for the administration of the risk adjustment program. The risk adjustment program is a permanent program created by section 1343 of the ACA that transfers funds from lower-than-average risk, risk adjustment covered plans to higher-than-average risk, risk adjustment covered plans in the individual, small group markets, or merged markets, inside and outside the Exchanges. In accordance with § 153.310(a), a State that is approved or conditionally approved by the Secretary to operate an Exchange may establish a risk adjustment program or have HHS do so on its behalf.<sup>26</sup> We did not receive any requests from States to establish and operate a risk adjustment program for the 2025 benefit year. Therefore, HHS will operate risk adjustment in every State and the District of Columbia for the 2025 benefit year.

##### 1. Sequestration

In accordance with the OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2024, the HHS-operated risk adjustment program is subject to the fiscal year 2024 sequestration.<sup>27</sup> The Federal Government's 2024 fiscal year began on October 1, 2023. Therefore, the HHS-operated risk adjustment program will be sequestered at a rate of 5.7 percent

for payments made from fiscal year 2024 resources (that is, funds collected during the 2024 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,<sup>28</sup> as amended, and the underlying authority for the HHS-operated risk adjustment program, the funds that are sequestered in fiscal year 2024 from the HHS-operated risk adjustment program will become available for payment to issuers in fiscal year 2025 without further Congressional action. If Congress does not enact deficit reduction provisions that replace the Joint Committee reductions, the program would be sequestered in future fiscal years, and any sequestered funding would become available in the fiscal year following that in which it was sequestered.

Additionally, we note that the Infrastructure Investment and Jobs Act<sup>29</sup> amended section 251A(6) of the Balanced Budget and Emergency Deficit Control Act of 1985 and extended sequestration for the HHS-operated risk adjustment program through fiscal year 2031 at a rate of 5.7 percent per fiscal year.<sup>30 31</sup>

##### 2. HHS Risk Adjustment (§ 153.320)

The HHS risk adjustment models predict plan liability for an average enrollee based on that person's age, sex, and diagnoses (also referred to as hierarchical condition categories (HCCs)), producing a risk score. The HHS risk adjustment methodology utilizes separate models for adults, children, and infants to account for clinical and cost differences in each age group. In the adult and child models, the relative risk assigned to an individual's age, sex, and diagnoses are added together to produce an individual risk score. Additionally, to calculate enrollee risk scores in the adult models, we added enrollment duration factors

<sup>28</sup> Public Law 99–177 (1985).

<sup>29</sup> Public Law 117–58, 135 Stat. 429 (2021).

<sup>30</sup> 2 U.S.C. 901a.

<sup>31</sup> The Infrastructure Investment and Jobs Act (Pub. L. 117–58) extended sequestration for the HHS-operated risk adjustment program through 2031 at a rate of 5.7 percent per fiscal year.

<sup>26</sup> See also 42 U.S.C. 18041(c)(1).

<sup>27</sup> OMB. (2023, March 13). OMB Report to the Congress on the BBEDCA 251A Sequestration for Fiscal Year 2024. [https://www.whitehouse.gov/wp-content/uploads/2023/03/BBEDCA\\_Sequestration\\_Report\\_and\\_Letter\\_3-13-2024.pdf](https://www.whitehouse.gov/wp-content/uploads/2023/03/BBEDCA_Sequestration_Report_and_Letter_3-13-2024.pdf).

beginning with the 2017 benefit year,<sup>32</sup> and prescription drug categories (RXC) beginning with the 2018 benefit year.<sup>33</sup> 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<sup>34</sup> applicable to certain severity and transplant HCCs.<sup>35</sup>

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. 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,<sup>36</sup> 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 2025 Benefit Year

We are proposing to recalibrate the 2025 benefit year HHS risk adjustment models with the 2019, 2020, and 2021 enrollee-level EDGE data. Consistent

with the approach outlined in the 2020 Payment Notice to no longer use MarketScan® data for recalibrating the HHS risk adjustment models, we propose to recalibrate the HHS risk adjustment models for the 2025 benefit year using only enrollee-level EDGE data, and we would continue to use blended, or averaged, coefficients from the 3 years of separately solved models for the 2025 benefit year model recalibration.<sup>37</sup> 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 incorporate the data in the draft recalibrated coefficients published in the proposed rule for the applicable benefit year,<sup>38</sup> and would not update the coefficients between the proposed and final rules if an additional year of enrollee-level EDGE data becomes available for incorporation. We believe this promotes stability, better 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.

In the 2024 Payment Notice (88 FR 25740 through 25749), we finalized the use of 2018, 2019 and 2020 benefit year enrollee-level EDGE data for recalibration of the 2024 benefit year HHS risk adjustment models for all model coefficients, with no exceptions. As explained in the 2024 Payment Notice proposed rule<sup>39</sup> and final rule,<sup>40</sup> we analyzed the 2020 benefit year data to identify possible impacts of the COVID-19 PHE and our analysis generally found that the 2020 enrollee-level EDGE data were anomalous primarily in the volume and frequencies of certain types of claims, but that the relative costs of specific services, at least those associated with payment HCCs in the HHS risk adjustment models, were largely unaffected. Because the HHS risk adjustment models predict relative costs of care for specific conditions on an enrollee-level basis and tend not to rely on overall patterns of utilization, the minimal impacts to relative costs of care for payment HCCs likewise resulted in minimal impacts on the coefficients fitted by the 2020 enrollee-level EDGE recalibration data.

Considering that the COVID-19 PHE was still in effect throughout the 2021 benefit year,<sup>41</sup> we recognize that some interested parties may continue to be concerned about the use of either the 2020 or 2021 enrollee-level EDGE data for the purposes of HHS risk adjustment model recalibration. In this regard, we conducted additional analyses to determine whether any anomalies in the 2021 benefit year enrollee-level EDGE data were present beyond expected year-to-year variation and whether the use of two years of PHE-impacted data presented any additional concerns. We did not identify any such anomalies and note that all draft coefficients for the 2025 benefit year HHS risk adjustment models in this proposed rule vary from their values in the 2024 HHS risk adjustment models within the range of previous year-to-year coefficient changes.

As such, we propose to determine coefficients for the 2025 benefit year based on a blend of separately solved coefficients from the 2019, 2020, and 2021 benefit years' enrollee-level EDGE data, with the costs of services identified from the data trended between the relevant year of data and the 2025 benefit year.<sup>42</sup> The draft coefficients listed in Tables 1 through 6 reflect the use of trended 2019, 2020, and 2021 benefit year enrollee-level EDGE data, as well as other HHS risk adjustment model updates proposed in this proposed rule (including, for example, the proposed pricing adjustment for Hepatitis C drugs). However, we note that the draft coefficients could change between the proposed and final rules if we identify an error after publication of this proposed rule or if any proposed model parameters are modified in response to comments. In addition, consistent with

<sup>32</sup> For the 2017 through 2022 benefit years, there is a set of 11 binary enrollment duration factors in the adult models that decrease monotonically from one to 11 months, reflecting the increased annualized costs associated with fewer months of enrollments. See, for example, 81 FR 94071 through 94074. These enrollment duration factors were replaced beginning with the 2023 benefit year with HCC-contingent enrollment duration factors for up to 6 months in the adult models. See, for example, 87 FR 27228 through 27230.

<sup>33</sup> 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.

<sup>34</sup> See Table 1 for a list of factors in the adult models, and Table 2 for a list of factors in the child models.

<sup>35</sup> See 87 FR 27224 through 27228.

<sup>36</sup> The State payment transfer formula refers to the 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 risk pool level (prior to the calculation of the high-cost risk pool payment and charge terms that apply beginning with the 2018 benefit year). See, for example, 81 FR 94080.

<sup>37</sup> 84 FR 17463 through 17466.

<sup>38</sup> 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 recalibration.

<sup>39</sup> 87 FR 78215 through 78216.

<sup>40</sup> 88 FR 25749 through 25753.

<sup>41</sup> See, for example, the Renewal of Determination that a Public Health Emergency Exists dated February 9, 2023. <https://aspr.hhs.gov/legal/PHE/Pages/COVID19-9Feb2023.aspx>.

<sup>42</sup> As described in the 2016 Risk Adjustment White Paper (<https://www.cms.gov/ccio/resources/forms-reports-and-other-resources/downloads/ra-march-31-white-paper-032416.pdf>) and the 2017 Payment Notice (81 FR at 12218), we subdivide expenditures into traditional drugs, specialty drugs, medical services, and preventive services and determine trend factors separately for each category of expenditure. In determining these trend factors, we consult our actuarial experts, review relevant Unified Rate Review Template (URRT) submission data, analyze multiple years of enrollee-level EDGE data, and consult National Health Expenditure Accounts (NHEA) data as well as external reports and documents published by third parties. In this process, we aim to determine trends that reflect changes in cost of care rather than gross growth in expenditures. As such, we believe the trend factors we used for each expenditure category for the 2025 benefit year are appropriate for the most recent changes in cost of care that we have seen in the market.

§ 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 2025 benefit year in guidance soon after the publication of the final rule.

We seek comment on the proposal to determine 2025 benefit year coefficients for the HHS risk adjustment models based on a blend of separately solved coefficients from the 2019, 2020, and 2021 enrollee-level EDGE data.

#### b. Pricing Adjustment for the Hepatitis C Drugs

For the 2025 benefit year, we propose to continue applying a market pricing adjustment to the plan liability associated with Hepatitis C drugs in the HHS risk adjustment models.<sup>43</sup> Since the 2020 benefit year HHS risk adjustment models, we have been making a market pricing adjustment to the plan liability associated with Hepatitis C drugs to reflect future market pricing prior to solving for coefficients for the models.<sup>44</sup> The purpose of this market pricing adjustment is to account for significant pricing changes between the data years used for recalibrating the models and the applicable benefit year of HHS risk adjustment as a result of the introduction of new and generic Hepatitis C drugs.<sup>45</sup>

We have committed to reassessing this pricing adjustment with additional years of enrollee-level EDGE data, as data becomes available. As part of the 2025 benefit year model recalibration analysis, we reassessed the cost trend for Hepatitis C drugs using available enrollee-level EDGE data (including

2021 benefit year data) to consider whether the adjustment was still needed and if it is still needed, whether it should be modified. We found that the data for the Hepatitis C RXC that would be used for the 2025 benefit year recalibration still do not account for the significant pricing changes due to the introduction of new and generic Hepatitis C drugs, and therefore, do not precisely reflect the average cost of Hepatitis C treatments applicable to the benefit year in question.

Specifically, although generic Hepatitis C drugs became available on the market in 2019,<sup>46</sup> and therefore were available for all 3 years of data proposed to be used for the 2025 benefit year model recalibration, our analysis of the data continued to observe that costs for Hepatitis C drugs are not increasing at the same rate as other drug costs between the data years and the applicable benefit year of HHS risk adjustment, likely due to continued increases in the proportion of Hepatitis C drug prescriptions for generic versions of the drugs. As such, we do not believe that the trends used to reflect growth in the cost of prescription drugs due to inflation and related factors for recalibrating the models will appropriately reflect the average cost of Hepatitis C treatments expected in the 2025 benefit year. Therefore, we continue to believe a market pricing adjustment specific to Hepatitis C drugs in the HHS risk adjustment models for the 2025 benefit year is necessary to account for the lack of growth in Hepatitis C drug prices relative to other

prescription drugs in the market between the data years used for recalibrating the models and the applicable benefit year of HHS risk adjustment due to the introduction of new and generic Hepatitis C drugs in recent years. We intend to continue to assess this pricing adjustment as part of future benefit year model recalibrations using available additional years of enrollee-level EDGE data.

We seek comment on our proposal to continue applying a market pricing adjustment to the plan liability associated with Hepatitis C drugs for the 2025 benefit year.

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

The proposed 2025 benefit year HHS risk adjustment model factors resulting from the equally weighted (averaged) blended factors from separately solved models using the 2019, 2020, and 2021 enrollee-level EDGE data are shown in Tables 1 through 6. The adult, child, and infant models have been truncated to account for the high-cost risk pool payment parameters by removing 60 percent of costs above the \$1 million threshold.<sup>47</sup> Table 1 contains proposed factors for each adult model, including the age-sex, HCCs, RXCs, RXC-HCC interactions, interacted HCC counts, and enrollment duration coefficients. Table 2 contains the proposed factors for each child model, including the age-sex, HCCs, and interacted HCC counts coefficients. Table 3 lists the proposed HCCs selected for the interacted HCC counts factors that would apply to the adult and child models. Table 4 contains the proposed factors for each infant model. Tables 5 and 6 contain the HCCs included in the infant models' maturity and severity categories, respectively.

<sup>47</sup> We are not proposing changes to the high-cost risk pool parameters for the 2025 benefit year. Therefore, we would maintain the \$1 million threshold and 60 percent coinsurance rate.

<sup>46</sup> See Miligan, J. (2018). A perspective from our CEO: Gilead Subsidiary to Launch Authorized Generics to Treat HCV. Gilead. <https://www.gilead.com/news-and-press/company-statements/authorized-generics-for-hcv>. See also AbbVie. (2017). AbbVie Receives U.S. FDA Approval of MAVYRET™ (glecaprevir/pibrentasvir) for the Treatment of Chronic Hepatitis C in All Major Genotypes (GT 1–6) in as Short as 8 Weeks. Abbvie. <https://news.abbvie.com/news/abbvie-receives-us-fda-approval-mavyret-glecaprevir-pibrentasvir-for-treatment-chronic-hepatitis-c-in-all-major-genotypes-gt-1-6-in-as-short-as-8-weeks.htm>.

<sup>43</sup> See for example, 84 FR 17463 through 17466.

<sup>44</sup> The Hepatitis C drugs market pricing adjustment to plan liability is applied for all enrollees taking Hepatitis C drugs in the data used for recalibration.

<sup>45</sup> Silseth, S., & Shaw, H. (2021). Analysis of prescription drugs for the treatment of hepatitis C in the United States. Milliman White Paper. <https://www.milliman.com/-/media/milliman/pdfs/2021-articles/6-11-21-analysis-prescription-drugs-treatment-hepatitis-c-us.ashx>.

**TABLE 1: Proposed Adult HHS Risk Adjustment Model Factors for the 2025 Benefit Year**

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
<b>Demographic Factors</b>						
	Age 21-24, Male	0.189	0.128	0.086	0.057	0.056
	Age 25-29, Male	0.197	0.133	0.088	0.056	0.055
	Age 30-34, Male	0.230	0.160	0.110	0.073	0.072
	Age 35-39, Male	0.249	0.174	0.119	0.077	0.076
	Age 40-44, Male	0.282	0.203	0.143	0.095	0.094
	Age 45-49, Male	0.312	0.228	0.164	0.112	0.111
	Age 50-54, Male	0.381	0.290	0.218	0.161	0.160
	Age 55-59, Male	0.428	0.330	0.254	0.191	0.189
	Age 60-64, Male	0.472	0.365	0.282	0.212	0.210
	Age 21-24, Female	0.285	0.196	0.127	0.078	0.076
	Age 25-29, Female	0.308	0.212	0.137	0.082	0.081
	Age 30-34, Female	0.370	0.268	0.188	0.126	0.125
	Age 35-39, Female	0.428	0.323	0.239	0.174	0.172
	Age 40-44, Female	0.482	0.372	0.284	0.211	0.209
	Age 45-49, Female	0.481	0.369	0.277	0.200	0.198
	Age 50-54, Female	0.519	0.404	0.307	0.226	0.224
	Age 55-59, Female	0.482	0.368	0.271	0.191	0.189
	Age 60-64, Female	0.475	0.358	0.261	0.179	0.176
<b>Diagnosis Factors</b>						
HCC001	HIV/AIDS	0.342	0.265	0.234	0.197	0.196
HCC002	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	9.075	8.875	8.830	8.740	8.739
HCC003	Central Nervous System Infections, Except Viral Meningitis	8.379	8.276	8.229	8.151	8.149
HCC004	Viral or Unspecified Meningitis	8.328	8.217	8.161	8.071	8.068
HCC006	Opportunistic Infections	8.532	8.478	8.419	8.333	8.330
HCC008	Metastatic Cancer	23.002	22.629	22.616	22.506	22.506
HCC009	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	12.575	12.312	12.271	12.156	12.155
HCC010	Non-Hodgkin Lymphomas and Other Cancers and Tumors	5.705	5.535	5.473	5.362	5.360
HCC011	Colorectal, Breast (Age < 50), Kidney, and Other Cancers	3.651	3.476	3.405	3.283	3.280
HCC012	Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	2.424	2.295	2.230	2.129	2.127
HCC013	Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	0.967	0.875	0.785	0.677	0.674
HCC018	Pancreas Transplant Status	6.320	6.253	6.239	6.228	6.219
HCC019	Diabetes with Acute Complications	0.259	0.214	0.172	0.130	0.128
HCC020	Diabetes with Chronic Complications	0.259	0.214	0.172	0.130	0.128
HCC021	Diabetes without Complication	0.259	0.214	0.172	0.130	0.128



HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC022	Type 1 Diabetes Mellitus, add-on to Diabetes HCCs 19-21	0.311	0.282	0.244	0.180	0.178
HCC023	Protein-Calorie Malnutrition	11.342	11.221	11.179	11.105	11.104
HCC026	Mucopolysaccharidosis	23.821	23.642	23.619	23.556	23.556
HCC027	Lipidoses and Glycogenosis	23.821	23.642	23.619	23.556	23.556
HCC029	Amyloidosis, Porphyria, and Other Metabolic Disorders	6.512	6.413	6.373	6.305	6.303
HCC030	Adrenal, Pituitary, and Other Significant Endocrine Disorders	1.314	1.237	1.184	1.108	1.104
HCC034	Liver Transplant Status/Complications	6.014	6.070	6.119	6.189	6.189
HCC035_1 <sup>a</sup>	Acute Liver Failure/Disease, Including Neonatal Hepatitis	7.464	7.288	7.254	7.181	7.184
HCC035_2	Chronic Liver Failure/End-Stage Liver Disorders	2.319	2.160	2.125	2.042	2.041
HCC036	Cirrhosis of Liver	0.613	0.534	0.490	0.417	0.416
HCC037_1	Chronic Viral Hepatitis C	0.514	0.454	0.403	0.348	0.347
HCC037_2	Chronic Hepatitis, Except Chronic Viral Hepatitis C	0.514	0.454	0.403	0.348	0.347
HCC041	Intestine Transplant Status/Complications	6.014	6.070	6.119	6.189	6.189
HCC042	Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	11.053	10.907	10.903	10.857	10.857
HCC045	Intestinal Obstruction	5.038	4.837	4.783	4.669	4.668
HCC046	Chronic Pancreatitis	2.467	2.298	2.253	2.167	2.166
HCC047	Acute Pancreatitis	2.467	2.298	2.251	2.147	2.146
HCC048	Inflammatory Bowel Disease	1.108	1.023	0.944	0.820	0.816
HCC054	Necrotizing Fasciitis	8.617	8.468	8.446	8.388	8.388
HCC055	Bone/Joint/Muscle Infections/Necrosis	4.567	4.401	4.381	4.321	4.322
HCC056	Rheumatoid Arthritis and Specified Autoimmune Disorders	1.082	0.993	0.930	0.845	0.843
HCC057	Systemic Lupus Erythematosus and Other Autoimmune Disorders	0.399	0.329	0.249	0.146	0.142
HCC061	Osteogenesis Imperfecta and Other Osteodystrophies	1.924	1.801	1.740	1.639	1.637
HCC062	Congenital/Developmental Skeletal and Connective Tissue Disorders	1.924	1.801	1.740	1.639	1.637
HCC063	Cleft Lip/Cleft Palate	0.922	0.819	0.759	0.678	0.676
HCC066	Hemophilia	72.761	72.491	72.466	72.379	72.380
HCC067	Myelodysplastic Syndromes and Myelofibrosis	11.237	11.118	11.090	11.024	11.020
HCC068	Aplastic Anemia	11.237	11.118	11.090	11.024	11.020
HCC069	Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	11.237	11.118	11.090	11.024	11.020
HCC070 <sup>b</sup>	Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero	1.690	1.607	1.553	1.479	1.477
HCC071 <sup>b</sup>	Sickle-Cell Disorders, Except Sickle-Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia Major	1.690	1.607	1.553	1.479	1.477
HCC073	Combined and Other Severe Immunodeficiencies	4.065	3.975	3.947	3.887	3.885
HCC074	Disorders of the Immune Mechanism	4.065	3.975	3.947	3.887	3.885

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC075	Coagulation Defects and Other Specified Hematological Disorders	2.148	2.068	2.020	1.947	1.946
HCC081	Drug Use with Psychotic Complications	1.602	1.472	1.377	1.233	1.229
HCC082	Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	1.602	1.472	1.377	1.233	1.229
HCC083	Alcohol Use with Psychotic Complications	0.902	0.788	0.716	0.612	0.610
HCC084	Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications	0.902	0.788	0.716	0.612	0.610
HCC087_1	Schizophrenia	2.227	2.063	1.986	1.864	1.862
HCC087_2	Delusional and Other Specified Psychotic Disorders, Unspecified Psychosis	2.190	2.030	1.951	1.820	1.818
HCC088	Major Depressive Disorder, Severe, and Bipolar Disorders	0.969	0.871	0.786	0.672	0.669
HCC090	Personality Disorders	0.663	0.586	0.492	0.379	0.376
HCC094	Anorexia/Bulimia Nervosa	2.000	1.894	1.827	1.722	1.719
HCC096	Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	8.590	8.557	8.527	8.484	8.481
HCC097	Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	0.938	0.875	0.826	0.764	0.763
HCC102	Autistic Disorder	0.718	0.641	0.553	0.455	0.452
HCC103	Pervasive Developmental Disorders, Except Autistic Disorder	0.663	0.586	0.492	0.379	0.376
HCC106	Traumatic Complete Lesion Cervical Spinal Cord	9.112	8.957	8.905	8.806	8.805
HCC107	Quadriplegia	9.112	8.957	8.905	8.806	8.805
HCC108	Traumatic Complete Lesion Dorsal Spinal Cord	6.380	6.241	6.187	6.089	6.087
HCC109	Paraplegia	6.380	6.241	6.187	6.089	6.087
HCC110	Spinal Cord Disorders/Injuries	5.153	4.975	4.928	4.826	4.824
HCC111	Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	5.090	4.946	4.876	4.755	4.753
HCC112	Quadriplegic Cerebral Palsy	0.730	0.629	0.565	0.467	0.465
HCC113	Cerebral Palsy, Except Quadriplegic	0.424	0.355	0.299	0.219	0.217
HCC114	Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	1.205	1.120	1.063	0.972	0.969
HCC115	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	5.216	5.134	5.117	5.076	5.076
HCC117	Muscular Dystrophy	1.393	1.304	1.236	1.136	1.134
HCC118	Multiple Sclerosis	2.218	2.101	2.042	1.944	1.941
HCC119	Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	1.393	1.304	1.236	1.136	1.134
HCC120	Seizure Disorders and Convulsions	1.040	0.948	0.884	0.792	0.789

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC121	Hydrocephalus	9.585	9.491	9.440	9.362	9.360
HCC122 <sup>c</sup>	Nontraumatic Coma, Except Diabetic, Hepatic, or Hypoglycemic; Nontraumatic Brain Compression/Anoxic Damage	10.181	10.044	9.986	9.886	9.884
HCC123	Narcolepsy and Cataplexy	4.533	4.405	4.340	4.237	4.235
HCC125	Respirator Dependence/Tracheostomy Status	21.869	21.665	21.623	21.532	21.534
HCC126	Respiratory Arrest	8.558	8.341	8.300	8.210	8.209
HCC127	Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	8.558	8.341	8.300	8.210	8.209
HCC128	Heart Assistive Device/Artificial Heart	17.404	17.301	17.262	17.214	17.224
HCC129	Heart Transplant Status/Complications	17.404	17.301	17.262	17.214	17.224
HCC130	Heart Failure	1.896	1.809	1.773	1.707	1.705
HCC131	Acute Myocardial Infarction	4.955	4.737	4.720	4.652	4.653
HCC132	Unstable Angina and Other Acute Ischemic Heart Disease	3.690	3.489	3.452	3.355	3.355
HCC135	Heart Infection/Inflammation, Except Rheumatic	8.848	8.756	8.695	8.602	8.599
HCC137	Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders	2.122	2.033	1.975	1.895	1.893
HCC138	Major Congenital Heart/Circulatory Disorders	2.122	2.033	1.975	1.895	1.893
HCC139	Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders	2.122	2.033	1.975	1.895	1.893
HCC142	Specified Heart Arrhythmias	1.921	1.819	1.752	1.645	1.645
HCC145	Intracranial Hemorrhage	10.648	10.490	10.444	10.356	10.355
HCC146	Ischemic or Unspecified Stroke	1.428	1.314	1.282	1.212	1.212
HCC149	Cerebral Aneurysm and Arteriovenous Malformation	2.218	2.102	2.044	1.944	1.941
HCC150	Hemiplegia/Hemiparesis	3.309	3.190	3.178	3.134	3.134
HCC151	Monoplegia, Other Paralytic Syndromes	2.494	2.386	2.342	2.264	2.262
HCC153	Atherosclerosis of the Extremities with Ulceration or Gangrene	7.988	7.837	7.849	7.827	7.828
HCC154	Vascular Disease with Complications	5.128	4.989	4.949	4.869	4.868
HCC156	Pulmonary Embolism and Deep Vein Thrombosis	7.621	7.535	7.461	7.345	7.341
HCC158	Lung Transplant Status/Complications	11.099	10.994	10.963	10.924	10.930
HCC159	Cystic Fibrosis	4.156	4.021	3.969	3.883	3.881
HCC160	Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	0.643	0.567	0.491	0.395	0.392
HCC161_1	Severe Asthma	0.643	0.567	0.491	0.395	0.392
HCC161_2	Asthma, Except Severe	0.643	0.567	0.491	0.395	0.392
HCC162	Fibrosis of Lung and Other Lung Disorders	1.615	1.529	1.476	1.391	1.388
HCC163	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	7.187	7.124	7.105	7.067	7.067

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC174	Exudative Macular Degeneration	1.224	1.097	1.010	0.878	0.874
HCC183	Kidney Transplant Status/Complications	6.320	6.253	6.239	6.228	6.219
HCC184	End Stage Renal Disease	20.669	20.237	20.330	20.158	20.046
HCC187	Chronic Kidney Disease, Stage 5	0.773	0.689	0.685	0.645	0.633
HCC188	Chronic Kidney Disease, Severe (Stage 4)	0.773	0.689	0.685	0.645	0.633
HCC203	Ectopic and Molar Pregnancy	1.850	1.673	1.534	1.319	1.314
HCC204	Miscarriage with Complications	0.646	0.565	0.439	0.260	0.254
HCC205	Miscarriage with No or Minor Complications	0.646	0.565	0.439	0.260	0.254
HCC207	Pregnancy with Delivery with Major Complications	3.756	3.470	3.289	2.991	2.985
HCC208	Pregnancy with Delivery with Complications	3.756	3.470	3.289	2.991	2.985
HCC209	Pregnancy with Delivery with No or Minor Complications	2.769	2.554	2.335	1.972	1.962
HCC210	(Ongoing) Pregnancy without Delivery with Major Complications	0.815	0.714	0.561	0.370	0.363
HCC211	(Ongoing) Pregnancy without Delivery with Complications	0.530	0.454	0.318	0.170	0.166
HCC212	(Ongoing) Pregnancy without Delivery with No or Minor Complications	0.018	0.005	0.000	0.000	0.000
HCC217	Chronic Ulcer of Skin, Except Pressure	1.557	1.464	1.433	1.375	1.374
HCC218	Extensive Third-Degree Burns	23.714	23.524	23.474	23.384	23.383
HCC219	Major Skin Burn or Condition	2.604	2.484	2.428	2.345	2.344
HCC223	Severe Head Injury	18.201	18.057	17.990	17.882	17.879
HCC226	Hip and Pelvic Fractures	8.018	7.783	7.765	7.688	7.688
HCC228	Vertebral Fractures without Spinal Cord Injury	4.277	4.116	4.047	3.925	3.922
HCC234	Traumatic Amputations and Amputation Complications	4.861	4.706	4.682	4.619	4.618
HCC251	Stem Cell, Including Bone Marrow, Transplant Status/Complications	18.571	18.584	18.547	18.531	18.535
HCC253	Artificial Openings for Feeding or Elimination	5.697	5.584	5.563	5.511	5.511
HCC254	Amputation Status, Upper Limb or Lower Limb	0.936	0.835	0.799	0.738	0.736
<b>Interacted HCC Counts Factors</b>						
	Severe illness, 1 payment HCC	-6.014	-6.070	-6.119	-6.189	-6.189
	Severe illness, 2 payment HCCs	-5.733	-5.806	-5.833	-5.886	-5.886
	Severe illness, 3 payment HCCs	-4.904	-4.952	-4.891	-4.846	-4.844
	Severe illness, 4 payment HCCs	-4.190	-4.178	-4.033	-3.871	-3.865
	Severe illness, 5 payment HCCs	-3.522	-3.432	-3.216	-2.954	-2.945
	Severe illness, 6 payment HCCs	-3.024	-2.835	-2.557	-2.202	-2.192
	Severe illness, 7 payment HCCs	-2.432	-2.116	-1.780	-1.330	-1.318
	Severe illness, 8 payment HCCs	-2.179	-1.784	-1.416	-0.910	-0.896
	Severe illness, 9 payment HCCs	-0.287	0.253	0.676	1.279	1.294
	Severe illness, 10 or more payment HCCs	7.398	8.299	8.836	9.657	9.679
	Transplant severe illness, 4 payment HCCs	3.792	3.704	3.651	3.531	3.516

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
	Transplant severe illness, 5 payment HCCs	7.054	6.949	6.906	6.792	6.775
	Transplant severe illness, 6 payment HCCs	12.584	12.463	12.431	12.324	12.304
	Transplant severe illness, 7 payment HCCs	15.636	15.506	15.473	15.364	15.346
	Transplant severe illness, 8 or more payment HCCs	31.955	31.916	31.908	31.845	31.825
<b>Enrollment Duration Factors</b>						
	Enrolled for 1 month, at least one payment HCC	11.208	9.742	8.808	7.844	7.818
	Enrolled for 2 months, at least one payment HCC	5.197	4.458	3.958	3.479	3.466
	Enrolled for 3 months, at least one payment HCC	3.378	2.898	2.549	2.224	2.216
	Enrolled for 4 months, at least one payment HCC	2.129	1.799	1.545	1.313	1.307
	Enrolled for 5 months, at least one payment HCC	1.586	1.340	1.143	0.959	0.955
	Enrolled for 6 months, at least one payment HCC	1.039	0.857	0.705	0.560	0.556
<b>Prescription Drug Factors</b>						
RXC 01	Anti-HIV Agents	5.097	4.612	4.345	3.920	3.908
RXC 02	Anti-Hepatitis C (HCV) Agents, Direct Acting Agents	8.273	7.809	7.812	7.711	7.714
RXC 03 <sup>d</sup>	Antiarrhythmics	0.080	0.072	0.064	0.051	0.036
RXC 04	Phosphate Binders	0.901	1.115	1.007	1.206	1.390
RXC 05	Inflammatory Bowel Disease Agents	1.324	1.227	1.105	0.941	0.936
RXC 06	Insulin	1.366	1.193	1.018	0.844	0.838
RXC 07	Anti-Diabetic Agents, Except Insulin and Metformin Only	0.800	0.702	0.582	0.409	0.403
RXC 08	Multiple Sclerosis Agents	15.175	14.409	14.206	13.774	13.767
RXC 09 <sup>e</sup>	Immune Suppressants and Immunomodulators	12.005	11.495	11.478	11.335	11.337
RXC 10	Cystic Fibrosis Agents	17.441	17.041	17.022	16.903	16.902
RXC 01 x HCC001	Additional effect for enrollees with RXC 01 and HCC 001	2.467	2.521	2.790	3.101	3.115
RXC 02 x HCC037_1, 036, 035_2, 035_1, 034	Additional effect for enrollees with RXC 02 and (HCC 037_1 or 036 or 035_2 or 035_1 or 034)	-0.514	-0.454	-0.403	-0.348	-0.347
RXC 03 x HCC142	Additional effect for enrollees with RXC 03 and HCC 142	0.000	0.000	0.000	0.000	0.000
RXC 04 x HCC184, 183, 187, 188	Additional effect for enrollees with RXC 04 and (HCC 184 or 183 or 187 or 188)	0.000	0.000	0.000	0.000	0.000
RXC 05 x HCC048, 041	Additional effect for enrollees with RXC 05 and (HCC 048 or 041)	-0.688	-0.631	-0.570	-0.471	-0.468

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
RXC 06 x HCC018, 019, 020, 021	Additional effect for enrollees with RXC 06 and (HCC 018 or 019 or 020 or 021)	0.402	0.444	0.532	0.544	0.546
RXC 07 x HCC018, 019, 020, 021	Additional effect for enrollees with RXC 07 and (HCC 018 or 019 or 020 or 021)	-0.258	-0.213	-0.172	-0.130	-0.128
RXC 08 x HCC118	Additional effect for enrollees with RXC 08 and HCC 118	-0.132	0.227	0.497	0.902	0.914
RXC 09 x HCC056 or 057 and 048 or 041	Additional effect for enrollees with RXC 09 and (HCC 048 or 041) and (HCC 056 or 057)	0.343	0.396	0.433	0.492	0.494
RXC 09 x HCC056	Additional effect for enrollees with RXC 09 and HCC 056	-1.082	-0.993	-0.930	-0.845	-0.843
RXC 09 x HCC057	Additional effect for enrollees with RXC 09 and HCC 057	-0.399	-0.329	-0.249	-0.146	-0.142
RXC 09 x HCC048, 041	Additional effect for enrollees with RXC 09 and (HCC 048 or 041)	1.315	1.406	1.499	1.634	1.638
RXC 10 x HCC159, 158	Additional effect for enrollees with RXC 10 and (HCC 159 or 158)	42.562	42.609	42.695	42.807	42.812

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

b/ For the proposed 2025 benefit year HHS risk adjustment models, we made the following changes to improve the prediction of sickle cell disease costs: we updated mappings for sickle cell disease so that additional diagnosis codes are included in the model (within HCC 71), ungrouped HCCs 70 and 71 in the adult and child models, and reassigned HCC 70 and 71 to a higher severity in the infant models. To reflect these changes, we also relabeled HCC 70 and HCC 71. These updated mapping and HCC label changes parallel the reclassified Medicare Part C V28 CMS-HCCs. See, for example, the Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (February 1, 2023). <https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf>.

c/ Consistent with fiscal year 2024 updates to ICD-10 codes (effective October 1, 2023; see <https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-cm>), we updated the label for HCC 122 from “Coma, Brain Compression/Anoxic Damage” to “Nontraumatic Coma, Except Diabetic, Hepatic, or Hypoglycemic; Nontraumatic Brain Compression/Anoxic Damage.” The specific ICD-10 code update that prompted this label change was the addition of code R402A “Nontraumatic coma due to underlying condition”, which we have mapped to HCC 122. HCC 122 is only assigned to enrollees who do not also have a head injury code, because HCC 223 (Severe Head Injury) captures codes for head injury with loss of consciousness and supersedes HCC 122 in a hierarchy. As such, the scope of HCC 122 is better reflected by the updated label. Because this ICD-10 update is effective October 1, 2023, future releases of benefit year 2023 and benefit year 2024 DIY software will also reflect the updated label and diagnosis-to-HCC mapping.

d/ We constrain RXC 03 to be equal to average plan liability for RXC 03 drugs, RXC 04 to be equal to the average plan liability for RXC 04 drugs, and we constrain RXC 03 x HCC142 and RXC 04 x HCC184, 183, 187, 188 to be equal to 0. See CMS. (2016, March 24). March 2016 Risk Adjustment Methodology Discussion Paper. <https://www.cms.gov/ccio/resources/forms-reports-and-other-resources/downloads/ra-march-31-white-paper-032416.pdf> (where we previously discussed the use of constraints in the HHS risk adjustment models).

e/ Similar to recalibration of the 2023 and 2024 benefit year HHS risk adjustment adult models and consistent with the policies adopted in the 2023 and 2024 Payment Notices, the proposed 2025 benefit year factors in this rule reflect the removal of the mapping of hydroxychloroquine sulfate to RXC 09 (Immune Suppressants and Immunomodulators) and the related RXC 09 interactions (RXC 09 x HCC056 or 057 and 048 or 041; RXC 09 x HCC056; RXC 09 x HCC 057; RXC 09x HCC048, 041) from the 2019 benefit year enrollee-level EDGE data sets for purposes of recalibrating the 2025 benefit year adult models. See 87 FR 27232 through 27235. Additionally, the proposed factors for the adult models reflect the use of the final, fourth quarter (Q4) RXC mapping document that was applicable for each benefit year of data included in the current year’s model recalibration (except under extenuating circumstances that can result in targeted changes to RXC mappings). See 87 FR 27231 through 27232.



**TABLE 2: Proposed Child HHS Risk Adjustment Model Factors for the 2025 Benefit Year**

<b>Factor</b>	<b>Platinum</b>	<b>Gold</b>	<b>Silver</b>	<b>Bronze</b>	<b>Catastrophic</b>
<b>Demographic Factors</b>					
Age 2-4, Male	0.270	0.191	0.141	0.105	0.104
Age 5-9, Male	0.204	0.135	0.096	0.071	0.071
Age 10-14, Male	0.224	0.156	0.115	0.090	0.089
Age 15-20, Male	0.260	0.187	0.137	0.102	0.101
Age 2-4, Female	0.223	0.153	0.113	0.089	0.088
Age 5-9, Female	0.149	0.086	0.053	0.034	0.034
Age 10-14, Female	0.222	0.153	0.113	0.089	0.088
Age 15-20, Female	0.300	0.212	0.145	0.097	0.095
<b>Diagnosis Factors</b>					
HIV/AIDS	4.355	3.942	3.856	3.659	3.657
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	14.567	14.370	14.294	14.176	14.174
Central Nervous System Infections, Except Viral Meningitis	13.944	13.811	13.745	13.658	13.656
Viral or Unspecified Meningitis	12.972	12.833	12.741	12.617	12.614
Opportunistic Infections	18.957	18.895	18.813	18.719	18.716
Metastatic Cancer	30.530	30.304	30.243	30.137	30.136
Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	8.962	8.738	8.640	8.486	8.484
Non-Hodgkin Lymphomas and Other Cancers and Tumors	7.708	7.523	7.421	7.266	7.263
Colorectal, Breast (Age < 50), Kidney, and Other Cancers	4.194	4.057	3.972	3.844	3.841
Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	4.194	4.057	3.972	3.844	3.841
Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.265	1.155	1.058	0.937	0.933
Pancreas Transplant Status	11.660	11.580	11.544	11.505	11.503
Diabetes with Acute Complications	2.364	2.121	1.914	1.622	1.615
Diabetes with Chronic Complications	2.364	2.121	1.914	1.622	1.615

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Diabetes without Complication	2.364	2.121	1.914	1.622	1.615
Protein-Calorie Malnutrition	19.614	19.505	19.457	19.397	19.396
Mucopolysaccharidosis	34.440	34.213	34.169	34.070	34.070
Lipidoses and Glycogenosis	34.440	34.213	34.169	34.070	34.070
Congenital Metabolic Disorders, Not Elsewhere Classified	4.690	4.583	4.523	4.442	4.439
Amyloidosis, Porphyria, and Other Metabolic Disorders	4.690	4.583	4.523	4.442	4.439
Adrenal, Pituitary, and Other Significant Endocrine Disorders	5.289	5.072	5.007	4.902	4.901
Liver Transplant Status/Complications	11.660	11.580	11.544	11.505	11.503
Acute Liver Failure/Disease, Including Neonatal Hepatitis	7.742	7.607	7.570	7.488	7.487
Chronic Liver Failure/End-Stage Liver Disorders	7.742	7.607	7.570	7.488	7.487
Cirrhosis of Liver	3.999	3.881	3.835	3.764	3.763
Chronic Viral Hepatitis C	1.257	1.152	1.093	1.027	1.025
Chronic Hepatitis, Except Chronic Viral Hepatitis C	0.294	0.249	0.198	0.140	0.138
Intestine Transplant Status/Complications	13.387	13.303	13.228	13.137	13.135
Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	19.019	18.756	18.703	18.597	18.597
Intestinal Obstruction	4.601	4.431	4.343	4.208	4.205
Chronic Pancreatitis	10.235	10.115	10.085	10.007	10.007
Acute Pancreatitis	4.988	4.771	4.687	4.541	4.538
Inflammatory Bowel Disease	9.947	9.582	9.498	9.313	9.311
Necrotizing Fasciitis	4.144	3.957	3.872	3.746	3.745
Bone/Joint/Muscle Infections/Necrosis	4.144	3.957	3.872	3.746	3.745
Rheumatoid Arthritis and Specified Autoimmune Disorders	4.632	4.397	4.315	4.181	4.179
Systemic Lupus Erythematosus and Other Autoimmune Disorders	0.878	0.777	0.679	0.559	0.555
Osteogenesis Imperfecta and Other Osteodystrophies	1.241	1.140	1.069	0.981	0.979
Congenital/Developmental Skeletal and Connective Tissue Disorders	1.241	1.140	1.069	0.981	0.979
Cleft Lip/Cleft Palate	0.972	0.841	0.742	0.616	0.613
Hemophilia	64.093	63.672	63.604	63.429	63.427
Myelodysplastic Syndromes and Myelofibrosis	12.305	12.163	12.117	12.039	12.038
Aplastic Anemia	12.305	12.163	12.117	12.039	12.038
Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	12.305	12.163	12.117	12.039	12.038
Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero <sup>a</sup>	3.564	3.400	3.303	3.173	3.170
Sickle-Cell Disorders, Except Sickle-Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia Major <sup>a</sup>	3.369	3.233	3.160	3.055	3.053
Combined and Other Severe Immunodeficiencies	5.105	4.975	4.918	4.826	4.824
Disorders of the Immune Mechanism	5.105	4.975	4.918	4.826	4.824

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Coagulation Defects and Other Specified Hematological Disorders	4.043	3.938	3.869	3.779	3.777
Drug Use with Psychotic Complications	2.350	2.204	2.111	1.972	1.969
Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	2.350	2.204	2.111	1.972	1.969
Alcohol Use with Psychotic Complications	0.899	0.765	0.658	0.502	0.499
Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications	0.899	0.765	0.658	0.502	0.499
Schizophrenia	3.545	3.304	3.188	3.007	3.004
Delusional and Other Specified Psychotic Disorders, Unspecified Psychosis	3.289	3.067	2.940	2.745	2.741
Major Depressive Disorder, Severe, and Bipolar Disorders	2.506	2.319	2.191	2.017	2.013
Personality Disorders	0.348	0.263	0.159	0.043	0.040
Anorexia/Bulimia Nervosa	2.207	2.070	1.977	1.846	1.843
Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	12.082	12.007	11.947	11.870	11.868
Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	0.867	0.758	0.686	0.583	0.581
Autistic Disorder	2.506	2.319	2.191	2.017	2.013
Pervasive Developmental Disorders, Except Autistic Disorder	0.374	0.303	0.222	0.140	0.139
Traumatic Complete Lesion Cervical Spinal Cord	10.147	9.959	9.908	9.810	9.809
Quadriplegia	10.147	9.959	9.908	9.810	9.809
Traumatic Complete Lesion Dorsal Spinal Cord	9.868	9.664	9.615	9.515	9.514
Paraplegia	9.868	9.664	9.615	9.515	9.514
Spinal Cord Disorders/Injuries	4.750	4.568	4.457	4.285	4.280
Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	49.556	49.316	49.259	49.139	49.137
Quadriplegic Cerebral Palsy	0.638	0.454	0.383	0.266	0.265
Cerebral Palsy, Except Quadriplegic	0.254	0.134	0.073	0.029	0.028
Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	1.624	1.514	1.448	1.345	1.342
Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	10.278	10.133	10.111	10.053	10.053
Muscular Dystrophy	5.546	5.399	5.326	5.206	5.203
Multiple Sclerosis	9.135	8.789	8.736	8.602	8.604
Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	5.546	5.399	5.326	5.206	5.203
Seizure Disorders and Convulsions	1.556	1.429	1.316	1.169	1.165
Hydrocephalus	11.666	11.630	11.604	11.580	11.579
Nontraumatic Coma, Except Diabetic, Hepatic, or Hypoglycemic; Nontraumatic Brain Compression/Anoxic Damage <sup>b</sup>	11.216	11.250	11.261	11.287	11.287
Narcolepsy and Cataplexy	4.058	3.911	3.807	3.664	3.659
Respirator Dependence/Tracheostomy Status	24.720	24.506	24.442	24.337	24.336

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Respiratory Arrest	15.720	15.472	15.398	15.267	15.266
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	15.720	15.472	15.398	15.267	15.266
Heart Assistive Device/Artificial Heart	13.387	13.303	13.228	13.137	13.135
Heart Transplant Status/Complications	13.387	13.303	13.228	13.137	13.135
Heart Failure	4.067	3.968	3.914	3.830	3.828
Acute Myocardial Infarction	1.060	1.025	1.005	0.979	0.979
Unstable Angina and Other Acute Ischemic Heart Disease	1.060	1.025	1.005	0.979	0.979
Heart Infection/Inflammation, Except Rheumatic	17.077	16.964	16.888	16.786	16.783
Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders	3.938	3.796	3.682	3.540	3.536
Major Congenital Heart/Circulatory Disorders	0.986	0.896	0.790	0.685	0.682
Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders	0.590	0.506	0.425	0.347	0.345
Specified Heart Arrhythmias	3.118	2.980	2.899	2.785	2.783
Intracranial Hemorrhage	12.686	12.611	12.565	12.497	12.495
Ischemic or Unspecified Stroke	1.470	1.362	1.304	1.210	1.208
Cerebral Aneurysm and Arteriovenous Malformation	1.049	0.952	0.899	0.807	0.804
Hemiplegia/Hemiparesis	5.471	5.353	5.295	5.207	5.205
Monoplegia, Other Paralytic Syndromes	1.374	1.253	1.183	1.072	1.070
Atherosclerosis of the Extremities with Ulceration or Gangrene	11.860	11.625	11.557	11.424	11.422
Vascular Disease with Complications	8.127	7.988	7.947	7.872	7.871
Pulmonary Embolism and Deep Vein Thrombosis	19.738	19.604	19.533	19.426	19.425
Lung Transplant Status/Complications	13.387	13.303	13.228	13.137	13.135
Cystic Fibrosis	48.718	48.241	48.201	48.054	48.055
Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	1.658	1.507	1.403	1.267	1.264
Severe Asthma	1.323	1.171	1.045	0.889	0.885
Asthma, Except Severe	0.320	0.250	0.170	0.102	0.100
Fibrosis of Lung and Other Lung Disorders	1.490	1.361	1.249	1.115	1.111
Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	11.216	11.250	11.261	11.287	11.287
Kidney Transplant Status/Complications	11.660	11.580	11.544	11.505	11.503
End Stage Renal Disease	29.641	29.391	29.371	29.278	29.278
Chronic Kidney Disease, Stage 5	0.787	0.749	0.722	0.685	0.683
Chronic Kidney Disease, Severe (Stage 4)	0.787	0.749	0.722	0.685	0.683
Ectopic and Molar Pregnancy	0.864	0.731	0.565	0.411	0.406
Miscarriage with Complications	0.474	0.369	0.227	0.089	0.086
Miscarriage with No or Minor Complications	0.474	0.369	0.227	0.089	0.086
Pregnancy with Delivery with Major Complications	3.166	2.876	2.634	2.231	2.219
Pregnancy with Delivery with Complications	3.166	2.876	2.634	2.231	2.219
Pregnancy with Delivery with No or Minor Complications	2.399	2.179	1.914	1.475	1.460
(Ongoing) Pregnancy without Delivery with Major Complications	0.420	0.308	0.152	0.039	0.036

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
(Ongoing) Pregnancy without Delivery with Complications	0.420	0.308	0.152	0.039	0.036
(Ongoing) Pregnancy without Delivery with No or Minor Complications	0.276	0.187	0.079	0.037	0.036
Chronic Ulcer of Skin, Except Pressure	1.877	1.782	1.712	1.634	1.632
Extensive Third-Degree Burns	22.876	22.657	22.576	22.440	22.437
Major Skin Burn or Condition	2.441	2.286	2.187	2.056	2.053
Severe Head Injury	22.876	22.657	22.576	22.440	22.437
Hip and Pelvic Fractures	4.636	4.428	4.327	4.191	4.188
Vertebral Fractures without Spinal Cord Injury	4.483	4.293	4.176	3.999	3.994
Traumatic Amputations and Amputation Complications	3.818	3.627	3.528	3.362	3.357
Stem Cell, Including Bone Marrow, Transplant Status/Complications	13.387	13.303	13.228	13.137	13.135
Artificial Openings for Feeding or Elimination	5.711	5.551	5.525	5.451	5.450
Amputation Status, Upper Limb or Lower Limb	3.818	3.627	3.528	3.362	3.357
<b>Interacted HCC Counts Factors</b>					
Severe illness, 1 payment HCC	-11.216	-11.250	-11.261	-11.287	-11.287
Severe illness, 2 payment HCCs	-11.137	-11.200	-11.218	-11.265	-11.266
Severe illness, 3 payment HCCs	-9.692	-9.760	-9.689	-9.658	-9.655
Severe illness, 4 payment HCCs	-8.984	-8.987	-8.809	-8.652	-8.645
Severe illness, 5 payment HCCs	-6.593	-6.543	-6.303	-6.068	-6.059
Severe illness, 6 or 7 payment HCCs	-2.061	-1.828	-1.468	-1.064	-1.051
Severe illness, 8 or more payment HCCs	17.868	18.550	19.132	19.858	19.877
Transplant severe illness, 4 or more payment HCCs	14.488	14.558	14.580	14.612	14.613

a/ For the proposed 2025 benefit year HHS risk adjustment models, we made the following changes to improve the prediction of sickle cell disease costs: we updated mappings for sickle cell disease so that additional diagnosis codes are included in the model (within HCC 71), ungrouped HCCs 70 and 71 in the adult and child models, and reassigned HCC 70 and 71 to a higher severity in the infant models. To reflect these changes, we also relabeled HCC 70 and HCC 71. These updated mapping and HCC label changes parallel the reclassified Medicare Part C V28 CMS-HCCs. See, for example, the Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (February 1, 2023). <https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf>.

b/ Consistent with fiscal year 2024 updates to ICD-10 codes (effective October 1, 2023; see <https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-cm>), we updated the label for HCC 122 from “Coma, Brain Compression/Anoxic Damage” to “Nontraumatic Coma, Except Diabetic, Hepatic, or Hypoglycemic; Nontraumatic Brain Compression/Anoxic Damage.” The specific ICD-10 code update that prompted this label change was the addition of code R402A “Nontraumatic coma due to underlying condition”, which we have mapped to HCC 122. HCC 122 is only assigned to enrollees who do not also have a head injury code, because HCC 223 (Severe Head Injury) captures codes for head injury with loss of consciousness and supersedes HCC 122 in a hierarchy. As such, the scope of HCC 122 is better reflected by the updated label. Because this ICD-10 update is effective October 1, 2023, future releases of the benefit year 2023 and benefit year 2024 DIY software will also reflect the updated label and diagnosis-to-HCC mapping.

**TABLE 3: Proposed HCCs Selected for the HCC Interacted Counts Variables for the Adult and Child Models for the 2025 Benefit Year**

Payment HCC	Severity Illness Indicator	Transplant Indicator
HCC 2 Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	X	
HCC 3 Central Nervous System Infections, Except Viral Meningitis	X	
HCC 4 Viral or Unspecified Meningitis	X	
HCC 6 Opportunistic Infections	X	
HCC 23 Protein-Calorie Malnutrition	X	
HCC 34 Liver Transplant Status/Complications	X	X
HCC 41 Intestine Transplant Status/Complications	X	X
HCC 42 Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	X	
HCC 96 Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	X	
HCC 121 Hydrocephalus	X	
HCC 122 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 HHS Risk Adjustment Model Factors for the 2025 Benefit Year**

Group	Platinum	Gold	Silver	Bronze	Catastrophic
Extremely Immature * Severity Level 5 (Highest)	204.040	202.652	202.406	201.915	201.913
Extremely Immature * Severity Level 4	149.999	148.437	148.051	147.377	147.372
Extremely Immature * Severity Level 3	32.887	31.619	31.251	30.693	30.687
Extremely Immature * Severity Level 2	32.887	31.619	31.251	30.693	30.687
Extremely Immature * Severity Level 1 (Lowest)	32.887	31.619	31.251	30.693	30.687
Immature * Severity Level 5 (Highest)	121.913	120.553	120.309	119.828	119.827
Immature * Severity Level 4	71.026	69.564	69.264	68.692	68.689
Immature * Severity Level 3	32.887	31.619	31.251	30.693	30.687
Immature * Severity Level 2	30.558	29.332	28.960	28.403	28.398
Immature * Severity Level 1 (Lowest)	25.110	23.887	23.485	22.871	22.863
Premature/Multiples * Severity Level 5 (Highest)	108.585	107.335	107.096	106.631	106.628
Premature/Multiples * Severity Level 4	29.666	28.404	28.060	27.490	27.486
Premature/Multiples * Severity Level 3	13.527	12.617	12.148	11.482	11.467
Premature/Multiples * Severity Level 2	8.071	7.368	6.849	6.149	6.131
Premature/Multiples * Severity Level 1 (Lowest)	5.765	5.167	4.644	4.023	4.005
Term * Severity Level 5 (Highest)	81.884	80.752	80.438	79.915	79.909
Term * Severity Level 4	16.190	15.254	14.803	14.170	14.158
Term * Severity Level 3	5.770	5.207	4.688	4.061	4.041
Term * Severity Level 2	3.712	3.231	2.707	2.109	2.092
Term * Severity Level 1 (Lowest)	1.968	1.597	1.135	0.784	0.776
Age1 * Severity Level 5 (Highest)	69.391	68.741	68.568	68.287	68.284
Age1 * Severity Level 4	12.653	12.170	11.942	11.641	11.635
Age1 * Severity Level 3	2.829	2.569	2.374	2.179	2.174
Age1 * Severity Level 2	1.855	1.628	1.423	1.216	1.210
Age1 * Severity Level 1 (Lowest)	0.581	0.487	0.431	0.394	0.393
Age 0 Male	0.604	0.566	0.539	0.475	0.473
Age 1 Male	0.090	0.076	0.060	0.042	0.041

**TABLE 5: HHS HCCs Included in Infant Model Maturity Categories**

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

**TABLE 6: HHS HCCs Included in Infant Model Severity Categories**

<b>Severity Category</b>	<b>HCC/Description</b>
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 <sup>a</sup>
Severity Level 4	Respiratory Arrest
Severity Level 4	Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes
Severity Level 4	Acute Myocardial Infarction

Severity Category	HCC/Description
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 <sup>b</sup>
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 Category	HCC/Description
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 <sup>a</sup>
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

a/ Consistent with fiscal year 2024 updates to ICD-10 codes (effective October 1, 2023; see <https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-cm>), we updated the label for HCC 122 from “Coma, Brain Compression/Anoxic Damage” to “Nontraumatic Coma, Except Diabetic, Hepatic, or Hypoglycemic; Nontraumatic Brain Compression/Anoxic Damage.” The specific ICD-10 code update that prompted this label change was the addition of code R402A “Nontraumatic coma due to underlying condition”, which we have mapped to HCC 122. HCC 122 is only assigned to enrollees who do not also have a head injury code, because HCC 223 (Severe Head Injury) captures codes for head injury with loss of consciousness and supersedes HCC 122 in a hierarchy. As such, the scope of HCC 122 is better reflected by the updated label. Because this ICD-10 update is effective October 1, 2023, future releases of the benefit year 2023 and benefit year 2024 DIY software will also reflect the updated label and diagnosis-to-HCC mapping.

b/ For the proposed 2025 benefit year HHS risk adjustment models, we made the following changes to improve the prediction of sickle cell disease costs: we updated mappings for sickle cell disease so that additional diagnosis codes are included in the model (within HCC 71), ungrouped HCCs 70 and 71 in the adult and child models, and reassigned HCC 70 and 71 to a higher severity in the infant models. To reflect these changes, we also relabeled HCC 70 and HCC 71. These updated mapping and HCC label changes parallel the reclassified Medicare Part C V28 CMS-HCCs. See, for example, the Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (February 1, 2023). <https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf>.

#### d. Cost-Sharing Reduction Adjustments

We propose to recalibrate the CSR adjustment factors for AI/AN zero cost

sharing and limited cost sharing CSR plan variant enrollees for the 2025 benefit year, and to retain these

proposed AI/AN CSR adjustment factors, if finalized, for all future benefit years unless changed through notice-

and-comment rulemaking. We also propose to maintain the current CSR adjustment factors for silver plan variant enrollees (70 percent, 73 percent, 87 percent, and 94 percent AV plan variants)<sup>48</sup> for the 2025 benefit year and beyond, unless changed through notice-and-comment rulemaking.

Since the beginning of the HHS-operated risk adjustment program in the 2014 benefit year, we included CSR adjustment factors in the calculations under the State payment transfer formula to account for anticipated increased demand for health care services due to lower cost sharing for CSR enrollees.<sup>49</sup> At that time, we did not have data available on the individual and small group (including merged) markets' use of services, and therefore, we based the CSR adjustment factors on the available large group market MarketScan® data.<sup>50</sup> We have proposed and finalized the same CSR adjustment factors since they were first established to maintain stability and certainty for issuers.<sup>51</sup> At the same time, we have continued to study these issues and have explored a range of options to update the CSR adjustments to improve prediction.<sup>52</sup> Interested parties have also repeatedly requested that HHS re-analyze the CSR adjustment factors and consider making updates.<sup>53</sup>

Because our prior analysis of the current CSR adjustment factors was based on the extraction and use of national enrollee-level EDGE data

without issuer or geographic markers,<sup>54</sup> we did not previously have the ability to analyze the distribution of the CSR populations at a more granular level (for example, at the issuer, State or rating area level). However, with policies finalized in the 2023 Payment Notice (87 FR 27241 through 27243) and the 2024 Payment Notice (88 FR 25784 through 25787), we can now extract and use multiple years of enrollee-level EDGE data with plan ID and rating area markers. This allowed for further study of the CSR populations at a more granular level to inform potential proposed changes to these factors, including, for example, whether certain issuers, States, or rating areas have a high percentage of AI/AN enrollment. We have now reconsidered the current CSR adjustment factors using several years of EDGE data available to HHS, including 2021 benefit year enrollee-level EDGE data with plan ID and rating area markers, and analyzed potential changes to the CSR adjustment factors at the State market risk pool level.

Based on further analysis of all CSR adjustment factors, HHS is not proposing changes to the CSR adjustment factors, with the exception of the AI/AN CSR plan variant factors.<sup>55</sup> Our continued study of these issues found that adjustments to the CSR adjustment factors for AI/AN CSR plan

variant enrollees were needed and would be appropriate. As described in the 2021 Risk Adjustment Technical Paper,<sup>56</sup> AI/AN CSR plan variant enrollees experienced higher expenditures than non-CSR silver enrollees, which may reflect increased demand associated with enrollee receipt of the AI/AN zero cost sharing or limited cost sharing CSR plan variants or risk characteristics specific to the AI/AN population which are not specifically captured by HCCs or other model factors. Given these findings, we conducted additional analysis using additional benefit years of available enrollee-level EDGE data, including the 2021 benefit year data with the plan ID and rating area markers, and found that AI/AN CSR plan variant enrollees were meaningfully underpredicted in the HHS risk adjustment models. Specifically, we evaluated the predictive accuracy of the current AI/AN CSR plan variant adjustment factors using the risk term PRs in Table 7 to measure the accuracy of the entire risk term (including PLRS, metal IDFs, CSR adjustment factors, and geographic cost factors) in predicting plan liability for this cohort, as measured by actual paid PMPM claims. Table 7 shows that in 2021 EDGE data, the risk term PRs demonstrate underprediction for AI/AN zero cost sharing and limited cost sharing bronze plan variants under the CSR adjustment factors for the 2024 benefit year relative to the proposed CSR adjustment factors for the 2025 benefit year and beyond.<sup>57</sup> The risk term PRs demonstrate similar underprediction for AI/AN zero cost sharing and limited cost sharing bronze plan variants in other EDGE data years.<sup>58</sup>

<sup>48</sup> See 83 FR 16930 at 16953; 84 FR 17478 through 17479; 85 FR 29190; 86 FR 24181; 87 FR 27235 through 27236; and 88 FR 25772 through 25774.

<sup>49</sup> 78 FR 15410 at 15421 through 15422.

<sup>50</sup> See 77 FR 73117 at 73127 and 78 FR 15410 at 15419 through 15420. See also HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes. (2021, October 26). CMS. <https://www.cms.gov/files/document/2021-ra-technical-paper.pdf>. Section A.3.1.

<sup>51</sup> See 83 FR 16930 at 16953; 84 FR 17478 through 17479; 85 FR 29190; 86 FR 24181; 87 FR 27235 through 27236; and 88 FR 25772 through 25774.

<sup>52</sup> See, for example, the 2024 Payment Notice, 88 FR 25772–25774. Also see Appendix A, HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes. (2021, October 26). CMS. <https://www.cms.gov/files/document/2021-ra-technical-paper.pdf>.

<sup>53</sup> Id.

<sup>54</sup> The 2021 Risk Adjustment Technical Paper provided initial analysis on the CSR adjustment factors and their performance with the geographical indicators. See Appendix A, HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes. (2021, October 26). CMS. <https://www.cms.gov/files/document/2021-ra-technical-paper.pdf>.

<sup>55</sup> In the 2021 Risk Adjustment Technical Paper, we concluded that, in aggregate, most of the current CSR adjustment factors contribute to a reasonable prediction of what plans are paying for CSR enrollees, with the exception of CSR adjustment factors for AI/AN enrollees. Our continued study of these issues, including the more recent analysis of 2021 benefit year data, affirmed these initial conclusions. Therefore, we propose in this rulemaking to update the CSR adjustment factors for AI/AN zero-cost sharing and limited cost sharing plan variants and propose to maintain the existing CSR adjustment factors for other enrollees. See Appendix A, HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes. (2021, October 26). CMS. <https://www.cms.gov/files/document/2021-ra-technical-paper.pdf>.

<sup>56</sup> HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes. (2021, October 26). CMS. <https://www.cms.gov/files/document/2021-ra-technical-paper.pdf>.

<sup>57</sup> Almost 90 percent of total billable member months in AI/AN zero-cost sharing and limited cost sharing CSR plan variants are in bronze plans.

<sup>58</sup> HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes. (2021, October 26). CMS. <https://www.cms.gov/files/document/2021-ra-technical-paper.pdf>.

**TABLE 7: Risk Term Predictive Ratios, Simulated for the 2021 Risk Adjustment Models Using 2021 EDGE Data**

<b>Metal Level &amp; CSR Plan Variant</b>	<b>Total Enrollment Months</b>	<b>Risk Term PRs - AI/AN CSR Adjustment Factors for Benefit Year 2021</b>	<b>Risk Term PRs – Proposed AI/AN CSR Adjustment Factors for Benefit Year 2025 and Beyond, as Applied to the 2021 Risk Adjustment Models</b>
Bronze, American Indian/Alaska Native, Zero Cost Sharing	537,986	0.78	0.98
Bronze, American Indian/Alaska Native, Limited Cost Sharing	73,265	0.93	0.95

To address concerns about the observed underprediction among AI/AN CSR plan variant enrollees, we propose to update the CSR adjustment factors for AI/AN zero-cost sharing and limited cost sharing plan variants and use the proposed factors for these enrollees as

shown in Table 8. We recalibrated these factors such that the risk term PRs for each CSR plan variant category equals 1.00 (accurate prediction<sup>59</sup>) but constrained each CSR adjustment factor so that no CSR adjustment factor would be less than 1.00 to avoid creating

incentives for issuers to avoid enrolling AI/AN CSR recipients. As shown in Table 7, the risk term PRs were demonstrated through simulation to improve under the proposed AI/AN CSR adjustment factors for the zero-cost sharing and limited cost sharing plans.

**TABLE 8: Proposed CSR Adjustment Factors for the 2025 Benefit Year and Beyond**

<b>Plan AV</b>	<b>Current Adjustment Factors for the 2024 Benefit Year</b>	<b>Proposed Adjustment Factors for the 2025 Benefit Year and Beyond</b>
<b>Silver Plan Variant Recipients (and Enrollees in State wrap-around or Medicaid-expansion plans of any metal level, as applicable)</b>		
Plan Variation 94%	1.12	1.12
Plan Variation 87%	1.12	1.12
Plan Variation 73%	1.00	1.00
Standard Plan 70%	1.00	1.00
<b>Zero Cost Sharing Plan Variant Recipients (that is, AI/AN Recipients)</b>		
Platinum (90%)	1.00	1.31
Gold (80%)	1.07	1.39
Silver (70%)	1.12	1.46
Bronze (60%)	1.15	1.51
<b>Limited Cost Sharing Plan Variant Recipients (that is, AI/AN Recipients)</b>		
Platinum (90%)	1.00	1.04
Gold (80%)	1.07	1.10
Silver (70%)	1.12	1.15
Bronze (60%)	1.15	1.19

We believe that these proposed changes to AI/AN CSR adjustment factors are important to our efforts to continuously improve the HHS risk adjustment models with incremental changes to improve model prediction by updating the AI/AN adjustment factors to more accurately predict plan liability

for this subpopulation. We also believe that these proposed changes would increase the incentives for issuers to engage the AI/AN population, whose communities have been historically underserved and who face significant health disparities. We also believe this proposed change would help advance

the agency's health equity goals and align with the policy objectives in the January 20, 2021 Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.<sup>60</sup>

<sup>59</sup> A subpopulation that is predicted perfectly would have a PR of 1.0.

<sup>60</sup> 86 FR 7009.

We also propose to retain the proposed 2025 benefit year CSR adjustment factors, if finalized, for future benefit years (that is, the 2026 benefit year and beyond)<sup>61</sup> unless changed through notice-and-comment rulemaking. Although we could analyze and consider potential updates to the CSR adjustment factors every year as part of the annual recalibration of the HHS risk adjustment models, we have found that the implied CSR adjustment factors calculated from 2018 through 2022 plan data were stable across each year of data. We also want to balance our approach to making changes as part of the annual recalibration of the HHS risk adjustment models in future benefit years with the desire to maintain stability and predictability for issuers. With the proposed changes to the AI/AN CSR adjustment factors, we believe the models would better predict risk for AI/AN CSR plan variant enrollees such that we do not expect to update the CSR factors on an annual basis.<sup>62</sup> However, if we were to pursue changes to any of the CSR adjustment factors in future benefit years, we would propose those updates through notice-and-comment rulemaking.

Lastly, separate from the proposal pertaining to AI/AN CSR adjustment factors, we note that for all plan liability risk score calculations under the State payment transfer formula, we use the CSR adjustment factors that align with the AV of the applicable plan for the enrollee. Thus, for unique State-specific plans, we apply the CSR adjustment factors that correspond to each plan's AV. Specifically, when we identify unique State-specific plans that have higher plan liability than the standard plan variants, we utilize the corresponding CSR adjustment factor in the plan liability risk score calculation that maps to the plan's AV. For example, we use a CSR adjustment factor of 1.12 for all Massachusetts wrap-around plans with AVs above 94 percent in the plan liability risk score

calculation.<sup>63 64</sup> This approach does not apply in the case of States whose State-specific plans take the form of Medicaid expansion plans offered on the Exchange (for example, Arkansas), because these 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 and sources of funding.<sup>65</sup> As we identify unique State-specific plans that have higher plan liability than the standard plan variants, such as those in Massachusetts, we work with the relevant State Department of Insurance and other relevant State institutions to identify the applicable CSR adjustment

<sup>63</sup> See, for example, 81 FR 12203 at 12228, 85 FR 29164 at 29190 and 29191, and 88 FR 25740 at 25772 through 25774.

<sup>64</sup> Massachusetts Cost Sharing Subsidies in ConnectorCare: Design, Administration, and Impact (2021 Aug.). <https://www.mahealthconnector.org/wp-content/uploads/MA-Cost-Sharing-Subsidies-in-ConnectorCare-Brief-083021.pdf>.

<sup>65</sup> The structure of wrap-around plans in some States, such as Massachusetts, differs from the coverage in States who offer Medicaid expansion plans on the Exchange. For example, in Massachusetts, the higher cost sharing wrap-around plans are variations of lower cost sharing plans. As such, the Massachusetts wrap-around plans do not have the same AVs as their comparable plans. That is why we use a CSR adjustment factor of 1.12 for all Massachusetts wrap-around plans with AVs above 94 percent. In contrast, in Arkansas, its Medicaid expansion plans are identical to other 94 percent and 100 percent AV CSR plan variants offered on the Exchange and are distinguished from these identical plans only in their sources of funding and eligibility criteria. As such, we presently direct issuers in Arkansas who provide Medicaid expansion plans with AVs of 94 percent and 100 percent to use specified plan variant codes for their Medicaid expansion plans only to differentiate the sources of funding and to differentiate between populations eligible for the Medicaid expansion plans from those who are eligible for standard 94 percent and 100 percent AV CSR plan variants. Because the Arkansas Medicaid expansion plans are identical to other 94 percent and 100 percent AV CSR plan variants available in Arkansas and therefore have the same AVs, 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 CMS approval of Arkansas's section 1115(a) demonstration, "Arkansas Health and Opportunity for Me." <https://www.medicare.gov/sites/default/files/2021-12/ar-arhome-ca.pdf>.

factor that corresponds to the unique State-specific plan's AV.<sup>66</sup> We would continue to follow this approach, working with the State to identify the applicable CSR adjustment factor that corresponds to that State's unique State-specific plan's AV, unless changed through notice-and-comment rulemaking.

We seek comment on these proposals.

#### e. 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.<sup>67</sup> Because we propose to blend the coefficients from separately solved models based on the 2019, 2020, and 2021 benefit years' enrollee-level EDGE data, we are publishing the R-squared statistic for each model separately to verify their statistical validity. The R-squared statistics for the proposed 2025 benefit models are shown in Table 9.

<sup>66</sup> For a list of the unique State-specific CSR levels that have higher plan liability than the standard plan variants, for which we utilize the corresponding CSR adjustment factor that maps to the plan's AV, refer to the applicable benefit year's DIY Software on the CMS website. See, for example, the Draft 2023 Benefit Year DIY Software on the CMS website (August 22, 2023). <https://www.cms.gov/files/document/cy2023-diy-instructions-08222023.pdf>.

<sup>67</sup> 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>.

<sup>61</sup> This includes the CSR adjustment factors in Table 8.

<sup>62</sup> As outlined previously in this rule, the proposed changes to the CSR adjustment factors focus on the AI/AN CSR plan variants because our analysis found the CSR adjustment factors for other enrollees to be adequate.

**TABLE 9: R-Squared Statistic for the Proposed 2025 HHS Risk Adjustment Models**

Models	2019 Enrollee-Level EDGE Data	2020 Enrollee-Level EDGE Data	2021 Enrollee-Level EDGE Data
Platinum Adult	0.4448	0.4360	0.4174
Gold Adult	0.4394	0.4302	0.4118
Silver Adult	0.4371	0.4278	0.4094
Bronze Adult	0.4330	0.4236	0.4051
Catastrophic Adult	0.4329	0.4236	0.4051
Platinum Child	0.3569	0.3436	0.3539
Gold Child	0.3541	0.3404	0.3511
Silver Child	0.3522	0.3383	0.3491
Bronze Child	0.3491	0.3351	0.3459
Catastrophic Child	0.3490	0.3350	0.3458
Platinum Infant	0.3165	0.2913	0.3059
Gold Infant	0.3133	0.2878	0.3025
Silver Infant	0.3122	0.2865	0.3012
Bronze Infant	0.3101	0.2842	0.2989
Catastrophic Infant	0.3101	0.2842	0.2989

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

In part 2 of the 2022 Payment Notice (86 FR 24183 through 24186), we finalized the proposal to continue to use the State payment transfer formula finalized in the 2021 Payment Notice for the 2022 benefit year and beyond, unless changed through notice-and-comment rulemaking. We explained that under this approach, we will no longer republish these formulas in future annual HHS notice of benefit and payment parameter rules unless changes are being proposed. We are not proposing any changes to the formula in this rule, and therefore, are not republishing the formulas in this rule. We therefore would continue to apply the formula as finalized in the 2021 Payment Notice (86 FR 24183 through 24186)<sup>68</sup> in the States where HHS operates the risk adjustment program in the 2025 benefit year. Additionally, as finalized in the 2020 Payment Notice (84 FR 17466 through 17468), we will maintain the high-cost risk pool parameters for the 2020 benefit year and beyond, unless amended through notice-and-comment rulemaking. We are not proposing any changes to the high-cost risk pool parameters for the 2025 benefit year; therefore, we would maintain the \$1 million threshold and 60 percent coinsurance rate.<sup>69</sup>

### 4. HHS Risk Adjustment User Fee for the 2025 Benefit Year (§ 153.610(f))

We propose an HHS risk adjustment user fee for the 2025 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 2025 benefit year, HHS will operate risk adjustment in every State and the District of Columbia. As described in the 2014 Payment Notice (78 FR 15416 through 15417), HHS' operation of risk adjustment on behalf of States is funded through a risk adjustment user fee. 45 CFR 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.<sup>70</sup> The HHS-operated risk adjustment program provides special benefits as defined in section 6(a)(1)(B) of OMB Circular No. A-25 to issuers of risk adjustment covered plans because it mitigates the financial instability associated with potential adverse risk selection.<sup>71</sup> 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 2024 Payment Notice (88 FR 25740), we calculated the Federal administrative expenses of operating the HHS risk adjustment program for the 2024 benefit year to result in a risk adjustment user fee rate of \$0.21 PMPM based on our estimated costs for HHS risk adjustment operations and estimated Billable Member Months (BMM) for individuals enrolled in risk adjustment covered plans. For the 2025 benefit year, HHS proposes to use the same methodology to estimate our administrative expenses to operate the HHS risk adjustment program. These costs cover development of the models and methodology, collections, payments, account management, data collection, data validation, program integrity and audit functions, operational and fraud analytics, interested parties training, operational support, and administrative and personnel costs dedicated to HHS-operated risk adjustment program activities. To calculate the HHS risk adjustment user fee, we divided HHS' projected total costs for administering the HHS risk adjustment program on behalf of States by the expected number of BMM in risk adjustment covered plans in States where the HHS-operated risk adjustment program will apply in the 2025 benefit year.

We estimate that the total cost for HHS to operate the risk adjustment program on behalf of States for the 2025 benefit year will be approximately \$65 million, which is more than the approximately \$60 million estimated for the 2024 benefit year. We are projecting increased costs due to increased

<sup>68</sup> Discussion provided an illustration and further details on the State payment transfer formula.

<sup>69</sup> See 81 FR 94081. See also 84 FR 17467.

<sup>70</sup> See Circular No. A-25 Revised. <https://www.whitehouse.gov/wp-content/uploads/2017/11/Circular-025.pdf>.

<sup>71</sup> Id.



contracting costs combined with increased labor costs.

We also project higher enrollment than our prior estimates in the 2024 and 2025 benefit years based on the increased enrollment, as measured by BMM, between the 2021 and 2022 benefit years in the individual non-catastrophic market risk pool in most States, likely due to the increased PTC subsidies provided for in the American Rescue Plan Act of 2021 (ARP).<sup>72 73</sup> In light of the passage of the Inflation Reduction Act of 2022 (IRA), in which section 12001 extended the enhanced PTC subsidies in section 9661 of the ARP through the 2025 benefit year, we project there will continue to be increased enrollment levels through the 2025 benefit year.<sup>74</sup> Because we project an increased budget to operate the HHS-operated risk adjustment program and estimated higher enrollment through the end of the 2025 benefit year, we propose a HHS risk adjustment user fee of \$0.20 PMPM for the 2025 benefit year.

We seek comment on the proposed HHS risk adjustment user fee for the 2025 benefit year.

#### 5. Audits and Compliance Reviews of Risk Adjustment Covered Plans (§ 153.620(c))

We propose amending § 153.620(c)(4) to require issuers of risk adjustment covered plans to complete, implement, and provide to HHS written documentation of any corrective action plans when required by HHS if a high-cost risk pool audit results in the inclusion of a finding<sup>75</sup> or certain observations<sup>76</sup> in the final audit report.

Currently, under § 153.620(c)(4), the completion, implementation, and submission of documentation of a corrective action plan to HHS is only required if the audit results in the inclusion of a finding in the final audit report. Upon completion of the first benefit year of high-cost risk pool audits (2018 benefit year audits), HHS found that some issuers of risk adjustment covered plans made data submission errors to their EDGE servers that constituted instances of noncompliance but did not result in a financial impact and were therefore only recorded as observations in the final audit report. For example, many issuers failed to provide adequate documentation of their policies and procedures that demonstrate that they are in compliance with the data submission requirements for the HHS-operated risk adjustment program, such as the applicable benefit year's EDGE Server Business Rules.<sup>77</sup> While such instances of noncompliance did not cause a financial impact, and therefore were not identified as audit findings, fully compliant policies and procedures, and documentation thereof, are critical to ensuring issuer adherence to HHS requirements and the submission of accurate data to an issuer's EDGE server.

Furthermore, in these situations, noncompliance may result from unintentional negligence where issuers lack proper documentation or the ability to locate data due to improper record maintenance and retention procedures. In these cases, the accuracy of the issuer's EDGE data may still be impacted, as EDGE claims data submission is incremental. For example, if an issuer identified an error in one file that does not have a financial impact and subsequently corrects the error in that file only during the submission period, but does not perform an impact analysis to review the accuracy of all claims file submissions and correct all claims file submissions that included the same error, the issuer's EDGE data will be incorrect even though there may be no financial impact with respect to the calculation of HHS risk adjustment State transfers or high-cost risk pool amounts. However, since enrollee-level

data that HHS extracts from issuers' EDGE servers is also used for HHS risk adjustment model recalibration, updates to the AV methodology and calculator, and other analyses for the commercial individual and small group market HHS programs and other Federal HHS related programs (for example, Medicaid expansion QHP population and non-Federal governmental plans),<sup>78</sup> it is important that issuers of risk adjustment covered plans also take corrective action to address instances of noncompliance, including those that result from audit findings and audit observations, to ensure that all instances of noncompliance identified through audits do not result in unaddressed material impact to the enrollee-level data that HHS extracts from issuers' EDGE servers and are not repeated in future benefit year data submissions. As § 155.620(c)(4) currently only requires corrective action plans for findings, instances of noncompliance that result in audit observations may be unaddressed by issuers. We are concerned that allowing these instances of noncompliance to be unaddressed may impact EDGE data integrity in future benefit years, and by requiring these corrective action plans, we also intend to help prevent EDGE data discrepancies in the future.

For these reasons, HHS is proposing to require corrective action plans for observations identified through HHS risk adjustment (including high-cost risk pool) audits when there is evidence of non-compliance with applicable Federal requirements if required by HHS to improve program and data integrity for accurate data submissions to issuer EDGE servers. HHS would communicate to the issuer, as part of the final audit report, which findings and observations require corrective action. Under this proposal, consistent with the existing framework in § 155.620(c)(4), HHS would require an issuer of a risk adjustment covered plan to provide, within 45 calendar days of the issuance of the final audit report, a written corrective action plan for any audit findings, as well as audit observations when there is evidence of non-compliance with applicable Federal requirements, to HHS for approval, implement that plan, and provide to HHS written documentation of the corrective actions taken to resolve the root cause of the noncompliance identified. This is the same timeline and framework that currently applies to corrective action plans that are required as a result of findings included in the

<sup>72</sup> ARP, Public Law 117–2 (2021).

<sup>73</sup> CMS, (2023, June 30). Summary Report on Permanent Risk Adjustment Transfers for the 2022 Benefit Year. (p. 8). <https://www.cms.gov/files/document/summary-report-permanent-risk-adjustment-transfers-2022-benefit-year.pdf>.

<sup>74</sup> Inflation Reduction Act, Public Law 1217–169 (2022).

<sup>75</sup> In the context of high-cost risk pool audits, a “finding” results from cases of confirmed non-compliance or discovery of evidence suggesting noncompliance with applicable Federal requirements related to high-cost risk pool payments, which require a recoupment of these payments. Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight (CCIIO). (Dec. 2022). Best Practices Overview: Benefit Year (BY) 2018 HCRP Payment Audits and General EDGE Server Requirements. [https://regtap.cms.gov/reg\\_library\\_openfile.php?id=4234&type=1](https://regtap.cms.gov/reg_library_openfile.php?id=4234&type=1) (Login Required).

<sup>76</sup> In the context of high-cost risk pool audits, an “observation” results from the identification of areas for improvement when there is no evidence of actual non-compliance with applicable Federal requirements or when there may be evidence of non-compliance with applicable Federal requirements that does not require recoupment of these payments. Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight (CCIIO). (Dec. 2022). Best

Practices Overview: Benefit Year (BY) 2018 HCRP Payment Audits and General EDGE Server Requirements. [https://regtap.cms.gov/reg\\_library\\_openfile.php?id=4234&type=1](https://regtap.cms.gov/reg_library_openfile.php?id=4234&type=1) (Login Required). This proposal is limited to observations where there may be evidence of non-compliance with applicable Federal requirements.

<sup>77</sup> Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight (CCIIO). (Nov. 2022). *EDGE Server Business Rules (ESBR) Version 22.0*. [https://regtap.cms.gov/reg\\_library\\_openfile.php?id=3765&type=1](https://regtap.cms.gov/reg_library_openfile.php?id=3765&type=1) (Login Required).

<sup>78</sup> See, for example, 84 FR at 17488 and 87 FR at 27243.

final audit report.<sup>79</sup> We propose that this change would be applicable beginning with 2020 benefit year audits, which we anticipate beginning in early 2024.<sup>80</sup>

We seek comment on this proposal.

*D. 45 CFR Part 155—Exchange Establishment Standards and Other Related Standards*

**1. Approval of a State Exchange (§ 155.105)**

We propose to amend § 155.105(b) to require that, in addition to meeting all other approval standards under § 155.105(b), a State seeking to operate a State Exchange must first operate a State-based Exchange using the Federal platform (SBE-FP), meeting all requirements under § 155.200(f), for at least one plan year, including its open enrollment period. This proposal is intended to give States sufficient time to create, staff, and structure a State Exchange that could transition to operating its own platform and establish relationships with interested parties critical to a State Exchange's success in operating a Navigator and consumer outreach program, assuming plan management responsibilities, and communicating effectively with consumers to support enrollment and avoid health care coverage gaps.

Sections 1311(b) and 1321(b) of the Affordable Care Act (ACA) allow States to elect to operate their own health insurance Exchanges to provide individuals and employers with health insurance coverage. Section 1321(a)(1)(A) of the ACA directs the Secretary to issue regulations setting standards with respect to the establishment and operation of those Exchanges. Section 155.106 describes different Exchange models that States may utilize. A State's choice of model may depend on the State's specific needs. State Exchanges offer States the ability to maintain more authority over policy and operational decisions, including health insurance issuer relationships, plan certification, and consumer assistance. However, building and maintaining a consumer-oriented, technology-driven marketplace platform requires extensive start-up resources, as well as investment of time and resources in the establishment of relationships with consumers, consumer assisters, partners in the coordination of

eligibility functions, issuers, and other interested parties.

To encourage more State authority over Exchange functions, we provided States with the flexibility to operate a State Exchange while relying on the Federally-facilitated Exchange (FFE) eligibility enrollment technology and infrastructure (known as the "Federal platform") to perform certain Exchange functions. Specifically, as finalized in the 2017 Payment Notice (81 FR 12244 through 12246), the SBE-FP model allows States to maintain their Exchange's legal status as a State Exchange while relying on the Federal platform to perform eligibility and enrollment functions and associated consumer call center and casework functions. Under the SBE-FP model, States retain authority and primary responsibility for plan management functions, including QHP certification, and consumer support functions, such as operating an informational website and toll-free telephone hotline. Under this model, States are also primarily responsible for operating a Navigator program. We charge issuers on the SBE-FPs a user fee calculated as a percentage of the user fee charged to issuers on the FFEs. HHS' Payment Notice final rules set forth the user fee for issuers participating in SBE-FPs every year. SBE-FPs may assess an additional State-level user fee on issuers for the purposes of operating the Exchanges. For Plan Year 2023, three States operated Exchanges under the SBE-FP model.

Over the past several years, we have observed the benefits of States first operating an SBE-FP for at least one plan year prior to transitioning fully from an FFE to a State Exchange. Operating an SBE-FP for at least one plan year, including its open enrollment period, prior to transitioning to a State Exchange gives States an opportunity to focus on investing time and resources needed to implement key Exchange functions that involve the establishment of critical and necessary relationships with consumers, consumer assisters, partners in the coordination of eligibility functions, issuers, and other interested parties. Operating an SBE-FP for at least one plan year prior to transitioning to a State Exchange also affords States time to implement eligibility and enrollment functions which require information technology platforms, call centers, and coordination with partners, such as State Medicaid agencies. In addition, operating an SBE-FP for at least one plan year prior to transitioning to a State Exchange gives States more time to engage with partners and interested parties to develop various consumer-facing content and

consumer outreach strategies, all while establishing and gaining experience operating a consumer assistance program. Further, when States operate an SBE-FP for at least one plan year before operating a State Exchange, they are more likely to have the time and resources needed to coordinate with the State Department of Insurance to establish policies and procedures associated with carrying out plan management functions, engage with the issuer community, and develop QHP certification requirements and processes. Finally, operating an SBE-FP for at least one plan year before transitioning to a State Exchange allows States time to familiarize consumers, consumer assisters, partners in the coordination of eligibility functions, issuers, and other interested parties with operations of the new State Exchange organization ahead of engaging with that Exchange, and it mitigates the risks and disruption associated with a transition to a State Exchange and simultaneous replacement of *HealthCare.gov* as the eligibility and enrollment pathway for those parties.

We propose to amend § 155.105(b)(4) to require that a State seeking to operate a State Exchange must first operate an SBE-FP for at least one plan year, including its first open enrollment period, for the reasons explained previously in this section.

We seek comment on this proposal, including the duration of time that a State must operate an SBE-FP prior to transitioning to a State Exchange.

**2. Election To Operate an Exchange After 2014 (§ 155.106)**

We propose changes to the Exchange Blueprint (OMB control number: 0938-1172) requirements for States seeking to operate a State Exchange. At § 155.106(a)(2), we propose to add that, as part of a State's activities for its establishment of a State Exchange, we would require that the State provide supporting documentation demonstrating progress toward meeting State Exchange Blueprint requirements, or documentation that details a State's plans for how it intends to implement and meet the Exchange functional requirements as laid out in the State Exchange Blueprint. This could include a State submitting detailed plans regarding its State Exchange consumer assistance programs and activities, such as information on its direct-to-consumer outreach plans, for HHS to assess comparability to the FFEs' consumer assistance programs and activities while allowing for State flexibility in its approach to best serve the State's

<sup>79</sup> See 45 CFR 153.620(c)(4). Also see 86 FR at 24192 through 24194.

<sup>80</sup> If 2020 benefit year audits begin in early 2024, we anticipate the final audit reports would be completed, with findings and observations identified, in late 2024.

consumers. Over the past few years, several States have transitioned off the Federal platform to establish and operate State Exchanges. In our experience providing technical assistance and oversight to States that are establishing State Exchanges, we have observed that requesting additional detail from States on various aspects of their State Exchange implementation plans is imperative to a successful establishment of a State Exchange. Ultimately, we seek to support the establishment of a successful State Exchange, and the ability to request additional detail on a State's State Exchange implementation plans is crucial to identifying areas the State may need to reconsider or further develop.

The current State Exchange Blueprint Application provides that we may require live demonstrations of Exchange functionality on the State Exchange's platform, and/or supporting documentation from a State, as evidence of its progress toward meeting State Exchange Blueprint Application requirements.<sup>81</sup> We propose to codify in our regulations in order to set a clear expectation for a State establishing a State Exchange that, as part of the State's submission of a State Exchange Blueprint Application, we have the authority to request any evidence we determine necessary for the State to detail its implementation of the required State Exchange functionality. This could include HHS requiring a State to submit detailed plans regarding its State Exchange consumer assistance programs and activities, such as information on its direct outreach plans. We would provide guidance and direction to each State regarding requests for evidence, so that each State understands the purpose of our requests as they relate directly to how the State meets the functional requirements for operating a State Exchange. We would request supporting documentation from States with the goal of imposing minimal burden on States' ability to meet its State Exchange Blueprint requirements, while maintaining the objective that our requests would provide us with the ability to sufficiently assess a State's readiness to operate a State Exchange and ensure that a State is sufficiently implementing and scaling policies, procedures, operations, technology, and administrative capacities to meet the needs of the State's consumers. We

would use the information in a State's Exchange Blueprint Application, as well as any supporting documentation and evidence, to make a determination of whether to grant approval for a State's establishment and operation of a State Exchange for its intended first open enrollment period.

We also propose to add new § 155.106(a)(2)(i) and (ii) to require that when a State submits its State Exchange Blueprint application to HHS for approval, the State must provide the public with notice and a copy of its State Exchange Blueprint application. To facilitate such public notice, HHS would post a State Exchange Blueprint application submitted by a State to its public-facing website within 90 calendar days of receipt. Further, we propose to require that at some point following a State's submission of its State Exchange Blueprint application to HHS, a State must conduct at least one public engagement (such as a townhall meeting or public hearing) in a timeline and manner (for instance, considering whether to conduct in-person and/or virtually) considered effective by the State, with concurrence from HHS, at which interested parties can learn about the State's intent to establish a State Exchange and the State's progress toward executing that transition. We also propose to require that while a State is in the process of establishing a State Exchange and until HHS has approved or conditionally approved the State Exchange Blueprint application, a State must conduct periodic public engagements at which interested parties would continue to learn about the State's progress towards establishing a State Exchange, in a timeline and manner considered effective by the State with concurrence from HHS.

As we explained previously, sections 1311(b) and 1321(b) of the ACA allow States to elect to operate their own health insurance Exchanges to provide individuals and employers with health insurance coverage, and section 1321(a)(1)(A) of the ACA directs the Secretary to issue regulations setting standards with respect to the establishment and operation of those Exchanges. The Exchange Blueprint serves as a vehicle for a State to document its progress toward implementing its intended Exchange operational model. Section 155.106(a)(2) requires States to 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 with a State Exchange. The submission and approval of Exchange Blueprints is an iterative process that generally takes place over

the course of 15 months prior to a State's first open enrollment as a State Exchange. HHS' review and approval of the Exchange Blueprint involves providing substantial technical assistance to States as they design, finalize, and implement their Exchange operations. Further, the establishment of a State Exchange involves significant collaboration between HHS and States to develop plans and document readiness for the State to transition from an Exchange that uses the Federal platform to one that operates its own eligibility and enrollment platform. State activities as part of this transition process include completing key milestones, meeting established deadlines, and implementing contingency measures.

Certain parties, such as consumers or advocate groups, who may be interested in a State's establishment of a State Exchange may not know if a State applied to HHS to establish a State Exchange or is in the process of establishing a State Exchange. A mandatory process whereby States notify the public of their plans to establish State Exchanges and provide an opportunity to meet with interested parties to provide updates would help ensure that interested parties are aware these activities are occurring and can provide input on how States can successfully establish State Exchanges. Based on our experience supporting and providing oversight to States in their establishment of State Exchanges, we believe that States would benefit from having a more transparent process to facilitate input from interested parties, especially given the impacts of a State Exchange transition on interested parties, including consumers and issuers. We believe that for a State to maximize consumer gains following its establishment of a State Exchange, its interested parties, including consumers, must have trust in its State Exchange. Providing opportunities for consumers to learn more about a State's planned State Exchange establishment process and plans can build that trust and help support a State's enrollment goals. We believe that all States that have established a State Exchange since PY 2020 conducted public events, such as town halls or hearings, where State Exchange establishment activities were discussed. States planning to establish State Exchanges could use such public events as opportunities to meet the requirements for public engagements being proposed. Our goal of the proposed changes at § 155.106(a)(2)(ii) is to clearly state, for States who are seeking to establish State Exchanges,

<sup>81</sup> CMS. (2021, November 30). *Blueprint For Approval of State-Based Health Insurance Exchanges, Coverage Years Beginning on or After 2019*. CMS. Section I, p. iii. <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CMS-Blueprint-Application.pdf>.

our expectations of the States engaging with the public regarding their transition to State Exchanges, thus strengthening the transparency requirements of the State Exchange Blueprint review and approval process. Finally, we believe this proposal would help States that establish State Exchanges meet the consultation requirements with interested parties in § 155.130 during the period when the States are establishing State Exchanges, by formalizing a process whereby States and interested parties communicate about the States' establishment of State Exchanges throughout the transition process.

We seek comment on this proposal, including comments related to additional ways States seeking to establish State Exchanges could provide greater transparency to interested parties, including consumers, regarding the process for establishing State Exchanges.

### 3. Additional Required Benefits (§ 155.170)

We propose to amend § 155.170(a)(2) to provide that benefits covered in a State's EHB-benchmark plan would not be considered in addition to EHB and thus would not be subject to defrayal by the State beginning with PY 2025.

Section 1311(d)(3)(B) of the ACA permits a State to require QHPs offered in the State to cover benefits in addition to EHB, but requires the 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.

In the EHB final rule (78 FR 12838), we finalized a standard at § 155.170(a)(2) that specifies that State-required benefits enacted on or before December 31, 2011, even if not effective until a later date, are considered EHB and therefore the costs of these benefits are not required to be defrayed by the State. In the 2017 Payment Notice (81 FR 12242 through 12244), we 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 to reflect that this section applies not only when benefits are mandated through State legislative action but also through regulation, guidance, or other State action. We also amended § 155.170(a)(2) to provide that benefits required after December 31, 2011, are in addition to EHB unless enactment is directly attributable to State compliance with Federal requirements.

Under our current policy, benefits mandated after December 31, 2011, other than for compliance with Federal

requirements, are considered in addition to EHB (and thus not EHB) without regard as to whether the mandated benefits are embedded in the State's EHB-benchmark plan. Specifically, under § 155.170, a State mandate is considered "in addition to EHB" if it: is a State action taken after December 31, 2011;<sup>82</sup> requires coverage of benefits specific to care, treatment, and services;<sup>83</sup> requires QHPs to cover the benefits;<sup>84</sup> and was not enacted to comply with Federal requirements. As a result, States must defray the associated costs of QHP coverage of such benefits, and those costs may not be included in the percentage of premium attributable to coverage of EHB for purpose of calculating APTC. In addition, because the benefits are not EHB, they are not subject to EHB nondiscrimination rules at § 156.125, the annual limitation on cost sharing at § 156.130, and restrictions on annual or lifetime dollar limits at § 147.126.

In the years since we finalized § 155.170, we have received feedback from States and other interested parties that we should reconsider this provision, including in comments submitted to the EHB RFI that we issued in 2022. This feedback indicates that States struggle to understand and operationalize § 155.170, and that States that seek to mandate coverage of benefits are unintentionally removing EHB protections from benefits already included in the State's EHB-benchmark plan.

Therefore, we propose to amend § 155.170(a)(2) to codify that "a covered benefit in the State's EHB-benchmark plan" is considered an EHB. Under this proposal, there would be no obligation for the State to defray the cost of a State mandate enacted after December 31, 2011, that requires coverage of a benefit covered in the State's EHB-benchmark plan. Benefits that are covered in a State's EHB-benchmark plan would not be considered in addition to EHB and would remain subject to the various rules applicable to the 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. We believe that this change would promote consumer protections and facilitate compliance with the defrayal requirement by making the identification of benefits in addition to EHB more intuitive.

Under the proposal, if a State mandates coverage of a benefit that is in its EHB-benchmark plan at the time the mandate is enacted, the benefit would continue to be considered EHB and the State would not have to defray the costs of that mandate. However, if at a future date the State updates its EHB-benchmark plan under § 156.111 and removes the mandated benefit from its EHB-benchmark plan, the State may have to defray the costs of the benefit under the factors set forth at § 155.170 as it would no longer be an EHB after its removal from the EHB-benchmark plan. In addition, starting in PY 2025, a State that is defraying the costs of a benefit required by a mandate that is in addition to EHB under § 155.170 would be permitted to cease defraying the costs of that benefit if the benefit is included in its EHB-benchmark plan or upon updating its EHB-benchmark plan in the future to include such benefit coverage.

We acknowledge that there are States that may have been defraying the costs of benefits under the current policy that would be able to stop defraying those costs if this proposal is finalized. We propose this change to be effective starting in PY 2025 to allow for issuers to make necessary modifications to their plan designs and plan filings to reflect any possible changes in designation of benefits as EHB as a result of this proposal, if finalized. For example, if we finalize this proposal and a State ceases defraying the costs of a State-mandated benefit to issuers because it is covered in its EHB-benchmark plan, issuers should update their plan filings accordingly beginning in PY 2025 to reflect that the benefit is covered as an EHB and should be included in the percentage of premium attributable to coverage of EHB for the purpose of calculating APTC. We also note that those States would not be able to recoup the cost of benefits they have already defrayed. In addition, we acknowledge that the start and end dates of State legislative sessions vary greatly by State, and that this change, if finalized, may occur during State legislative sessions that are considering State actions that would be impacted by the change.

We note that this proposal may impact health plans that are not directly subject to the EHB requirements, such as self-insured group health plans and fully-insured group health plans in the

<sup>82</sup> EHB Rule (78 FR 12838). A State action can be by statute, regulation, guidance, or other State action. 2017 Payment Notice (81 FR 12242).

<sup>83</sup> Requirements related to provider types, cost sharing, benefit delivery methods, or reimbursement methods are not specific to care, treatment, and services. EHB Rule (78 FR 12838).

<sup>84</sup> If a State action applies to the individual and small group markets, it applies to QHPs; if a State allows for the sale of large group plans as QHPs, a State-mandated benefit for the large group market applies to QHPs. EHB Proposed Rule (77 FR 70647 through 70648) (finalized without modification in the EHB Rule (78 FR 12838)).

large group market that are required to comply with the annual limitation on cost sharing and restrictions on annual or lifetime dollar limits in accordance with applicable regulations with respect to such EHBs.<sup>85</sup> Sponsors of such plans would be affected by this proposal, if finalized, only to the extent a State changes benefits in its EHB-benchmark plan and such plan selects that State's EHB-benchmark plan for purposes of complying with sections 2707 and 2711 of the PHS Act. It may also impact State Basic Health Programs (BHPs) established under section 1331 of the ACA and Medicaid Alternative Benefit Plans (ABPs) implemented pursuant to section 1937 of the Act.

We solicit comment on the proposal.

#### 4. Consumer Assistance Tools and Programs of an Exchange (§ 155.205)

At § 155.205(a), we propose to establish additional minimum standards for Exchange call center operations. Currently, § 155.205(a) requires that Exchanges provide for operation of a consumer-accessible, toll-free call center that addresses the needs of consumers requesting assistance. For a State requesting to establish a State Exchange, we review its plans to implement and meet call center requirements under § 155.205(a) as described in the State Exchange Blueprint Application. Through the Blueprint process, we review and assess a State's call center operational plan for consistency with standards governing its hours of operation, staffing levels, and service level goals (including wait times and abandonment rates), as well as for consistency with best practices utilized by existing Exchanges, including the FFEs' call center. Once a State Exchange has been established and is operating, HHS monitors Exchange call center operations through the annual collection of performance monitoring data, as specified at § 155.1200(b)(3). The data collected includes call center volume, wait times, calls abandoned, and average call center handle time.<sup>86</sup>

We recognize the value in each Exchange being able to tailor customer service level expectations based on their experience in the areas they serve, including setting hours of operation that meet the needs of their consumers. As such, we are not proposing to establish minimum standards for customer service staffing levels. We will continue

to assess and monitor Exchanges' compliance with § 155.205(a) through the Blueprint process and annual collection of compliance reports, as specified at § 155.1200(b)(2). We also intend to utilize, if finalized, the proposed requirement that transitioning States submit documentation through their Blueprint application, which would strengthen our review of Exchange call center plans.

In this proposed rule, we are proposing to require that all Exchanges, other than SBE-FPs and SHOP Exchanges that do not provide for enrollment in SHOP coverage through an online SHOP enrollment platform, meet the following additional requirements: their call center must provide consumers with access to a live call center representative during the Exchanges' published hours of operation; and their live call center representatives must be able to assist consumers with their QHP application, which includes providing consumers information on their APTC and CSR eligibility, helping consumers understand their QHP options, helping consumers select a QHP, and helping consumers submit QHP enrollment applications to the Exchange.

Sections 1311(d)(4)(B) and 1321 of the ACA require that Exchanges provide for the operation of a toll-free telephone hotline to respond to requests for assistance, and section 1413(b)(1)(A)(ii) of the ACA requires that a consumer's application for QHP coverage can be filed by telephone. We believe that our proposal would support the intent of these statutory requirements by codifying the requirement that consumers have access to live representatives with Exchange call centers who can assist consumers with their QHP applications, including helping them submit QHP enrollment applications to the Exchange. Similarly, requiring that Exchange call centers provide consumers with a reliable window for live representative support would support compliance with sections 1311(d)(4)(B) and 1413(b)(1)(A)(ii) of the ACA.

We believe that all State Exchange call centers already meet the minimum standards being proposed, and we know that the call center for the Exchanges on the Federal platform is meeting them. As such, this proposal seeks to standardize and strengthen Exchange consumer assistance capabilities without imposing additional burden on current Exchanges or hindering Exchanges' ability to be innovative in their call center functions. The changes being proposed here would ensure that regardless of where a consumer is in the

United States, the consumer would be able to speak to a live representative who can assist the consumer with the QHP application process during the hours of operation for that State's call center. We also want to ensure that a State does not solely rely on an automated telephone system for QHP application assistance because we believe speaking to a live representative would help troubleshoot consumer QHP application issues, provide in real time an opportunity for a live representative to explain QHP application terminology to a consumer, provide a live representative to ensure the consumer provides the most correct information in the QHP application to alleviate unnecessary follow-up, and provide greater overall consumer satisfaction. We believe that call centers should have a basic level of customer service especially as they relate to hours and operations and staffing levels to limit wait times for QHP application assistance. We also know based on our work with State Exchanges and the Exchanges on the Federal platform that the Exchanges have created and continue to maintain robust call centers.

We seek comment on this proposal.

#### 5. Requirement for Exchanges To Operate a Centralized Eligibility and Enrollment Platform on the Exchange's Website (§§ 155.205(b); 155.302(a)(1))

We propose to amend § 155.205(b)(4) to require that an Exchange operate a centralized eligibility and enrollment platform on the Exchange's website (or, for an SBE-FP, the Federal eligibility and enrollment platform), such that the Exchange allows for the submission of the single, streamlined application for enrollment in a QHP and insurance affordability programs by consumers, in accordance with § 155.405, through the Exchange's website and the Exchange performs eligibility determinations for all consumers based on submissions of the single, streamlined application. Further, we propose to amend § 155.302(a)(1) to clarify that the Exchange, through the centralized eligibility and enrollment platform operated on the Exchange's website (or, for an SBE-FP, the Federal eligibility and enrollment platform), is the entity responsible for making all determinations regarding the eligibility for QHP coverage and insurance affordability programs regardless of whether an individual files an application for enrollment in a QHP on the Exchange's website or on a non-Exchange website operated by an entity described under § 155.220, such as a web-broker defined at § 155.20, or a DE entity or QHP issuer described under

<sup>85</sup> See parallel requirements to § 147.126 at 26 CFR 54.9815–2711, and 29 CFR 2590.715–2711. Additionally, section 2707(b) of the PHS Act, as added by the ACA, was incorporated by reference into section 9815 of the Code and section 715 of the Employee Retirement Income Security Act (ERISA).

<sup>86</sup> OMB Control Number: 0938–1119.

§ 155.221. As we believe the eligibility determination function is inherently a function that should only be performed by the Exchange, the proposed amendment to § 155.302(a)(1) would also clarify that only the private vendors or State entities that an Exchange contracts with to operate its centralized eligibility and enrollment platform can perform this function on behalf of an Exchange, and would prohibit an Exchange from solely relying on non-Exchange entities, including a web-broker (defined at § 155.20) or other entities under §§ 155.220 or 155.221, to make such eligibility determinations on behalf of an Exchange.

We also propose to amend § 155.205(b)(5) to require that an Exchange operate a centralized eligibility and enrollment platform on the Exchange's website (or, for an SBE-FP, by relying on the Federal eligibility and enrollment platform) so that the Exchange (or, for an SBE-FP, the Federal eligibility and enrollment platform) meets the requirement under § 155.400(c) to maintain records of all effectuated enrollments in QHPs, including changes in effectuated QHP enrollments.

As background for these proposed amendments, § 155.205(b) states that an Exchange must maintain an up-to-date website that allows consumers to receive eligibility determinations for QHPs and insurance affordability programs and provides standardized comparative information on each available QHP and a calculator to facilitate the comparison of available QHPs after the application of any APTC and any CSRs. Section 1413(c)(1) of the ACA also requires that Exchanges develop a secure electronic interface that allows consumers to apply for health insurance coverage online and electronically receive an eligibility determination and that Exchanges conduct verifications of eligibility through electronic data interfaces. However, currently, there is no explicit regulatory or statutory requirement that Exchanges operate a centralized eligibility and enrollment platform on their website for performing all eligibility determinations for QHPs and insurance affordability programs. Nonetheless, all Exchanges currently provide access to a centralized eligibility and enrollment platform and process for consumers that they serve, and all Exchanges also currently perform all eligibility determinations through the operation of a centralized eligibility and enrollment platform on their websites. In order to codify existing policy and practices and help set clear expectations for existing

Exchanges and States that may seek to operate State Exchanges in the future, we propose these amendments to require that Exchanges may not allow eligibility determinations to be made outside of the Exchanges' own centralized eligibility and enrollment platform by another entity for applications for QHP coverage nor for selections for enrollment in a QHP.

We also propose to amend § 155.302(a) to codify the Exchange's obligation and role as the sole entity responsible for conducting eligibility determinations. For example, if an Exchange permits an eligible web-broker to operate a non-Exchange website that interfaces with an Exchange to assist consumers with DE in QHPs offered through the Exchange as described in §§ 155.220(c)(3) and 155.221, the Exchange must ensure that the Exchange continues to maintain responsibility for conducting all eligibility determinations for applications submitted for QHP coverage and related insurance affordability programs. While HHS has not delegated these functions to DE entities in FFE and SBE-FP States, currently, Exchanges may allow entities described in § 155.220, among others that meet applicable requirements, to be able function as an eligible contracting entity under § 155.110(a) that can carry out determinations regarding QHP coverage eligibility and eligibility for related insurance affordability programs on behalf of the Exchange. This proposed amendment to § 155.302(a) would prohibit Exchanges from delegating the responsibility to conduct eligibility determinations to any non-Exchange entities, besides entities that the Exchanges have elected to contract with to operate the centralized eligibility and enrollment platform. Consistent with these amendments, we propose to maintain the current requirement under § 155.302(a) that SBE-FPs rely on HHS, through the operation of the centralized *HealthCare.gov* eligibility and enrollment platform, to carry out all eligibility determinations for their Exchanges.

This proposal would tie together the disparate, but related, requirements that exist across 45 CFR part 155 that speak to the real-time and tightly integrated nature of the online eligibility functions that Exchanges are required to perform (specifically the tight integration needed between the Exchange-operated website, single streamlined application, and back-end automated eligibility verifications based on information provided by applicants to arrive at an eligibility determination), by clearly

stating the principle that Exchanges are solely responsible for conducting eligibility determinations, and that Exchanges would need to meet the required eligibility functions that exist across 45 CFR part 155 through operating a centralized eligibility and enrollment platform on their website, regardless of whether an application is submitted through the Exchanges' website or through eligible non-Exchange entities that are assisting an individual in enrolling in a QHP.

We believe the lack of a clear statement in the regulations at 45 CFR part 155 affirming the requirement that the Exchange must make all determinations regarding eligibility for QHP coverage and related insurance affordability programs through a centralized eligibility and enrollment platform on the Exchange's website are oversights, as other sections of the regulations implementing the ACA in title 45 of the CFR allude to a requirement or expectation that an Exchange operates in this way already, or the regulations are written in a way such that it would be difficult to fulfill their requirements if an Exchange did not operate as proposed in these amendments.

As an example of an implementing regulation of the ACA that would require an Exchange to operate in this manner, § 155.220 permits qualified individuals to be enrolled in a QHP through the Exchange with the assistance of a web-broker, while § 155.220(c)(3)(ii)(A), and by reference § 155.220(c)(3)(i)(F), require that if the non-Exchange website of a web-broker is used to complete an Exchange eligibility application, that web-broker's website must also provide consumers with the ability to withdraw from the process and use the Exchange's website described in § 155.205(b) instead at any time. If an Exchange did not provide an ability on its website for a consumer to complete an eligibility application, then it would not be possible to fulfill the requirements of §§ 155.220(c)(3)(ii)(A) and (c)(3)(i)(F).

To ensure that the requirements of §§ 155.220(c)(3)(ii)(A) and (c)(3)(i)(F), and 155.205(b) are fulfilled, we believe it is important that Exchanges allow a consumer to continue the application process through the centralized eligibility and enrollment platform operated on the Exchange's own website should the consumer chose to withdraw from the application process that was begun on a web-broker's non-Exchange website; or, if the Exchange is an SBE-FP, allow the consumer to continue the application process through the website of the Federal platform.

As another example, QHP issuers that assist consumers with enrollment in QHPs are currently required under § 156.265(b)(2) to either direct the consumer to the Exchange's website to file an eligibility application or ensure that the consumer's eligibility application is completed through the Exchange website or submitted through Exchange-approved web services in order for the Exchange to conduct an eligibility determination. To align with these requirements, we believe that it is important to amend § 155.302(a)(1) to provide that an Exchange must perform all eligibility determinations through operating a centralized eligibility and enrollment platform on the Exchange's website, and that only those entities that an Exchange chooses to enter into an agreement with to operate its centralized eligibility and enrollment platform, as allowed for under § 155.110(a), can carry out this function on behalf of the Exchange.

In addition to these examples of how current regulations may require an Exchange to operate according to the proposed amendments to §§ 155.205 and 155.302, we believe that consumers may be harmed if these proposals are not adopted. If an entity other than the Exchange conducted eligibility determinations, consumers might receive incorrect or inconsistent eligibility determinations, as entities other than the Exchange may not update their systems with the same eligibility determination rules or logic as the Exchange itself when Federal or State policies or regulations impacting eligibility for QHP coverage and insurance affordability programs come into effect or are updated, including the implementation and maintenance of State-specific eligibility rules and logic for Medicaid and CHIP programs. As a result, a non-centralized eligibility system model would introduce increased program integrity risk as to the accuracy of eligibility determinations, which would introduce increased risk of inaccurate APTC payments to QHP issuers and increased risk to consumers of potential tax liability when filing taxes and reconciling their PTC.

In addition, the websites and eligibility platforms provided by non-Exchange entities may not include the same informational content for consumers that an Exchange provides to consumers through the Exchange's website, such as information related to Medicaid and CHIP programs or the availability of special enrollment periods before or after the open enrollment period. As a result, some consumers might not provide

information in their application in such a manner as to receive a correct eligibility determination and thus, enroll in the wrong coverage or not enroll in any coverage. Lastly, consumers may prefer to enroll directly through the eligibility and enrollment platform hosted and operated on an Exchange's website because they are more comfortable with sharing their personal information through a platform hosted by the Exchange.

In light of these considerations, we propose to amend §§ 155.205(b)(4) and (5) and 155.302(a)(1) to address these gaps. Since all Exchanges currently provide access to a centralized eligibility and enrollment platform and process for consumers that they serve, and all Exchanges also currently perform all eligibility determinations through the operation of a centralized eligibility and enrollment platform on their websites, we believe the impact of these proposals would be minimal.

We seek comment on these proposals.

#### 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(h))

We propose to amend §§ 155.220(h)(2) and (3) by deleting the current references to "the HHS reconsideration entity" and replacing them with "the CMS Administrator" and by specifying that, instead of the HHS reconsideration entity, the CMS Administrator, who is a principal officer,<sup>87</sup> would be the entity responsible for handling these reconsideration decisions. Agents, brokers, and web-brokers whose Exchange agreement(s) to participate in the FFEs or SBE-FPs have been terminated for cause would continue to have the ability to request a reconsideration of such action in the manner and form established by HHS by requesting a reconsideration within 30 calendar days of the date of the written termination notice from HHS. We propose that the request for reconsideration would be made to the CMS Administrator. This proposal would improve transparency by specifying who would review reconsideration requests under § 155.220(h).

Exchange agreement suspensions and terminations play a critical role in stopping potentially fraudulent enrollments or other fraudulent behavior in the FFEs and SBE-FPs. Currently, § 155.220(g) establishes the framework for suspension and

termination of an agent's, broker's, or web-broker's Exchange agreement(s) for cause in four instances.<sup>88</sup> First, § 155.220(g)(1) allows HHS to terminate an agent's, broker's, or web-broker's Exchange agreement(s) when there is a specific finding of noncompliance or pattern of noncompliance that is sufficiently severe. Second, § 155.220(g)(3)(ii) enables HHS to terminate an agent's or broker's Exchange agreement(s) when an agent or broker fails to maintain the appropriate license in every State in which the agent or broker actively assists consumers with applying for APTC and CSRs or with enrolling in QHPs through the FFEs and SBE-FPs. Third, HHS will terminate an agent's, broker's, or web-broker's Exchange agreement(s) under § 155.220(g)(5)(ii) when there is a finding or determination by a Federal or State entity that an agent, broker, or web-broker engaged in fraud or abusive conduct that may result in imminent or ongoing consumer harm using personally identifiable information (PII) of Exchange enrollees or applicants or in connection with an Exchange enrollment or application. Fourth, under § 155.220(g)(5)(i)(B), HHS may terminate an agent's, broker's, or web-broker's Exchange agreement(s) following a suspension of the agreement(s) under § 155.220(g)(5)(i)(A) if the agent, broker, or web-broker submitted rebuttal evidence that does not persuade HHS to lift the suspension, or if the agent, broker, or web-broker fails to submit rebuttal evidence during the suspension period.

If an agent's, broker's, or web-broker's Exchange agreement(s) has been terminated for cause, under § 155.220(h)(1), the agent, broker, or web-broker can request reconsideration of such action in the manner and form established by HHS. The agent, broker, or web-broker must submit the reconsideration request to the HHS reconsideration entity within 30 calendar days of the date of the written termination notice from HHS.<sup>89</sup> Current regulations also require the HHS reconsideration entity to notify the agent, broker, or web-broker of its decision, in writing, within 60 calendar days of the date it receives the request for reconsideration.<sup>90</sup> Currently,

<sup>88</sup> Section 155.220(f) establishes the framework for an agent, broker, or web-broker to terminate an agent's, broker's, or web-broker's Exchange agreement(s) with HHS. We are not proposing any changes with respect to the terminations under § 155.220(f). These terminations are not eligible for reconsideration under § 155.220(h) because they are agent, broker, or web-broker initiated actions.

<sup>89</sup> 45 CFR 155.220(h)(2).

<sup>90</sup> 45 CFR 155.220(h)(3).

<sup>87</sup> A principal officer is an individual nominated by the President and confirmed by the Senate.



§ 155.220(h)(3) further provides that this decision constitutes HHS' final determination.

The current framework in § 155.220(h) does not define or identify "the HHS reconsideration entity" responsible for making these decisions. As noted earlier in this rule, we propose revising §§ 155.220(h)(2) and (3) by deleting the existing references to "the HHS reconsideration entity" and replacing them with "the CMS Administrator." This proposal would ensure that authority to review requests for reconsideration of decisions to terminate an agent's, broker's, or web-broker's Exchange agreement(s) for cause are vested in a principal officer. We seek comments on this proposal.

#### 7. Adding and Amending Language To Ensure Web-Brokers Operating in State Exchanges Meet Certain HHS Standards Applicable in the FFEs and SBE-FPs (§ 155.220)

We propose to amend § 155.220 to apply certain existing HHS standards for Exchanges that use the Federal platform that apply to web-brokers<sup>91</sup> assisting the FFEs' and SBE-FPs'<sup>92</sup> consumers and/or applicants with enrolling in QHPs and assisting consumers with applying for APTC/CSRs in State Exchanges, for both the State Exchange's Individual Exchange and SHOP. Specifically, our proposals would ensure that minimum HHS standards governing web-broker non-Exchange website display of standardized QHP comparative information, disclaimer language, information on eligibility for APTC/CSRs, operational readiness, standards of conduct, and access by web-broker downstream agents and brokers apply to web-brokers across all Exchanges.<sup>93</sup> We believe that extending these standards across all Exchanges, to newly apply to

State Exchanges, is important given the increased interest from State Exchanges in using web-brokers to assist consumers with enrollment, as to maximize enrollment opportunities. The ability of consumers and applicants to have consistent, reliable information from web-brokers who, to the extent permitted by the State and the applicable Exchange, assist consumers with enrolling and applying for QHPs offered on the Exchange, with or without APTC and CSRs, in a manner that constitutes enrollment through the Exchange<sup>94</sup> is an important consumer safeguard, particularly given that web-brokers may operate across Exchange models. These proposals are intended to ensure that certain HHS standards are extended to protect State Exchange consumers as minimum requirements while also providing State Exchanges with continued flexibility and discretion to decide whether and how to utilize web-brokers to assist State Exchange consumers and applicants with enrolling in QHPs and applying for APTC/CSRs. Finally, these proposals align with our other proposals as described later in this proposed rule to extend certain existing HHS standards at § 155.221 that currently apply to DE entities<sup>95</sup> assisting the FFEs' and SBE-FPs' consumers and applicants with direct enrollment in QHPs and applying for APTC/CSRs to also apply in State Exchanges. These proposals, if finalized, would be effective on the date of publication of the final rule.

Section 1312(e) of the ACA provides that the HHS Secretary shall establish procedures under which a State may allow agents, brokers, and web-brokers to enroll individuals and small employers in QHPs offered through an Exchange and to assist individuals in applying for APTC/CSRs for QHPs sold through an Exchange. The Secretary also has authority under section 1321(a) of the ACA to promulgate regulations with respect to the establishment and operation of Exchanges, the offering of QHPs through such Exchanges, and such other requirements as the Secretary determines appropriate.<sup>96</sup> HHS previously leveraged these authorities to establish the existing agent, broker, and web-broker standards applicable in FFE

and SBE-FP States codified in § 155.220.<sup>97</sup>

In new proposed paragraph (n), we propose to apply the web-broker standardized QHP comparative information and the accompanying Enrollment Support disclaimer requirements in § 155.220(c)(3)(i)(A) to web-brokers operating in State Exchanges, and consequently to these State Exchanges. Consistent with § 155.220(c)(3)(i)(A)(1) through (6), web-broker non-Exchange websites used to complete the QHP selection must disclose and display the standardized comparative QHP information provided by the Exchange or directly by QHP issuers, consistent with the requirements of § 155.205(c) for all QHPs, including Qualified Dental Plans (QDPs),<sup>98</sup> offered through the Exchange. The standardized comparative information on each available QHP that must be displayed by the web-broker on its non-Exchange website is the following information provided by the Exchange or directly by QHP issuers: (1) premium and cost-sharing information (total and net premium based on APTC and CSR, if applicable);<sup>99</sup> (2) the summary of benefits and coverage; (3) identification of whether the QHP is a bronze, silver, gold or platinum level plan, or a catastrophic plan; (4) the results of the enrollee satisfaction survey; (5) quality ratings assigned by HHS; and (6) the provider directory made available to the Exchange. The results of the enrollee satisfaction survey should be displayed in accordance with instructions in the CMS Quality Rating Information Bulletin.<sup>100</sup> As described in the CMS

<sup>97</sup> See 77 FR 18444, as amended at 78 FR 15533; 78 FR 54134; 79 FR 13837; 81 FR 12338; 81 FR 94176; 84 FR 17563; 85 FR 37248; 86 FR 24288; 87 FR 27388; and 88 FR 25917.

<sup>98</sup> With some limited exceptions, QDPs are considered a type of QHP. See 77 FR at 18315. Web-brokers participating in the FFEs and SBE-FPs are expected to follow the same requirements for QDPs as for QHPs, including display of all applicable QDPs offered through the Exchange and all available information specific to each QDP on their websites. However, because it is not possible to enroll in QDPs through DE unless also enrolling in medical QHPs, web-brokers are permitted to modify their QDP displays accordingly (for example, display QDPs after medical QHPs to ensure a consumer has first selected a medical QHP). See CMS. (2023, July 12). *Federally-facilitated Exchange (FFE) Enrollment Manual*. CMS. Section 4.3, p.47 and Section 4.4.2, p. 52. <https://www.cms.gov/files/document/ffe-enrollment-manual-2023-5cr-071323.pdf>. Under this proposal, these same standards governing QDPs would also apply to web-brokers in State Exchanges.

<sup>99</sup> See CMS. (2023, July 12). *Federally-facilitated Exchange (FFE) Enrollment Manual*. CMS. Section 4.4.2, p. 52. <https://www.cms.gov/files/document/ffe-enrollment-manual-2023-5cr-071323.pdf>.

<sup>100</sup> See CMS. (2023, May 2). *Quality Rating Information Bulletin*. CMS. Section III, p. 3. <https://>

<sup>91</sup> Web-broker is defined at 45 CFR 155.20 as "an individual agent or broker, group of agents or brokers, or business entity registered with an Exchange under § 155.220(d)(1) that develops and hosts a non-Exchange website that interfaces with an Exchange to assist consumers with direct enrollment in QHPs offered through the Exchange as described in § 155.220(c)(3) or § 155.221. The term also includes an agent or broker direct enrollment technology provider."

<sup>92</sup> See § 155.220(l).

<sup>93</sup> The amendments to § 155.220 we are proposing would not impact how agents, brokers, or web-brokers may assist consumers and applicants in SBE-FP States. Section 155.220(l) currently provides that an agent, broker or web-broker who enrolls qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through an SBE-FP or assists individual market consumers with submission of applications for APTC and CSRs through an SBE-FP, must comply with all applicable FFE standards in § 155.220. We are not proposing any changes to this existing framework for agents, brokers, or web-brokers who provide assistance in SBE-FP States.

<sup>94</sup> See 77 FR 18334 through 18336.

<sup>95</sup> DE entities permitted to participate in the FFEs and SBE-FPs include, to the extent permitted by applicable State law: (1) QHP issuers that meet the applicable requirements in §§ 155.221 and 156.1230, and (2) web-brokers that meet the applicable requirements in §§ 155.220 and 155.221. 45 CFR 155.221(a).

<sup>96</sup> Section 1321(a)(1)(A), (B), and (D) of the ACA.



Quality Rating Information Bulletin, State Exchanges already have some flexibility to customize the display of quality ratings assigned by HHS for their respective QHPs.<sup>101</sup> For example, State Exchanges can make some State-specific customizations, such as to incorporate additional State or local quality information or to modify the display names of the quality ratings assigned by HHS. Under this proposal, web-brokers in State Exchanges should use the same consumer-facing labels for the quality ratings that HHS displays on *HealthCare.gov* (that is, “Overall Rating,” “Medical Care,” “Member Experience,” and “Plan Administration”) unless the State Exchange modified the display names for these labels. If the State Exchange has modified the display names, web-brokers operating in State Exchanges should use the display names used on the State Exchange website. Web-brokers operating in State Exchanges should also align their display of the quality ratings to reflect any permitted State-specific customizations, such as the addition of State or local quality information. Additionally, consistent with the approach for display of quality ratings by web-brokers in the FFEs and SBE-FPs and by State Exchanges, if a QHP was not eligible to receive a rating or did not receive a rating for other reasons, web-brokers participating in State Exchanges would need to display “New plan—Not Rated” or “Not Rated” in place of the quality ratings.<sup>102</sup> When displaying the quality rating assigned by HHS on their non-Exchange websites, web-brokers operating in State Exchanges would be required to prominently display the disclaimer language specified in the CMS Quality Rating Information Bulletin, which mirrors the language that web-brokers in the FFEs and SBE-FPs must display on their non-Exchange websites.<sup>103</sup>

State Exchanges are also currently required to display the quality ratings assigned by HHS and the results of the enrollee satisfaction survey, in the form and manner specified by the

Secretary.<sup>104</sup> This includes prominently displaying the same disclaimer language on the State Exchange website or a static website when displaying the quality ratings assigned by HHS and the results of the enrollee satisfaction survey.<sup>105</sup> Web-brokers would be able to access QHP quality rating information for a State Exchange they are operating in, including the quality ratings assigned by HHS and enrollee satisfaction survey results,<sup>106</sup> from the State Exchange.

This list of standardized QHP comparative information that web-brokers must disclose and display on their non-Exchange websites used to complete QHP selection in FFE and SBE-FP States mirrors the information that Exchanges are required to disclose and display on their respective websites.<sup>107</sup> This approach ensures consumers have access to the same QHP comparative information whether they elect to enroll through the Exchange’s website or through a web-broker’s non-Exchange website. We propose to extend these same standardized comparative information requirements, as minimum Federal standards, that would need to be met by web-brokers participating in State Exchanges and consequently to these State Exchanges. We similarly propose to extend the Enrollment Support disclaimer referenced in § 155.220(c)(3)(i)(A) beyond FFE and SBE-FP States to also extend to web-brokers participating in State Exchanges and consequently to these State Exchanges. The goal of this disclaimer is to ensure consumers are clearly informed about any enrollment limitations on a web-broker’s non-Exchange website and similarly have clear instructions for accessing the Exchange website if they wish to enroll in those QHPs. In particular, when a website of a web-broker is used in FFE or SBE-FP States to complete the QHP selection, but it does not support

enrollment for a QHP,<sup>108</sup> the web-broker’s website must prominently display the standardized Enrollment Support disclaimer<sup>109</sup> provided by HHS, as follows:

“(Name of Company) does not support enrollment in this Qualified Health Plan at this time. To enroll in this Qualified Health Plan, visit the Health Insurance Marketplace® website at *HealthCare.gov*.”

We propose to require web-brokers assisting consumers in State Exchanges to comply with these same requirements, while also providing these State Exchanges some flexibility regarding the disclaimer language required to be displayed by their web-brokers. First, to prominently display the disclaimer, it must be written in a font size no smaller than the majority of text on the website page and must be noticeable in the context of the website by (for example) using a font color that contrasts with the background of the website page.<sup>110</sup> In addition, the Enrollment Support disclaimer must appear on the web-broker’s non-Exchange website in close proximity to where the QHP information is displayed if the web-broker does not support enrollment in any such QHP, so it is noticeable to the consumer.<sup>111</sup> Web-brokers can also meet this prominent display requirement if a visual cue is displayed where the enrollment button (or another similar mechanism) would otherwise appear for a particular QHP that clearly directs the consumer to the required disclaimer on the same website page or otherwise displays the required disclaimer (for example, in a pop-up bubble that appears while hovering over the visual cue).<sup>112</sup>

With respect to State flexibility, under this proposal, the HHS-provided disclaimer language must be used as a minimum starting point, but State Exchanges may add State-specific language to the Enrollment Support

<sup>104</sup> See §§ 155.1400 and 155.1405. Also see § 155.205(b)(1)(iv) and (v). Exchanges can satisfy the requirement to display the enrollee satisfaction survey results by displaying the quality ratings assigned by HHS (which incorporate member experience data from the survey). See 79 FR at 30310 through 30311.

<sup>105</sup> See CMS. (2023, May 2). *Quality Rating Information Bulletin*. CMS. Section III, p. 3. <https://www.cms.gov/files/document/py2024-qrs-display-bulletin.pdf>.

<sup>106</sup> Consistent with the approach for Exchanges, for purposes of compliance with the Federal minimum standards, web-brokers would be able to satisfy the requirement to display the enrollee satisfaction survey results by displaying the quality ratings assigned by HHS (which incorporate member experience data from the survey).

<sup>107</sup> See § 155.205(b)(1). Also see 87 FR at 642 (explaining that “(i)including this [list of] information within § 155.220, instead of through a cross-reference to § 155.205(b)(1), would provide better clarity and ease of reference . . .”).

<sup>108</sup> A web-broker’s non-Exchange website may not support enrollment in a QHP if a web-broker does not have an appointment with a QHP issuer and therefore is not permitted under State law to enroll consumers in coverage offered by that issuer.

<sup>109</sup> CMS. (2023, July 12). *Federally-facilitated Exchange (FFE) Enrollment Manual*. CMS. Section 4.4.2, p. 52. <https://www.cms.gov/files/document/jfe-enrollment-manual-2023-5cr-071323.pdf>.

<sup>110</sup> See 78 FR at 27260. Also see CMS. (2023, July 12). *Federally-facilitated Exchange (FFE) Enrollment Manual*. CMS. Section 4.4.1, p. 49–50 and Section 4.4.2, p. 54–55. <https://www.cms.gov/files/document/jfe-enrollment-manual-2023-5cr-071323.pdf>.

<sup>111</sup> See 78 FR at 27260. Also see CMS. (2023, July 12). *Federally-facilitated Exchange (FFE) Enrollment Manual*. CMS. Section 4.4.2, p. 52. <https://www.cms.gov/files/document/jfe-enrollment-manual-2023-5cr-071323.pdf>.

<sup>112</sup> *Id.*

[www.cms.gov/files/document/py2024-qrs-display-bulletin.pdf](https://www.cms.gov/files/document/py2024-qrs-display-bulletin.pdf). See Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule, 79 FR 30240 at 30310–30311 (May 27, 2014).

<sup>101</sup> §§ 155.1400 and 155.1405. Also see 85 FR at 29214 through 29216.

<sup>102</sup> See CMS. (2023, May 2). *Quality Rating Information Bulletin*. CMS. Section III, p. 3. <https://www.cms.gov/files/document/py2024-qrs-display-bulletin.pdf>.

<sup>103</sup> See CMS. (2023, May 2). *Quality Rating Information Bulletin*. CMS. Section III, p. 3. <https://www.cms.gov/files/document/py2024-qrs-display-bulletin.pdf>.

disclaimer, provided the additional language does not conflict with the HHS-provided standardized disclaimer. This would permit a State Exchange to replace references and links to the Health Insurance Marketplace® and *HealthCare.gov* in the HHS-provided disclaimer language with the appropriate reference or links to the State Exchange's website for the Enrollment Support disclaimer that web-brokers assisting consumers in the State Exchange would be required to prominently display on their non-Exchange websites. Additionally, State Exchanges may require web-brokers operating in their State to translate the disclaimer text into languages appropriate for the State as this type of additional requirement would not conflict with the HHS-provided disclaimer language or minimum standards. As with all informational materials, standard plain language practice is to write at or near a fourth grade reading level and not to exceed an eighth grade reading level. We expect that any additional State-specific customizations to this disclaimer would be written accordingly. We would be available to provide technical assistance to State Exchanges that want to add State-specific language. We propose to codify this State flexibility in new proposed paragraph (n)(1).

In addition, consistent with § 155.220(c)(3)(i)(G), when used to assist FFE consumers, the web-broker's non-Exchange website must also prominently display a standardized disclaimer<sup>113</sup> provided by HHS, referred to as the General non-FFE disclaimer, that informs consumers and applicants that the web-broker's website is not the Exchange website, notes that the web-broker's non-Exchange website may not support enrollment in all QHPs, and provides a web link to the Exchange's website. This same requirement extends beyond the FFEs and also applies to SBE-FPs today.<sup>114</sup> In new paragraph (n), we propose to extend this disclaimer requirement to also apply to web-brokers operating in State Exchanges, and consequently to these State Exchanges, while providing these State Exchanges some flexibility to add State-specific language to this disclaimer, provided the additional language does not conflict with the HHS-provided disclaimer language. We propose to codify this State flexibility in new proposed paragraph (n)(1). Similar

to the adoption of this disclaimer for consumers in an FFE or an SBE-FP,<sup>115</sup> we continue to believe this additional standard is in the best interest of consumers, as it would help them distinguish between the Exchange website and web-broker non-Exchange websites. We therefore also identified it as an important baseline consumer protection that should extend to consumers across all Exchanges.

The General non-FFE disclaimer provided by HHS that must be prominently displayed by web-brokers participating in the FFEs and SBE-FPs reads:

“Attention: This website is operated by (Name of Company) and is not the Health Insurance Marketplace® website. In offering this website, (Name of Company) is required to comply with all applicable Federal law, including the standards established under 45 CFR 155.220(c) and (d) and standards established under 45 CFR 155.260 to protect the privacy and security of personally identifiable information. This website may not support enrollment in all Qualified Health Plans (QHPs) being offered in your State through the Health Insurance Marketplace® website. For enrollment support in all available QHP options in your State, go to the Health Insurance Marketplace® website at *HealthCare.gov*.

Also, you should visit the Health Insurance Marketplace® website at *HealthCare.gov* if:

- You want to select a catastrophic health plan. (This only needs to be included if the web-broker does not offer catastrophic plans.)
- You want to enroll members of your household in separate QHPs. (This only needs to be included if the web-broker does not allow multiple enrollment groups for its Classic DE pathway; note that EDE Entities are required to support multiple enrollment groups.)
- You want to enroll members of your household in dental coverage. The plans offered here do not offer pediatric dental coverage and you want to choose a QHP offered by a different issuer that covers pediatric dental services or a separate dental plan with pediatric coverage. (This only needs to be included if the web-broker does not offer assistance with enrollment in adult coverage or pediatric dental coverage.)

(Name of web-broker's website) offers the opportunity to enroll in either QHPs or off-Marketplace coverage. Please visit *HealthCare.gov* for information on the benefits of enrolling in a QHP. Off-Marketplace coverage is not eligible for

the cost savings offered for coverage through the Marketplaces. (This final paragraph must be displayed if the web-broker offers consumers assistance with off-Marketplace coverage options.)”

To prominently display this disclaimer, it must be written in a font size no smaller than the majority of text on the website page and must be noticeable in the context of the website by (for example) using a font color that contrasts with the background of the website page.<sup>116</sup> In addition, the disclaimer must be prominently displayed on both the initial user landing page and on the landing page displaying QHP options that appear before the applicant makes a decision to purchase coverage (QHP selection page). In FFE and SBE-FP States, the disclaimer must use the exact language provided by HHS, must include a functioning web link to *HealthCare.gov*, and must be viewable without requiring the user to select or click on an additional link. The disclaimer must also be displayed in the same non-English language as any language(s) the web-broker maintains screens for on its website.<sup>117</sup> The web-broker may change the font color, size, or graphic context of the information to ensure that it is noticeable to the user in the context of its website or the other written material.

Consistent with the proposed approach for the extension of the Enrollment Support disclaimer to State Exchanges and their web-brokers, under this proposal, the HHS-provided disclaimer language must be used as a minimum starting point, but State Exchanges may add State-specific language, provided the additional language does not conflict with the HHS-provided standardized disclaimer.

This would permit State Exchanges to replace references and links to the Health Insurance Marketplace® and *HealthCare.gov* in the HHS-provided disclaimer language with the appropriate reference or links to the State Exchange's website for the disclaimer under § 155.220(c)(3)(i)(G) that web-brokers assisting consumers in State Exchanges would be required to prominently display on their non-Exchange websites. Additionally, while web-brokers assisting consumers in State Exchanges must specify in their disclaimer that they are subject to applicable Federal requirements, under this proposal, we anticipate State

<sup>113</sup> CMS. (2023, July 12). *Federally-facilitated Exchange (FFE) Enrollment Manual*. CMS. Section 4.4.2, p. 54. <https://www.cms.gov/files/document/ffe-enrollment-manual-2023-5cr-071323.pdf>.

<sup>114</sup> 45 CFR 155.220(l).

<sup>115</sup> 78 FR 37046.

<sup>116</sup> See 78 FR at 27260. Also see CMS. (2023, July 12). *Federally-facilitated Exchange (FFE) Enrollment Manual*. CMS. Section 4.4.1, p. 49–50 and Section 4.4.2, p. 54–55. <https://www.cms.gov/files/document/ffe-enrollment-manual-2023-5cr-071323.pdf>.

<sup>117</sup> See 45 CFR 155.205(c)(2)(iv)(C).

Exchanges would leverage this flexibility to direct their web-brokers to omit citations to Federal requirements included in the HHS-provided language to the extent those provisions do not apply, such as § 155.220(d). State Exchanges would also be permitted under this proposal to modify the disclaimer required under § 155.220(c)(3)(i)(G) to specify applicable provisions of State law. Further, to the extent that web-brokers in State Exchanges may offer off-Exchange coverage options, we would require them to include the HHS-provided disclaimer language that distinguishes between such coverage options and QHPs sold through the Exchange, noting in particular that such off-Exchange coverage options are not eligible for cost savings offered with a QHP sold through the Exchange, and providing a link to the State Exchange website for more information. Similar to the approach adopted for web-brokers participating in FFE and SBE-FP States, bracketed language included in the HHS-provided disclaimer language would not be required for web-brokers assisting consumers in State Exchanges to comply with the Federal minimum standards unless applicable or otherwise required by the State Exchange. State Exchanges may also require web-brokers operating in their State to translate the disclaimer text required under § 155.220(c)(3)(i)(G) into languages appropriate for the State as this type of additional requirement would not conflict with the HHS-provided disclaimer language or minimum standards. As with all informational materials, standard plain language practice is to write at or near a fourth grade reading level and not to exceed an eighth grade reading level. HHS expects that any State-specific additions or customizations to this disclaimer would be written accordingly. We would be available to provide technical assistance to State Exchanges that want to add State-specific language to this disclaimer that a web-broker in a State Exchange would be required to prominently display on its non-Exchange website to distinguish it from the State Exchange website.

In new proposed paragraph (n), we also propose to extend the requirement in § 155.220(c)(3)(i)(I), which requires the prominent display by web-brokers of the information provided by HHS pertaining to a consumer's eligibility for APTC or CSRs on the web-broker's non-Exchange website, to web-brokers operating in State Exchanges and consequently to these State Exchanges. We established this requirement for

web-brokers in FFE and SBE-FP States to increase the likelihood that consumers understand their potential eligibility for APTC and CSRs and potential liability for excess APTC repayment and can factor those determinations into their QHP selection and the amount of APTC they elect to take.<sup>118</sup> We identified this as another important consumer protection that should be part of the Federal minimum web-broker standards in § 155.220 that also extends to web-brokers in State Exchanges. Consistent with the proposals described above to extend the requirements at § 155.220(c)(3)(i)(A) and (G), we propose to also extend the display obligations in § 155.220(c)(3)(i)(I) to apply to web-brokers in State Exchanges. As such, to prominently display this information, it must appear in a font size no smaller than the majority of text on the website page and must be noticeable in the context of the website by (for example) using a font color that contrasts with the background of the website page.<sup>119</sup> We similarly propose to require web-brokers in State Exchanges to display information provided by, and as specified by, the State Exchange regarding a consumer's eligibility for APTC or CSRs. Additionally, we propose flexibility in how consumer eligibility information for APTC or CSRs is displayed on websites by web-brokers in State Exchanges, at the direction of the State Exchange on the display of that information. This flexibility is intended to provide State Exchanges the ability to define how consumer education information about the State Exchanges, including the consumer eligibility information for APTC or CSRs, is customized and presented on their web-brokers' websites. For example, we recognize that State Exchanges may wish to require their web-brokers include additional consumer educational information or State-specific content to meet the particular needs of their consumers and applicants. We believe allowing the flexibility for State Exchanges and their web-brokers to customize consumer-facing educational information with the HHS minimum standard requiring the prominent display of the consumer eligibility information for APTC or CSRs as provided by the applicable Exchange that must be adopted by web-brokers across all Exchanges would provide a

necessary baseline. Meeting these standards would also provide consistency for all Exchange consumers receiving assistance from web-brokers through their non-Exchange websites and would ensure that all Exchange consumers are provided accurate and sufficient information on potential eligibility for APTC and CSRs and the potential liability for excess APTC repayment. We propose to codify this State flexibility in new proposed paragraph (n)(1).

We also propose to add new § 155.220(c)(4)(iii) to extend certain downstream agent and broker requirements at § 155.220(c)(4)(i) that currently apply to web-brokers in FFE and SBE-FP States and govern the use of the web-broker's non-Exchange website by other agents or brokers assisting Exchange consumers to also apply to web-brokers, and their downstream agents and brokers in States with State Exchanges, and consequently to these State Exchanges. Under the proposed new provision, web-brokers that permit other agents or brokers, through a contract or other arrangement, to use the web-broker's non-Exchange website to help an applicant or enrollee complete a QHP selection or complete the Exchange eligibility application would be required to meet the standards at § 155.220(c)(4)(i)(A), (B), (D), and (F) when assisting consumers in States with a State Exchange. As noted in proposed new § 155.220(c)(4)(iii) and described further below, to extend this framework to also apply in State Exchanges, we propose that all references to "HHS" and "Federally-facilitated Exchange" in § 155.220(c)(4)(i)(A), (B), (D), and (F) would be understood to mean and be replaced with a reference to the applicable State Exchange.

The goal of the downstream agent and broker framework codified in § 155.220(c)(4)(i) is to ensure that agents or brokers who utilize a web-broker's non-Exchange website to help applicants complete a QHP selection or complete the Exchange eligibility application comply with necessary safeguards related to transparency, oversight, and consumer support. It ensures appropriate oversight by the web-broker and allows for closer monitoring by the applicable Exchange. For example, the proposed extension of § 155.220(c)(4)(i)(A) to web-brokers operating in State Exchanges would require these web-brokers to provide the State Exchanges in which it they are operating a list of all agents or brokers utilizing the web-broker website to facilitate enrollment of a consumer. The proposed extension of

<sup>118</sup> 81 FR 61499.

<sup>119</sup> See 78 FR 27260. Also see CMS. (2023, July 12). *Federally-facilitated Exchange (FFE) Enrollment Manual*. CMS. Section 4.4.1, p. 49–50 and Section 4.4.2, p. 54–55. <https://www.cms.gov/files/document/ffe-enrollment-manual-2023-5cr-071323.pdf>.

§ 155.220(c)(4)(i)(B) would also offer a basic consumer protection that all agents or brokers utilizing a web-broker website to facilitate enrollment of a consumer in a manner that constitutes enrollment through the State Exchange are licensed in the State in which the consumer is selecting the QHP, have completed training and registration, and have signed all required agreements with the State Exchange. Finally, the proposed extension of § 155.220(c)(4)(i)(F) to also apply to web-brokers operating in State Exchanges that make their non-Exchange website available to other agents and brokers would require the web-brokers to obtain approval from the State Exchanges verifying that all applicable requirements are met.

The proposed extension of the § 155.220(c)(4)(i)(A), (B), (D), and (F) framework to State Exchanges and their web-brokers would equip the State Exchanges with information needed to oversee their web-brokers and the use of web-broker non-Exchange websites by other web-brokers. Ultimately, the application of § 155.220(c)(4)(i)(A), (B), (D), and (F) would extend these safeguards to the State Exchange and their consumers when web-brokers participating in the State Exchanges permit downstream agents and brokers to utilize their non-Exchange websites to help applicants or enrollees complete their QHP selection or complete their Exchange eligibility applications in a manner that constitutes enrollment through the State Exchanges. In particular, requiring compliance with the HHS minimum standards at § 155.220(c)(4)(i)(A), (B), (D), and (F) for web-brokers participating in State Exchanges that contract with or enter into arrangements with downstream agents and brokers to provide applicants or enrollees with assistance when selecting QHPs or completing Exchange eligibility applications through their non-Exchange websites would maximize transparency and provide necessary safeguards to applicants or enrollees who rely on those downstream agents and brokers to enroll in coverage. We believe the extension of these HHS minimum standards is especially important since some agents, brokers, and web-brokers operate in multiple States and would benefit from a standardized framework and set of requirements. As part of the State Exchanges' oversight of the use of web-broker non-Exchange websites, we also encourage State Exchanges adopt a temporary suspension framework similar to § 155.220(c)(4)(ii) that applies in FFE and SBE-FP States. This

provision permits HHS to temporarily suspend the ability of a web-broker to make its non-Exchange website available to its downstream agents and brokers to transact information with HHS if HHS discovers a security or privacy incident or breach. The suspension extends for the period in which HHS begins to conduct an investigation and until the incident or breach is remedied to HHS' satisfaction. It is another important feature of HHS' oversight of the use of web-broker non-Exchange websites in FFE and SBE-FP States that protects consumers data and safeguards Exchange operations and systems. State Exchanges that choose to permit web-brokers to host non-Exchange websites to assist consumers with QHP selections and submission of Exchange eligibility applications should consider adoption of similar measures.

In addition, in new paragraph (n)(2), we propose to extend web-broker operational readiness requirements to State Exchanges and their web-brokers. Under this proposal, web-brokers operating in State Exchanges would be required to demonstrate operational readiness to the applicable State Exchange prior to the web-broker's website being used to complete an Exchange eligibility application or a QHP selection. The standards under § 155.220(c)(6) applicable to operational readiness reviews performed by HHS of web-brokers' non-Exchange websites used to assist the FFEs' and SBE-FPs' consumers to apply and enroll in QHP coverage through the Exchange, with or without APTC and CSRs, is a critical part of the oversight framework for HHS' Direct Enrollment (DE) program (including both Classic DE and Enhanced Direct Enrollment (EDE)). DE is a service that allows approved web-brokers to enroll consumers in Exchange coverage, with or without the assistance of an agent/broker, directly from their non-Exchange websites.<sup>120</sup> In Classic DE, consumers start on a web-broker's website by indicating they are interested in Exchange coverage. The web-broker redirects users to *HealthCare.gov* to complete the eligibility application portion of the process. After completing their eligibility application, *HealthCare.gov* redirects users back to the web-broker website to shop for a plan and enroll in Exchange coverage. EDE is a service that allows approved EDE web-brokers to provide a comprehensive consumer experience including the eligibility application, Exchange enrollment, and post-

enrollment year-round customer service capabilities for consumers and agents/brokers working on behalf of consumers, directly on web-broker websites. Through EDE, approved web-broker EDE entities<sup>121</sup> build and host a version of the *HealthCare.gov* eligibility application directly on their non-Exchange websites that securely integrates with a back-end suite of FFE application programming interfaces (APIs) to support application, enrollment and more.

In the 2018 Payment Notice final rule, we adopted rules to capture operational readiness requirements applicable to web-brokers that host non-Exchange websites to complete QHP selection.<sup>122</sup> In the 2020 Payment Notice final rule, we finalized amendments that moved the parallel operational readiness requirements for web-brokers and QHP issuers to § 155.221(b)(4), accounting for the fact that DE entities participating in EDE in the FFEs and SBE-FPs host the Eligibility application in addition to QHP selection.<sup>123</sup> In the 2022 Payment Notice final rule, we finalized amendments to codify more detail describing the operational readiness reviews applicable to web-brokers participating in FFE and SBE-FP States by adding a new § 155.220(c)(6).<sup>124</sup> This included codifying requirements for a web-broker to demonstrate operational readiness and compliance with applicable requirements prior to the web-broker's non-Exchange website being used to complete an Exchange eligibility application or a QHP selection, which may include submission or completion, in a form and manner specified by HHS,<sup>125</sup> of certain information, data, or testing results. As part of these reviews, HHS may request a web-broker submit a number of artifacts or documents or complete certain testing processes to demonstrate the operational readiness of its non-Exchange website. The required documentation may include operational data including licensure information, points of contact, and third-party relationships; security and privacy assessment documentation, including penetration testing results, security and

<sup>121</sup> QHP issuers are also eligible to become approved EDE entities. See 45 CFR 155.221(a)(1).

<sup>122</sup> 81 FR 94120.

<sup>123</sup> 84 FR 17522 through 17525.

<sup>124</sup> 86 FR 24208 through 24209.

<sup>125</sup> For additional information, including technical specifications on, the HHS web-broker operational readiness reviews, see CMS. (2023, March 1). *Third-party Auditor Operational Readiness Reviews for the Enhanced Direct Enrollment Pathway and Related Oversight Requirements*. CMS. <https://www.cms.gov/files/document/guidelines-enhanced-direct-enrollment-audits-year-6-final.pdf>.

<sup>120</sup> QHP issuers are also eligible to become approved DE entities and participate in HHS' DE program. See 45 CFR 155.221(a)(1).

privacy assessment reports, vulnerability scan results, plan of action and milestones, and system security and privacy plans; and an agreement between the web-broker and HHS documenting the requirements for participating in the applicable DE pathway.<sup>126</sup> The required testing may include enrollment testing, prior to approval or at the time of renewal, and website reviews performed by HHS to evaluate prospective web-brokers' compliance with applicable website display requirements prior to approval.<sup>127</sup> We identified these operational readiness requirements as necessary safeguards to protect consumer data and the efficient and effective operation of the Exchange while also supporting innovation and the creation of additional approved pathways for FFE and SBE-FP consumers to enroll in QHP coverage in a manner that constitutes enrollment through the Exchange.

As part of the proposal to extend an operational readiness review requirement to State Exchanges and their web-brokers, we propose in new paragraph (n)(2) to require these State Exchanges to establish the form and manner for their web-brokers to demonstrate operational readiness, which may include submission or completion of the same items addressed in § 155.220(c)(6)(i)–(v) to the State Exchanges, in the form and manner specified by the applicable State Exchanges. These standards, which apply in FFE and SBE-FP States, ensure operational readiness and compliance with all applicable requirements prior to the web-broker's non-Exchange website being used to complete Exchange eligibility application or a QHP selection. They make sure consumers and applicants are not able to enroll in Exchange coverage nor submit an Exchange application via a web-broker's non-Exchange website that is not operationally ready. Websites that have not been tested to see if they are operationally ready may not provide consumers and applicants with proper eligibility determinations or may have security flaws that could make a breach involving consumer PII more likely. Mandating that web-brokers participating in State Exchanges meet standards set by the applicable State Exchange to demonstrate operational readiness would help reduce this risk in all Exchanges. We encourage State Exchanges to adopt operational readiness review standards consistent with the requirements captured in

§ 155.220(c)(6)(i)–(v) and also consider leveraging the audits that web-brokers use to demonstrate compliance with the operational readiness review requirements applicable in FFE and SBE-FP States. Such an approach would promote standardization across Exchanges in terms of operational readiness requirements applicable for web-brokers while building in flexibility for State Exchanges. We recognize it is important to provide State Exchanges flexibility to tailor the operational readiness review process to best serve their operational and business needs. For example, State Exchanges may have the need to structure their operational readiness reviews to emphasize or prioritize different web-broker functionalities that meet State-specific needs. Therefore, we are proposing to establish a general requirement that State Exchanges must establish operational readiness requirements for their web-brokers to demonstrate compliance with applicable requirements and technological readiness prior to the web-broker's website being used to complete an Exchange eligibility application or a QHP selection, while providing these State Exchanges with flexibility to define the contours of those requirements. We propose to capture at the end of the new paragraph (n) the accompanying proposed requirement that web-brokers in States with State Exchanges comply with the applicable State Exchanges' operational readiness standards under paragraph (n)(2).

Finally, we propose in new paragraph (n)(1) to extend the current web-broker FFE standard of conduct established at § 155.220(j)(2)(i) to also apply to web-brokers assisting consumers in State Exchanges, and consequently to these State Exchanges. Section 155.220(j)(2)(i) requires agents, brokers, or web-brokers that assist with or facilitate enrollment of qualified individuals, qualified employers, or qualified employees, in coverage in a manner that constitutes enrollment through an FFE, or assist individuals in applying for APTCs and CSRs for QHPs sold through an FFE, must provide consumers with correct information, without omission of material fact, regarding the FFEs, QHPs offered through the FFEs, and insurance affordability programs,<sup>128</sup> and refrain from marketing or conduct that is misleading (including by having a DE 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. This FFE standard already extends to web-brokers SBE-FP States.<sup>129</sup> As proposed to be applied in State Exchanges, web-brokers would be required to provide consumers with correct information, without omission of material fact, regarding the applicable State Exchange, QHPs offered through the applicable State Exchange, and insurance affordability programs.<sup>130</sup> In addition, web-brokers who assist with or facilitate enrollment of qualified individuals, qualified employers, or qualified employees, in coverage in a manner that constitutes enrollment through a State Exchange, or assist individuals in applying for APTCs and CSRs for QHPs sold through a State Exchange, would also be required to refrain from marketing or conduct that is misleading (including by having a website that the State Exchange determines could mislead a consumer into believing they are visiting the State Exchange's website), coercive, or discriminates based on race, color, national origin, disability, age, or sex. As noted in the last sentence of proposed new paragraph (n), to extend this FFE standard of conduct to State Exchanges, we propose that all references to “HHS” and “the Federally-facilitated Exchanges” in § 155.220(j)(2)(i) would be understood to mean and be replaced with a reference to “the applicable State Exchange, applied to web-brokers,” and the reference to “*HealthCare.gov*” in § 155.220(j)(2)(i) would be understood to mean and be replaced with a reference to “the State Exchange website, applied to web-brokers.”

We seek comment on these proposals, especially from States operating, or seeking to operate, State Exchanges. We also seek comment on which of the other current provisions at § 155.220 should or should not apply to State Exchanges and web-brokers that assist consumers in State Exchanges.

#### 8. Establishing Requirements for DE Entities Mandating *HealthCare.gov* Changes Be Reflected on DE Entity Non-Exchange Websites Within a Notice Period Set by HHS (§ 155.221(b))

We propose to revise § 155.221(b) to require that *HealthCare.gov* changes be reflected and prominently displayed on

<sup>126</sup> See 45 CFR 155.220(c)(6)(i), (iv), and (v).

<sup>127</sup> See 45 CFR 155.220(c)(6)(ii) and (iii).

<sup>128</sup> See 42 CFR 435.4 for the definition of insurance affordability programs.

<sup>129</sup> See 45 CFR 155.220(l). A parallel requirement also applies to QHP issuer DE entities in FFE and SBE-FP States. See 45 CFR 155.221(a)(1) and (i), and 156.1230(b)(2). As discussed below, in this rulemaking, we propose to extend the parallel QHP issuer DE entity requirement to State Exchanges and their QHP issuer DE entities.

<sup>130</sup> See 42 CFR 435.4 for the definition of insurance affordability programs.

DE entity non-Exchange websites within a specific notice period<sup>131</sup> set by HHS. We conduct various DE entity monitoring programs, including website display reviews, and routinely identify areas where DE entity non-Exchange websites can improve the user experience and more closely align with *HealthCare.gov*. The changes that we propose to require DE Entities to make to their non-Exchange websites include changes that enhance the consumer experience, simplify the plan selection process, and increase consumer understanding of plan benefits, cost-sharing responsibilities, and eligibility for financial assistance. This proposal would codify our existing practice of communicating important changes to the *HealthCare.gov* display to EDE entities to ensure their EDE websites conform to those changes and provide the same vital information to consumers, expand our existing change requests processes to permit entities to request deviations from required display changes, require DE entities that do not participate in EDE to comply with this practice, and require State Exchanges that choose to implement a DE program to require their DE entities to implement and prominently display changes adopted for display on the State Exchanges' websites on their non-Exchange websites for purposes of assisting consumers with DE in QHPs offered through the Exchange in a manner that constitutes enrollment through the Exchange.

Section 1312(e) of the ACA directs the Secretary to establish procedures under which a State may permit agents and brokers to enroll qualified individuals and qualified employers in QHPs through an Exchange and to assist individuals in applying for financial assistance for QHPs sold through an Exchange. In addition, section 1413 of the ACA directs the Secretary to establish, subject to minimum requirements, a streamlined enrollment process for enrollment in QHPs and all insurance affordability programs. At § 155.221(a) and (i), we established that the FFEs and SBE-FPs will permit QHP issuers, which meet the applicable requirements of § 155.221 and § 156.1230, and web-brokers, which meet the applicable requirements of § 155.220 and § 155.221, to assist consumers with DE in QHPs offered through the Exchange in a manner that is considered to be through the Exchange and to the extent permitted by

applicable State law.<sup>132</sup> Collectively, QHP issuers and web-brokers that meet the applicable requirements to assist Exchange consumers with DE in QHPs are referred to as "DE entities." DE entities may assist consumers with DE in QHPs offered through an Exchange by redirecting consumers from the non-Exchange website to *HealthCare.gov* to complete the eligibility application and obtain an eligibility determination, referred to as "Classic DE." DE entities may also assist consumers with DE in QHPs offered through an Exchange by hosting an eligibility application on their non-Exchange website and allowing consumers to complete the eligibility application and obtain an eligibility determination from the Exchange without being redirected to *HealthCare.gov*, referred to as "Enhanced Direct Enrollment (EDE)." Section 155.221(b) establishes requirements that DE entities must meet to assist consumers in FFE and SBE-FP States.<sup>133</sup> Additional requirements that apply to web-brokers and QHP issuers that assist consumers with enrollment in coverage offered through the FFEs and SBE-FPs are captured in §§ 155.220, 156.265, and 156.1230.<sup>134</sup>

The display requirements for DE entity non-Exchange websites are captured in §§ 155.220, 155.221, 156.265, and 156.1230. The website display requirements are often technical in nature and can require subsequent release of guidance to provide technical and operational details to support their implementation. When HHS makes changes to the *HealthCare.gov* display, we notify EDE entities participating in the FFEs and SBE-FPs of these changes and require that they make them to their non-Exchange websites via the HHS-initiated change request process outlined in the Third Party Auditor Operational Readiness Reviews for the Enhanced Direct Enrollment Pathway and Related Oversight Requirements guidance document referred to as the "Third Party Auditor Guidelines."<sup>135</sup> This process helps ensure consumers

receive vital information they need in a timely fashion.

This proposal would codify and expand this existing, HHS-initiated change request practice for EDE entities' non-Exchange websites and support consistency as to the timing of display changes across enrollment platforms, which would help ensure all Exchange consumers have timely access to accurate, clear information as they navigate the QHP selection and enrollment processes. Most DE partners in FFE and SBE-FP States participate in EDE and therefore are already familiar with and complying with this proposal because it is part of the existing requirements, as outlined in the Third Party Auditor Guidelines. However, the requirements of this proposal would be new for some DE partners, such as those that only participate in Classic DE, because they are not currently subject to these requirements, which currently only apply to DE entities that participate in EDE. It is especially important that changes to the *HealthCare.gov* display are reflected on non-Exchange websites, including websites used for both Classic DE and EDE, as a steadily increasing number of the FFEs' and SBE-FPs' consumers enroll in Exchange plans via these DE pathways. This proposal would help ensure consumers using these DE pathways benefit from the policies we introduce to improve the *HealthCare.gov* website display by enhancing the consumer experience, increasing consumer understanding, and simplifying the plan selection process.

We recognize that the technical details necessary to implement website display changes must be communicated to DE entities with sufficient notice for development prior to implementation. As such, this proposal provides that HHS would provide DE entities with advance notice to give them time to implement the changes on their non-Exchange websites. We intend for the duration of the advance notice period to correspond to the complexity of the change and the urgency with which the change must be reflected on the DE entity's non-Exchange website (that is, we intend to provide a longer advance notice period for implementation of changes requiring more complex website-development work, or for lower-urgency changes). We would categorize display changes as simpler versus more complex based on a combination of factors, including, but not limited to, consideration of the following: number of website pages affected; number of data fields affected; nature of the change (that is, text-based versus data-based); whether the change

<sup>131</sup> "Notice period" refers to the time period that DE entities have to reflect and prominently display *HealthCare.gov* changes communicated to them by HHS pursuant to this proposal.

<sup>132</sup> 84 FR 17523 through 17524, 86 FR 6176 and 6177.

<sup>133</sup> In this rulemaking, we propose to extend certain Federal minimum standards under § 155.221(b) to State Exchanges and their DE entities.

<sup>134</sup> In this rulemaking, we propose to extend certain Federal minimum standards under §§ 155.220 and 156.1265 to State Exchanges, their web-brokers, and their QHP issuer DE entities.

<sup>135</sup> CMS. (2023, March 1). *Third-party Auditor Operational Readiness Reviews for the Enhanced Direct Enrollment Pathway and Related Oversight Requirements*. CMS. Section IX.B., pp. 72–74. <https://www.cms.gov/files/document/guidelines-enhanced-direct-enrollment-audits-year-6-final.pdf>.

is static or dynamic based on user input; whether the change updates QHP data provided by us<sup>136</sup> or involves the display of new data not previously provided by us (that is, new data types would be considered a more complex change due to the web-development work required to integrate a new PUF data field or MAPI data variable); and whether the change may affect backend algorithms for plan sorting, filtering, or recommendations. The complexity of the change would be the primary factor determining the length of the advance notice period. Generally, we would expect to provide approximately 30 calendar days' advance notice of simpler display changes and up to 90 or more calendar days' advance notice for more complex changes. However, in situations where we have determined that it is urgent that *HealthCare.gov* display changes are similarly made to DE entities' non-Exchange websites to communicate necessary information to consumers regarding their plan selection or enrollment, we may provide fewer than 30 days' advance notice, but not less than 5 business days' advance notice. When considering the urgency of a display change, we would consider a number of factors, including, but not limited to, the following: potential to impact the consumers' understanding of plan benefits and cost-sharing responsibilities; potential for consumers to receive an incorrect eligibility determination; potential impact to the consumer's understanding of their eligibility for financial assistance (that is, APTC or CSR); proximity to the Open Enrollment period (with changes becoming more urgent as Open Enrollment nears, as implementing changes prior to Open Enrollment is critical for ensuring the greatest number of consumers are able to benefit from the changes); and whether failure to implement the change may result in a display that is misleading or confusing to consumers.

We propose to amend § 155.221 to add new paragraph (b)(6), which would require DE entities to implement and prominently display website changes in a manner consistent with what is adopted by HHS for display on *HealthCare.gov* by meeting standards

communicated and defined by HHS within a time period set by HHS, unless HHS approves a deviation from those standards. Consistent with § 155.221(i), this new proposed DE entity non-Exchange website display requirement would also apply to DE entities that enroll qualified individuals in coverage in a manner that constitutes enrollment through an SBE-FP or assist individual market consumers with submission of applications for APTC and CSRs through an SBE-FP.

We are cognizant of, and support, DE entity non-Exchange websites' use of innovative decision-support tools and user interface design for consumers to help them shop for and select QHPs that best fit their needs. This proposal is not intended to prohibit or otherwise stand in the way of DE entities' development of such tools and consumer interfaces. Consistent with the existing approach for implementation of HHS-initiated changes described in the Third Party Auditor Guidelines, we would implement this requirement with a focus on requiring DE entities in FFE and SBE-FP States to mirror any display changes made to *HealthCare.gov* that impact a consumer's understanding of plan benefits, cost-sharing responsibilities, and eligibility for financial assistance. For each required change, DE entities in FFE and SBE-FP States would need to implement on their non-Exchange websites conforming changes that meet standards defined by HHS for display in a manner consistent with that adopted by HHS for display on *HealthCare.gov*. We would provide DE entities flexibility in their user interface graphic design, provided that their design complies with the standards defined by HHS in the notification of required change(s). As part of this proposal, we would require that all front-end website changes (that is, website changes that would affect the visual aspects of the website that users see and interact with) be prominently displayed on DE entity non-Exchange websites. "Prominently displayed" means that text must be written in a font size no smaller than the majority of the text on the web page, text must be displayed in the same non-English language as any language(s) the DE entity maintains translations for on its website,<sup>137</sup> and any display changes must be noticeable in the context of the website (that is, DE entity non-Exchange websites must use a font or graphic color that contrasts with the background of the web page and ensure any graphics and iconography that they are required to display are readable without

requiring the user to increase their magnification percentage greater than 100 percent). The DE entity may change the font color, size, or graphic context of the information to ensure that it is noticeable to the user in the context of its website or other written material.

For example, in a scenario where *HealthCare.gov* is updated to display new help text communicating educational content to consumers that is designed to help a consumer better understand plan benefits, cost-sharing responsibility, or eligibility for financial assistance, we would require the DE entity's non-Exchange website to display that help text or similar text. When notifying DE entities about the required change, we would establish and communicate the standards that must be met for display of the required change, such as the new help text that must be prominently displayed on their websites. If the standards allow the DE entity to display similar text to the language used on *HealthCare.gov* (for example, when information must be communicated but there is a low risk of misinterpretation of the information such that we would not require DE entities to display the exact language used on *HealthCare.gov*), we would provide DE entities with information on how the help text is displayed on *HealthCare.gov*, along with the standards that must be met, while also outlining the flexibility for DE entities to adapt the language to reflect their own entity branding if it generally conveys the same information and meaning as the help text displayed on *HealthCare.gov*. In this example, we would also allow flexibility as to the location of the help text if it adheres to the prominent display requirements discussed earlier in this proposal. In this scenario, DE entities would be able to adjust the language and decide on the location of the help text on the QHP selection page(s) without seeking prior approval from us. However, we would monitor implementation through existing periodic website review monitoring per § 155.220(c)(5) and, as described in the Third Party Auditor Guidelines,<sup>138</sup> may notify the DE entity if we find that their language does not convey the same meaning as the help text displayed on *HealthCare.gov* or if we find the help text is not prominently displayed. Such notification would occur via a letter that would provide the DE entity with feedback explaining the

<sup>136</sup> We provide DE entities with the QHP comparative information that must be displayed in accordance with § 155.220(c)(3)(i)(A) and § 156.1230(a)(1)(ii). We provide this data via the Public Use Files (PUF) (<https://www.cms.gov/ccio/resources/data-resources/marketplace-puf>) and through non-Exchange website integration with the Marketplace Application Program Interface (MAPI) (<https://developer.cms.gov/marketplace-api/>). In this context, website integration refers to connecting the non-Exchange website with Exchange data by using the MAPI.

<sup>137</sup> 45 CFR 155.205(c)(2)(iv).

<sup>138</sup> CMS. (2023, March 1). *Third-party Auditor Operational Readiness Reviews for the Enhanced Direct Enrollment Pathway and Related Oversight Requirements*. CMS. Section X.F., p. 69. <https://www.cms.gov/files/document/guidelines-enhanced-direct-enrollment-audits-year-6-final.pdf>.



noncompliance and required corrective actions (such letter is referred to as “Technical Assistance”). If Technical Assistance fails, we may potentially take enforcement action to address the identified instances of non-compliance, which could include temporarily suspending the DE entity’s ability to transact information with the Exchange if we discover circumstances that pose unacceptable risk to eligibility determination, Exchange operations, or Exchange systems, if warranted.<sup>139</sup>

Additionally, we recognize that some DE entities may have system constraints that prevent them from precisely mirroring the *HealthCare.gov* display approach, and so we propose that if a DE entity is unable to implement the standards defined by HHS, or the DE entity has an idea for implementation that does not meet the standards but would effectively communicate the same information to consumers, we may permit a deviation. We propose that DE entities that are interested in pursuing a deviation must submit deviation requests to HHS and propose that such requests would be subject to review by HHS in advance of implementation of any alternative display approaches. Deviation requests must include a proposed alternative display and accompanying rationale. The rationale must explain why the DE entity is unable to implement the standards or the DE entity’s idea for implementation that does not meet the standards but would effectively communicate the same information to consumers. Therefore, similar to the differential website display requirements for standardized plans applicable to web-broker and QHP issuer DE entities at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv) and the HHS-initiated change request process, we propose to allow DE entities to request a deviation from the standards communicated by HHS for required display changes to align with *HealthCare.gov* by submitting a proposed alternative display and accompanying rationale or explanation for why a deviation is necessary. In reviewing deviations, HHS would consider whether the same level of differentiation and clarity is being provided under the deviation requested by the DE entity as is provided on *HealthCare.gov*. Other factors and criteria HHS would consider include, but are not limited to, whether the proposed alternative website display adheres to the standards for prominent display described in this proposal and whether the display provides correct information, without omission of

material fact, that does not have the potential to be misleading to consumers.

Under this proposed approach, the deviation request would have to be submitted and approved by HHS before DE entities would be permitted to implement any alternative website displays. Deviation requests would not toll the advance notice period. This deviation request process described in this paragraph is separate and distinct from the flexibilities in user interface graphic design that we would allow without preapproval as long as the design and display otherwise meets the applicable standards defined and communicated by HHS for the display change. DE entities would only need to request a deviation from the requirements of the standards communicated by HHS if the DE entity seeks to deviate from those standards or specifications when it implements a display change to its Non-Exchange website that is required by HHS pursuant to this proposal.

Pursuant to proposed new § 155.221(j)(3), we also propose to extend this new proposed DE entity non-Exchange website display requirement to require State Exchanges that choose to implement a DE program to require their DE entities to implement and prominently display changes adopted for display on the State Exchanges’ websites on their non-Exchange websites for purposes of assisting consumers with DE in QHPs offered through the Exchange in a manner that constitutes enrollment through the Exchange. We believe it is necessary for consumers utilizing DE entities in State Exchanges to have access to the same vital information pertaining to their plan selection and enrollment process as they would have if they were enrolling via the State Exchanges’ websites. Under this proposal, we would require State Exchanges to establish and communicate standards for required display changes and to set the time period within which display changes must be implemented on DE entities’ non-Exchange websites. State Exchanges would also be required to review deviation requests submitted by DE entities and establish their own deviation request process if the State Exchange wants to permit deviations. We would provide flexibility for State Exchanges to develop their own process for communicating those standards, setting advance notice periods, and establishing a deviation request process as needed to meet the business needs of the State Exchange. We would encourage State Exchanges to consider the same factors described above (that

is, urgency and complexity of the change) when determining the advance notice period. Similarly, we would encourage State Exchanges to provide their DE entities with examples of the State Exchange website display change and technical assistance, including technical implementation guidance, to ease the burden of implementing and prominently displaying required changes. We would require State Exchanges to apply HHS’s standard for “prominently display,” explained earlier in this section of this proposed rule, to help ensure that important enrollment, eligibility, and other information is as noticeable and clear to consumers using DE entities’ websites in State Exchanges as it is to consumers using State Exchange websites or *HealthCare.gov*, which we believe would enhance the user experience, increase understanding, and simplify the plan selection process for all consumers.

As part of this proposal to extend the requirement for DE entities to reflect Exchange website changes on their non-Exchange websites to State Exchanges and their DE entities, we would rely on State Exchanges that choose to implement a DE program to enforce compliance with these requirements and take enforcement action when their DE entities fail to comply and update their non-Exchange websites to mirror changes made to the State Exchange website. We would be available to provide technical assistance to support the State Exchanges’ efforts to take appropriate enforcement action as needed to ensure compliance with applicable requirements. There may exist scenarios where the website display requirements may differ between the FFEs or SBE-FPs versus the State Exchanges (for example, in scenarios where a State Exchange uses the *HealthCare.gov* disclaimer language and adds State-specific information such as replacing a *HealthCare.gov* hyperlink with the State Exchange hyperlink). In such scenarios, DE entities must tailor their non-Exchange website display to the requirements of the State the consumer is seeking assistance in. Based on our experience providing oversight of DE entity website displays, we understand that many DE entities are familiar with and have the capability to tailor website displays based on different scenarios and, as such, we anticipate DE entities would have the capability to tailor website displays to mirror the Exchange website of the State the consumer is shopping for coverage in.

With an increasing number of consumers utilizing the DE pathways to

<sup>139</sup> 45 CFR 155.221(e).



enroll in coverage through the Exchanges, we believe it is important to codify a requirement to mandate changes adopted by *HealthCare.gov* (or for State Exchanges, the State Exchanges' websites) be implemented on DE entity non-Exchange websites within a timeframe specified by HHS (or, for DE entities participating in State Exchanges, within a timeframe specified by the State Exchange). These proposals would ensure consumers using DE entity non-Exchange websites have a similar user experience, with access to the same information in a similar manner as provided on *HealthCare.gov* and State Exchange websites.

We seek comment on all aspects of this proposal.

#### 9. Adding and Amending Language To Ensure DE Entities Operating in State Exchanges Meet Certain Standards Applicable in the FFEs and SBE-FPs (§ 155.221)

We propose to amend § 155.221 to extend certain existing HHS standards for Exchanges that use the Federal platform that apply to DE entities assisting the FFEs' and SBE-FPs' <sup>140</sup> consumers and applicants with direct enrollment in QHPs and applying for APTC/CSRs to DE entities operating in State Exchanges, for both the State Exchanges' Individual Exchange and SHOP. These proposals would extend certain Federal DE program standards to DE entities operating in State Exchanges, and consequently to those State Exchanges that, to the extent permitted by applicable State law, permit DE entities to assist their consumers and applicants with direct enrollment in QHPs and applying for APTC/CSRs in a manner that constitutes enrollment through an Exchange. <sup>141</sup> These proposals would also ensure that certain minimum Federal standards—those governing DE entity marketing and display of QHPs and non-QHPs, providing consumer with correct information and refraining from certain conduct, marketing of non-QHPs, website disclaimer language, and operational readiness—would apply to DE entities across all Exchanges. These proposals, if finalized, would be effective on the date of publication of the final rule.

Notably, our regulations do not currently address whether and how DE entities may assist consumers and applicants with DE in QHPs and submission of applications for APTC/CSRs in a manner that constitutes

enrollment in State Exchanges. We believe that current and future State Exchanges may seek to implement DE programs similar to the FFEs and SBE-FPs. As such, we believe that DE entities seeking to assist State Exchange consumers with DE in QHPs and submission of applications for APTC/CSRs in a manner that constitutes enrollment through an Exchange should meet the same or, at a minimum, similar standards as are required in the FFEs and SBE-FPs to protect consumers. These safeguards focus on mitigating the potential for confusion between QHPs and non-QHPs (including the eligibility for APTC and/or CSR as it relates to QHPs versus non-QHPs) and as to which products are available through the Exchange and what products are not, ensuring proper eligibility determinations, protecting against security breaches or incidents through implementation of operational readiness reviews (as websites that have not been tested to see if they are operationally ready may provide improper eligibility determinations or may have security flaws that could make a breach involving consumer PII more likely) and through the other minimum Federal standards in § 155.221 that we propose to extend to State Exchanges and their DE entities. <sup>142</sup> We recognize that to date, no State Exchanges have implemented DE programs; however, as stated, we anticipate that there may be growing interest in doing so. As such, we recognize a potential burden on State Exchanges that would newly be subject to the standards being proposed, if they choose to implement DE programs. This would include drafting new policies, updating standards, and potentially hiring additional staff to perform functions not currently being performed by the State Exchanges, including providing technical assistance during development and implementation of DE programs in the State Exchanges, creating the framework for and conducting operational readiness reviews, including developing and maintaining documentation needed to complete the operational readiness reviews, as well as conducting ongoing oversight and taking appropriate

<sup>142</sup> The amendments to § 155.221 we are proposing would not impact how DE entities may assist consumers and applicants in SBE-FP States. Section 155.221(i) provides that a DE entity that enrolls qualified individuals in coverage in a manner that constitutes enrollment through an SBE-FP or assists individual market consumers with submission of applications for APTC and CSRs through an SBE-FP, must comply with all applicable FFE standards in § 155.221. We are not proposing any changes to this existing framework for DE entities who assist consumers and applicants in SBE-FP States.

enforcement action for DE entity non-compliance with applicable requirements. It would also include requiring and overseeing web-development and the hosting of non-Exchange websites by DE entities participating in these State Exchanges to ensure compliance with the proposed minimum standards outlined in this rulemaking.

Section 1312(e) of the ACA provides that the HHS Secretary shall establish procedures under which a State may allow agents, brokers, and web-brokers to enroll individuals in QHPs. The Secretary also has authority under section 1321(a) of the ACA to promulgate regulations with respect to the establishment and operation of Exchanges, the offering of QHPs through such Exchanges, and such other requirements as the Secretary determines appropriate. <sup>143</sup> As explained earlier, HHS previously leveraged these authorities to establish the existing agent, broker, and web-broker standards applicable in FFE and SBE-FP States, which are currently codified in §§ 155.220 and 155.221. <sup>144</sup> In addition, section 1413 of the ACA directs the Secretary to establish, subject to minimum requirements, a streamlined enrollment process for enrollment in QHPs and all insurance affordability programs. This authority, along with the Secretary's rulemaking authority under section 1321(a) of the ACA, was previously leveraged to establish the existing QHP issuer DE Entity requirements applicable in FFE and SBE-FP States, which are currently codified in §§ 155.221, 156.265, and 156.1230. <sup>145</sup>

Similar to the agent, broker and web-broker requirements in § 155.220, currently § 155.221 only applies to DE entities assisting consumers and applicants in the FFEs and SBE-FPs. Section 155.221(a) provides that the FFEs will permit the following entities to assist consumers with DE in QHPs offered through the Exchange in a manner that is considered to be through the Exchange, to the extent permitted by applicable State law: (1) QHP issuers that meet the applicable requirements in §§ 155.221 and 156.1230, and (2) web-brokers that meet the applicable requirements in §§ 155.220 and 155.221. These same entities are permitted to

<sup>143</sup> Section 1321(a)(1)(A), (B) and (D) of the ACA.

<sup>144</sup> See 77 FR 18334–18336; 78 FR 15533; 78 FR 54134; 79 FR 13837; 81 FR 12338; 81 FR 94176; 83 FR 16981–16982; 84 FR 17563; 85 FR 37248; 86 FR 24288; 87 FR 27388; and 88 FR 25917.

<sup>145</sup> See 77 FR 18425–18246; 78 FR 54124–54126; 81 FR 12309–12310; 81 FR 94152; 81 FR 94184; 83 FR 16981–16982, 17030; 84 FR 17521–17525, 17546–17547; and 86 FR 24209–24214.

<sup>140</sup> 45 CFR 155.221(i).

<sup>141</sup> See 78 FR at 37065 through 37066 and 78 FR at 54124 through 54126.

assist consumers with DE in QHPs offered through the Exchange in a manner that is considered to be through the Exchange, to the extent permitted by applicable State law, in SBE-FP States.<sup>146</sup> As explained above, DE allows approved entities to enroll consumers in Exchange coverage, with or without the assistance of an agent/broker, directly from their non-Exchange websites. The HHS DE Program includes two DE pathways: Classic DE and EDE. In Classic DE, consumers start on a DE entity's website by indicating they are interested in Exchange coverage. The DE entity's website redirects users to *HealthCare.gov* to complete the eligibility application portion of the process. After completing their eligibility application, *HealthCare.gov* redirects the users back to the DE entity's non-Exchange website to shop for a plan and enroll in Exchange coverage. EDE allows approved EDE entities to provide a comprehensive consumer experience including the eligibility application, Exchange enrollment, and post-enrollment year-round customer service capabilities for consumers and agents/brokers working on behalf of consumers, directly on the DE entities' non-Exchange websites. Through EDE, approved EDE entities build and host a version of the *HealthCare.gov* eligibility application directly on their websites that securely integrates with a back-end suite of FFE application programming interfaces (APIs) to support application, enrollment, and more. References to "Direct Enrollment" or "DE" within § 155.221 include both the Classic DE and EDE pathways. Similarly, the proposal to extend certain existing HHS standards applicable to DE entities participating in FFE and SBE-FP States to State Exchanges and their DE entities would also apply to the operation of Classic DE and/or EDE within these State Exchanges. That is, under this proposal, State Exchanges that choose to implement DE programs in their States would be permitted to adopt the same pathways or tailor their configuration in a manner best suited to their operational and business needs, so long as their DE programs meet the proposed Federal minimum standards in § 155.221 that we propose in this rulemaking to extend to State Exchanges and their DE entities. We would be available to provide extensive technical assistance to State Exchanges that choose to implement DE programs.

As detailed further below, we propose to add a new paragraph (j) to § 155.221 to extend certain Federal minimum DE

entity standards in § 155.221 to DE entities operating in State Exchanges, and consequently, to these State Exchanges that choose to implement DE programs in their States. We seek to ensure that DE entities assisting these State Exchanges' consumers with DE in QHPs and applying for APTC/CSRs in a manner that constitutes enrollment through the Exchange meet Federal minimum standards governing DE entity marketing and display of QHPs, providing consumers with correct information and refraining from certain conduct, marketing of non-QHPs, website disclaimer language, and operational readiness. We also encourage State Exchanges to require DE entities to engage a third-party auditor to perform the operational readiness review audits of their DE entities, consistent with the operational readiness framework adopted by HHS for the FFEs and SBE-FPs. As stated earlier, we recognize that there may be a growing interest from State Exchanges to operate DE programs, and we seek to establish a set of Federal minimum standards to ensure appropriate safeguards are in place, regardless of the Exchange model. Further, the proposed approach to establish a minimum set of Federal standards that would apply to DE entities across all Exchanges would support efficiency in DE entity operations across all Exchanges, including State Exchanges, while also providing flexibility for State Exchanges to tailor their DE program and establish their own standards with respect to operational readiness demonstrations by their DE entities, including whether to require third-party audits of DE entities and to impose additional requirements beyond the proposed Federal minimum standards as they determine may be appropriate based on their operational or business needs. As described above, if they choose to implement DE programs, the State Exchanges would be required to draft policies, update standards, and potentially hire additional staff to perform functions and activities not currently being performed by the State Exchanges in order to comply with these proposals.

We propose to update § 155.221(a), which identifies the entities permitted to be DE entities in FFE and SBE-FP States, to apply across all Exchanges, including State Exchanges. Under this proposal, State Exchanges that choose to implement a DE program may permit QHP issuers and web-brokers that meet applicable requirements to assist consumers with submitting applications for APTC/CSRs and DE in QHPs offered through the Exchange in a manner that

is considered to be through the Exchange. Under the framework proposed in this rulemaking, the applicable requirements that would extend to web-brokers DE entities in States with State Exchanges would include certain subparagraphs of §§ 155.220(c) and (j) and 155.221(a), (b), (c), (d), and (j). We describe above the proposed extension of certain FFE web-broker standards in § 155.220(c) and (j) to State Exchanges and their web-brokers and detail below the FFE web-broker DE entity standards in § 155.221(a), (b), (c), (d), and (j) we propose extending to web-broker DE entities in State Exchanges. As described further below, we propose the applicable requirements that would apply to QHP issuer DE entities in State Exchanges would be certain FFE QHP issuer DE entity standards in §§ 155.221(a), (b), (c), (d), and (j) and 156.1230(b). The proposals to extend certain FFE requirements in § 155.221 to these State Exchanges' web-broker DE entities are intended to align with the proposals described above to extend certain FFE standards and consumer protections in § 155.220 to these State Exchanges' web-brokers.<sup>147</sup> The proposals to extend certain FFE requirements to QHP issuer DE entities are similarly intended to establish a minimum set of standards and consumer protections, with the HHS requirements generally serving as a floor, for State Exchanges that choose to implement DE programs. As detailed further below, as part of these proposals to extend certain FFE requirements to DE entities, we would rely on State Exchanges to enforce compliance with these requirements and take enforcement action as needed when a DE entity fails to comply with applicable requirements. However, we would provide technical assistance to support State Exchange efforts to take appropriate enforcement action as needed to ensure compliance with applicable requirements.

First, consistent with the cross-reference in § 155.221(a)(1), we propose to extend the FFE requirements of § 156.1230(b) governing QHP issuer DE entities to also apply to QHP issuer DE entities assisting consumers with submitting applications for APTC/CSRs and DE in QHPs offered through the Exchange in States with State Exchanges. As reflected in new section § 155.221(a)(1)(i), for purposes of extending the FFE requirements of

<sup>146</sup> 45 CFR 155.221(i).

<sup>147</sup> As previously noted, the FFE requirements for web-brokers in §§ 155.220 and 155.221 also currently extend to web-brokers participating in SBE-FPs. See 45 CFR 155.220(l) and 155.221(i).

§ 156.1230(b) to these States Exchanges and their QHP issuer DE entities, references in § 156.1230(b) to “Federally-facilitated Exchange”, “HHS”, and “HealthCare.gov” would be understood to mean “the applicable State Exchange”, “the applicable State Exchange”, and “the applicable State Exchange website”, respectively. Consistent with §§ 156.1230(b)(1) and (2), to directly enroll consumers in a manner that is considered to be through the Exchange, QHP issuer DE entities are required to comply with the applicable requirements in § 155.221 and provide consumers with correct information, without omission of material fact, regarding the Exchanges, QHPs offered through the Exchanges, and insurance affordability programs,<sup>148</sup> and refrain from marketing or conduct that is misleading (including by having a DE 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. This FFE standard already extends to QHP issuer DE entities in SBE–FP States.<sup>149</sup> In this rulemaking, we propose to extend these FFE requirements to also apply them to QHP issuer DE entities in State Exchanges. As proposed to be applied in these State Exchanges, QHP issuer DE entities would similarly be required to provide consumers with correct information, without omission of material fact, regarding the Exchanges, QHPs offered through the Exchanges, and insurance affordability programs.<sup>150</sup> In addition, QHP issuer DE entities in State Exchanges would also be required to refrain from marketing or conduct that is misleading (including by having a DE website that the State Exchange determines could mislead a consumer into believing they are visiting the Exchange’s website), coercive, or discriminates based on race, color, national origin, disability, age, or sex. We solicit comments on whether § 156.1230 should also be amended to affirm its applicability to these State Exchanges and their QHP issuer DE entities.<sup>151</sup>

In addition, we propose that all Exchanges, including State Exchanges that choose to implement DE programs

must require their DE entities, both web-broker and QHP issuer DE entities, to meet the Federal standards under § 155.221(b)(1) governing plan display and marketing for QHPs and any other products offered on the Exchange. These Federal standards governing plan display and marketing for QHPs and any other products offered on the Exchange currently apply today to approved web-broker and QHP issuer DE entities in FFE and SBE–FP States.<sup>152</sup> As such, in new paragraph (j), we propose to extend § 155.221(b)(1), including the exceptions in § 155.221(c), to DE entities participating in State Exchanges, and consequently to these State Exchanges. Under this proposal, DE entities participating in State Exchanges would be required to display and market QHPs offered through the Exchange, individual health insurance coverage as defined in § 144.103 offered outside the Exchange (including QHPs and non-QHPs other than excepted benefits) and any other products, such as excepted benefits, on at least three separate website pages on its non-Exchange website, except as permitted under § 155.221(c). Pursuant to the exception under § 155.221(c)(1), a DE entity operating in a State Exchange would be permitted to display and market individual health coverage offered outside the Exchange (including QHPs and non-QHPs other than excepted benefits) on the same website pages when assisting individuals who have communicated receipt of an offer of an individual coverage health reimbursement arrangement as described in § 146.123(c), as a standalone benefit, or in addition to an offer of an arrangement under which the individual may pay the portion of the premium for individual health insurance coverage that is not covered by an individual coverage health reimbursement arrangement using a salary arrangement pursuant to a cafeteria plan under section 125 of the Code, but would be required to clearly distinguish between the QHPs offered through the Exchange and individual health insurance coverage offered outside the Exchange (including QHPs and non-QHPs other than excepted benefits), and prominently communicate that APTCs and CSRs are available only for QHPs purchased through the Exchange, that APTCs are not available to individuals who accept an offer of an individual coverage health reimbursement arrangement or who opt out of an individual coverage health reimbursement arrangement that is considered affordable, and that a salary

reduction arrangement under a cafeteria plan may only be used toward the cost of premiums for plans purchased outside the Exchange. Pursuant to the exception in § 155.221(c)(2), DE entities operating in States with State Exchanges would be permitted to display and market Exchange-certified stand-alone dental plans offered outside the Exchange and non-certified stand-alone dental plans on the same website pages.

In new proposed paragraph (j), we also propose to extend the Federal marketing standard at § 155.221(b)(3) to DE entities participating in State Exchanges and consequently to State Exchanges that choose to implement a DE program, such that these DE entities would also be required to limit marketing of non-QHPs during the Exchange eligibility application and QHP selection process in a manner that minimizes the likelihood that consumers would be confused as to which products and plans are available through the Exchange and which products and plans are not, except as permitted under § 155.221(c)(1). Refer to the discussion above regarding the exception in § 155.221(c)(1) pertaining to DE entities assisting individuals who have communicated receipt of an offer of an individual coverage health reimbursement arrangement as described in § 146.123(c), as a standalone benefit, or in addition to an offer of an arrangement under which the individual may pay the portion of the premium for individual health insurance coverage that is not covered by an individual coverage health reimbursement arrangement using a salary arrangement pursuant to a cafeteria plan under section 125 of the Code.

We believe requiring DE entities participating in all Exchanges to meet the plan display and marketing requirements in § 155.221(b)(1) and (3) adopted by HHS for FFE and SBE–FP States would provide necessary safeguards for consumers who may participate in DE programs across all Exchange models, including in State Exchanges. Requiring DE entities across all Exchanges to meet these Federal plan display and marketing requirements would protect consumers by minimizing their confusion regarding which products and plans are available through the Exchange, which products and plans are not, and which products and plans are eligible for APTC and CSRs. Further, the adoption of uniform requirements across Exchanges in this regard can also alleviate burden on DE entities from having to build different programs and comply with disparate requirements for each State Exchange

<sup>148</sup> See 42 CFR 435.4 for the definition of insurance affordability programs.

<sup>149</sup> See 45 CFR 155.221(a)(1) and (i).

<sup>150</sup> Id.

<sup>151</sup> If § 156.1230 is amended to affirm its applicability to these State Exchanges and their QHP issuer DE entities, parallel revisions may be made to § 156.1230 in the final rule to also capture and affirm its applicability to SBE–FPs and their QHP issuer DE entities.

<sup>152</sup> 45 CFR 155.221(b)(1) and (i).

that chooses to implement a DE program, as well as burden on a State Exchange from having to develop different requirements than what HHS has already found to be beneficial and effective for FFE and SBE-FP States. We recognize that elsewhere in this rulemaking, we have built in more operational flexibility for State Exchanges to tailor certain aspects of their programs or oversight processes to best suit their operational and business needs (for instance, the operational readiness review requirements for web-brokers and DE entities in States with State Exchanges). In this case, however, we believe that the benefits to consumers of uniformly applying the plan display and marketing requirements in § 155.221(b)(1) and (3) to ensure they apply to all Exchanges as minimum standards outweigh the potential drawbacks of reducing discretion and flexibility to State Exchanges with respect to modifying these baseline requirements. We solicit comments on whether State Exchanges should instead be provided with broader discretion and flexibility to establish their own plan display and marketing requirements tailored to their consumers or local needs.

In new proposed paragraph (j), we also propose to extend the existing standardized disclaimer requirement in § 155.221(b)(2) to apply to DE entities participating in States with State Exchanges and consequently to these State Exchanges. Pursuant to § 155.221(b)(2) and (i), DE entities in FFE and SBE-FP States are required to prominently display a standardized disclaimer in the form and manner provided by HHS.<sup>153</sup> This disclaimer is separate from the Enrollment Support and General non-FFE standardized disclaimers under § 155.220(c)(3)(i)(A) and (G), respectively, that web-brokers are required to display when their non-Exchange websites are used to complete a QHP selection or complete the Exchange eligibility application.<sup>154</sup> The standardized disclaimer required under § 155.221(b)(2) instead is intended to help consumers understand the difference between QHPs and non-QHPs, and that financial assistance is only available for QHPs. Under this proposal, DE entities in State Exchanges, and DE entities in FFEs and SBE-FPs under existing § 155.221(b)(2), would also be required to prominently display a standardized disclaimer that

similarly informs consumers about the differences between QHPs and non-QHPs, and that financial assistance is only available for QHPs. Its purpose is to assist consumers in distinguishing between DE entity website pages that display QHPs and those that display non-QHPs, and for which products APTC and CSRs are available. Consistent with the current practice for the other standardized disclaimers provided by HHS under §§ 155.220 and 156.1230, we will provide further details on the text and other display details for the standardized disclaimer in technical guidance.

This proposal requires that the disclaimer must be displayed prominently on a DE entity's website in State Exchanges, and in FFEs and SBE-FPs under existing § 155.221(b)(2), when a consumer navigates away from any website page that markets or displays QHPs offered through the Exchange (that is, on-Exchange QHPs) to any website page that markets or displays QHPs offered outside the Exchange (that is, off-Exchange QHPs) or non-QHPs. DE entities would be required to display this disclaimer on its own interstitial website page or on a pop-up window.

We propose in paragraph (j)(1) to provide State Exchanges with flexibility regarding the standardized disclaimer language that would be required to be displayed by their DE entities, provided that the additional language does not conflict with the HHS-provided standardized disclaimer. This proposed flexibility is similar to the proposed flexibility for State Exchanges to modify the web-broker Enrollment Support and General non-FFE standardized disclaimers under § 155.220(c)(3)(i)(A) and (G) described above, such that the HHS-provided language for the standardized disclaimer under § 155.221(b)(2) must be used as a minimum starting point, but State Exchanges may add State-specific information to the disclaimers, provided the additional language does not conflict with the HHS-provided standardized disclaimer. This would permit State Exchanges to replace references to the Exchange or Marketplace with the appropriate reference to the State-specific Exchange name. State Exchanges may also require web-brokers and QHP issuers operating as DE entities in their States to translate the disclaimer text into languages appropriate for the States as this type of additional requirement would not conflict with the HHS-provided disclaimer language or minimum standards. As with all informational materials, standard plain language

practice is to write at or near a fourth grade reading level and not to exceed an eighth grade reading level. We expect that any State-specific additions or customizations to this disclaimer would be written accordingly. We would be available to provide technical assistance to State Exchanges that want to add State-specific language to the standardized disclaimer under § 155.221(b)(2). In using HHS-provided disclaimer language as a minimum starting point, DE entities in State Exchanges would be required to display a disclaimer that provides information to assist consumers in distinguishing between DE entity website pages that display QHPs and those that display non-QHPs and for which products APTC and CSRs are available, all during a single shopping experience for consumers.

We believe establishing the HHS language as a minimum standard for the standardized disclaimer under § 155.221(b)(2) that DE entities must display across all Exchanges would provide a necessary baseline, and meeting these standards would ensure consumers and applicants are receiving sufficient information to help consumers distinguish between DE entity website pages displaying QHPs versus pages displaying non-QHPs and provide general uniformity among the different Exchange models when enrollment or enrollment information is provided outside of the Exchange through a DE entity's non-Exchange website.

Similar to the proposed requirement to extend operational readiness requirements to web-brokers in States with State Exchanges, we also propose to extend operational readiness requirements to DE entities in State Exchanges and consequently to these State Exchanges. DE entities that participate in FFE and SBE-FP States are required, pursuant to § 155.221(b)(4) and (i), to demonstrate to HHS operational readiness and compliance with applicable requirements prior to the DE entity's non-Exchange website being used to complete an Exchange eligibility application or a QHP selection. In new paragraph (j)(2), we propose to extend DE entity operational readiness requirements to State Exchanges. Under this proposal, DE entities participating in State Exchanges would be required to demonstrate operational readiness and compliance with applicable requirements to the State Exchange prior to the DE entity's website being used to complete an Exchange eligibility application or a QHP selection. We also propose in new paragraph (j)(2) to require these State

<sup>153</sup> See 84 FR 17523.

<sup>154</sup> As detailed above, we propose to extend the Enrollment Support and General non-FFE standardized disclaimers to State Exchanges and web-brokers participating in those State Exchanges.

Exchanges to establish the form and manner for their DE entities to demonstrate operational readiness and compliance with applicable requirements, which may include submission or completion of the same items business audit documentation or security and privacy audit documentation in § 155.221(b)(4)(i) and (ii) to the State Exchange, in the form and manner specified by the applicable State Exchange. Pursuant to § 155.221(b)(4)(i) and (ii), HHS may request a DE entity submit a number of documents to demonstrate compliance with applicable requirements, as well as the operational readiness of its non-Exchange website. The required documentation may include privacy questionnaires, privacy policy statements, and terms of services, business audit reports, interconnection security agreements, security and privacy controls assessment and plans, security and privacy assessment reports, plans of action and milestones, privacy impact assessments, system security and privacy plans, incident response plans, and vulnerability scan results. We propose to codify these documentation standards in new paragraphs (j)(2)(i) and (ii) as illustrative examples of the type of requirements that we encourage State Exchanges that choose to implement a DE program to adopt as part of their operational readiness and compliance reviews of DE entities non-Exchange websites.

This proposal would require DE entities participating in State Exchanges to meet operational readiness requirements established by the State Exchanges, and State Exchanges would have the flexibility to decide which particular operational readiness requirements to implement to support their respective DE programs, potentially leveraging the items in § 155.220(b)(4)(i) and (ii) as the starting point for their operational readiness reviews. Similar to the web-broker operational readiness reviews under § 155.220(c)(6), the standards under § 155.221(b)(4) governing the HHS operational readiness reviews of DE entity non-Exchange websites are also a critical part of the oversight framework for HHS' DE program (including both Classic DE and EDE) available in the FFEs and SBE-FPs. These standards as they apply to DE entities participating in FFE and SBE-FP States help ensure operational readiness and compliance with applicable requirements prior to the DE entity's non-Exchange website being used to complete Exchange eligibility application or a QHP selection and help ensure consumers

would not be able to enroll via a DE entity's website that is not operationally ready. Websites that have not been tested to see if they are operationally ready may not provide consumers with proper eligibility determinations or may have security flaws that could make a breach involving consumer PII more likely. Mandating DE entities that participate in State Exchanges meet minimum standards set by the State Exchanges for operational readiness would help reduce this risk in all Exchanges.

We recognize that some State Exchanges that choose to implement a DE program may seek to utilize DE entities already participating in DE in the FFEs or SBE-FPs. We specifically encourage those State Exchanges to consider adopting the same operational readiness requirements established by HHS, including the third-party auditor framework adopted by HHS pursuant to § 155.221(f) and (g), as well as accept HHS' review of those third-party audits and determinations made as to the DE entities' operational readiness without conducting additional review, unless there are other unique State specific requirements that warrant further targeted review. This approach would permit DE entities to also participate in State Exchanges when HHS determined that those DE entities demonstrated operational readiness and compliance with applicable requirements as they apply to FFE and SBE-FP States would minimize burden of the operational readiness reviews on the State Exchanges and on their DE entities. For example, if the DE entity is using the single streamlined application described in § 155.405 and has already been approved to participate in the FFEs or SBE-FPs, we encourage State Exchanges to accept HHS' review of and determinations made as to the DE entity's audit documentation without conducting further review to confirm compliance with the Federal minimum standards. However, we also recognize that it is important to provide these State Exchanges with flexibility to adopt their own operational readiness requirements in a manner that is tailored to best meet the operational and business needs of the State Exchanges since State Exchanges are best positioned to make that judgement. We therefore encourage, but do not propose to require, these State Exchanges to adopt the same operational readiness requirements and third-party auditor framework that HHS adopted under § 155.221(b)(4), (f) and (g) for DE entities assisting FFE and SBE-FP consumers.

We encourage State Exchanges that choose to implement a DE program to

consider requiring their DE entities to engage a third-party auditor, consistent with standards adopted by HHS at § 155.221(f) and (g) that apply in FFE and SBE-FP States, to perform the operational readiness reviews, for example, to provide an unbiased confirmation that the DE entities are able to appropriately conduct eligibility determinations. However, we do not propose to mandate these State Exchanges require their DE entities to perform such third-party audits as we recognize that State Exchanges may want to adopt their own mechanisms or impose State-specific requirements to confirm DE entity operational readiness and compliance with applicable requirements (which may include additional State-specific standards), and we want to ensure State Exchanges have the flexibility to establish operational readiness review requirements that are tailored to support their respective DE programs. For example, as noted above, if the State Exchange uses an alternative to the single streamlined application described in § 155.405, we would not recommend leveraging HHS' eligibility application audit under § 155.221(b)(4)(iii), as the HHS audit results may not be applicable to the State Exchange's alternative eligibility applications. However, if the State Exchange requires the use of the single streamlined application described in § 155.405, for DE entities that have already been approved to participate in the FFEs or SBE-FPs, we would encourage the State Exchange to use the same third-party auditor framework and requirements that HHS adopted for FFE and SBE-FP States, as well as accept HHS' review of the third-party audits and determinations made as to the DE entity's operational readiness and compliance with applicable requirements without conducting further review, unless there are other unique State specific requirements that warrant further targeted review.

As State Exchanges establish DE programs, it may be in their interest to permit a DE entity to provide consumers with access to DE entity application assisters, as defined at § 155.20, to provide assistance with applying for a determination or redetermination of eligibility for individual market coverage through the Exchange and insurance affordability programs. As such, in new proposed paragraph (j), we propose to also extend § 155.221(d) to State Exchanges and their DE entities to allow DE entity application assisters, when permitted by the applicable State Exchange and only to the extent permitted by applicable State law, to

assist individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the Exchange and for insurance affordability programs, provided that such DE entities ensure that each of its DE entity application assisters meets the requirements in § 155.415(b). Section 155.415(b) establishes minimum standards for QHP issuer and DE entity application assisters regarding required training on QHP options and insurance affordability programs, eligibility, and benefits rules and regulations at paragraph (b)(1), compliance with the Exchange's privacy and security standards at paragraph (b)(2), and compliance with applicable State laws related to the sale, solicitation and negotiation of insurance products; licensure; confidentiality and conflict of interest at paragraph (b)(3). Although § 155.415(b) is generally applicable to all Exchanges, paragraph (b)(1) establishes required training on QHP options and insurance affordability programs, eligibility, and benefits rules and regulations with respect to providing assistance in the FFEs or SBE-FPs. As proposed to be applied in State Exchanges, DE entities and their application assisters would be required at new paragraph (j) to complete appropriate State-required training and registration in a manner specified by the State Exchange consistent with § 155.415(b)(1), which should similarly include training on QHP options and insurance affordability programs, eligibility, and benefits rules and regulations as training on this content is necessary to ensure consumers are provided with vital information about these topics if DE entities and their application assisters would be permitted to assist consumers with QHP shopping and DE in coverage offered through State Exchanges.

In addition, under this proposal, to meet the requirements of § 155.415(b)(2) and (3), DE entities that participate in a State Exchange and want to use DE entity application assisters would be required to coordinate with the State Exchange and appropriate State agencies to ensure they are meeting the Exchange privacy and security standards at § 155.260 consistent with § 155.415(b)(2), as well as complying with State law related to the sale, solicitation, and negotiations of health insurance products consistent with § 155.415(b)(3).

As part of their establishment of DE programs, we also encourage the State Exchange to adopt an immediate suspension framework, similar to § 155.221(e) that applies in FFE and

SBE-FP States, that provides for the immediate suspension of a DE entity's ability to transact information with the State Exchange if the State Exchange discovers circumstances that pose unacceptable risk to the accuracy of the State Exchange's eligibility determinations, operations, or information-technology systems until the incident or breach is remedied or sufficiently mitigated to the State Exchange's satisfaction. This provision is an important feature of HHS' oversight of the use of DE entity non-Exchange websites in FFE and SBE-FP States that protects consumers data and safeguards Exchange operations and systems. State Exchanges that choose to establish a DE program and permit DE entities to use non-Exchange websites to assist consumers with QHP selections and submission of Exchange eligibility applications should consider adoption of similar measures.

Finally, at new proposed § 155.221(j)(3), we propose to extend the new proposed requirement that would be applicable in FFE and SBE-FP States to mandate *HealthCare.gov* changes be reflected on DE entity websites in a manner consistent with that adopted for display on *HealthCare.gov* within a notice period set by HHS by conforming with display changes defined and communicated as standards by HHS, at new proposed § 155.221(b)(6), to apply to DE entities operating in State Exchanges and consequently to these State Exchanges. As reflected in the last clause of new proposed § 155.221(j)(3), for the purposes of extending this requirement to DE entities operating in the State Exchanges, references to an FFE website would be understood to mean the State Exchange website and references to HHS would be understood to mean the State Exchange. Refer to the discussion in the proposal for new § 155.221(b)(6) for additional details on how State Exchanges would implement the extension of this proposal to their DE entities.

We seek comment on these proposals, especially from States operating, or seeking to operate, State Exchanges. We are particularly interested in comments regarding which of the other current Federal standards at § 155.221 should or should not apply to State Exchanges that choose to implement a DE program.

#### 10. Failure To Reconcile (FTR) Process (§ 155.305(f)(4))

We are proposing in connection with the FTR process described in § 155.305(f)(4), to require all Exchanges, including State Exchanges, to send notices to tax filers for the first year in which they failed to reconcile APTC

starting in PY 2025 as an initial warning to inform and educate tax filers that they need to file and reconcile or risk being determined ineligible for APTC if they fail to file and reconcile for a second consecutive year. As part of the 2024 Payment Notice (88 FR 25814 through 25816), we changed the FTR process such that an Exchange may only determine enrollees ineligible for APTC after a tax filer (or a tax filer's spouse, if married) has failed to file a Federal income tax return and reconcile their past APTC for two consecutive years (specifically, years for which tax data will be utilized for verification of household income and family size). However, in that rule, we did not impose a requirement for Exchanges to notify enrollees during the first year that the applicable tax filer failed to file and reconcile.

We are proposing to require that all Exchanges be required to send informative notices at least annually to tax filers who have failed to file and reconcile. Since Exchanges are prohibited from sending protected Federal tax information (FTI) to an individual who may not be the tax filer, only the FTR Open Enrollment notices sent *directly* to the tax filer may directly state that the IRS data indicates the tax filer failed to file and reconcile, consistent with standards applicable to the protection of FTI. An Exchange may not always be able to send FTR Open Enrollment notices directly to the tax filer because Exchange notices are sent to the household contact or subscriber on the household's Exchange account or insurance policy, and this person is not necessarily the tax filer. Therefore, to comply with the prohibition on sending FTI (including information about failing to file and reconcile) in cases where the household contact is not the tax filer, the Exchange may send notices that contain broad, general language regarding FTR referred to as "combined notices." For example, an Exchange can send the same Exchange Open Enrollment Notice to multiple groups of consumers at risk for APTC discontinuation in the upcoming coverage year such as those flagged as FTR, those for whom the Exchange has received updated income information that suggests the consumers may have income too high to qualify for APTC, and those who did not permit the Exchange to check IRS data. Because the combined notices apply and are sent to some consumers who are currently unaffected by FTR, and not exclusively to individuals who are affected by FTR, these notices are generally not considered FTI under IRS rules may be

sent using the standard notice functionality.

As background, Exchange enrollees whose tax filer fails to comply with current § 155.305(f)(4) are referred to as having failed to “file and reconcile.” These individuals are referred to as having FTR status, and the Exchanges conduct the FTR process to identify such individuals. In the 2024 Payment Notice (88 FR 25814 through 25816), we finalized a new process for Exchanges to conduct FTR to address concerns that the pre-existing FTR process requiring Exchanges to determine an enrollee ineligible for APTC after one year of having an FTR status could be overly punitive. Under the previous policy, enrollees occasionally had their APTC ended due to delayed data processing, in which case their only remedy was to appeal to get their APTC reinstated. Enrollees or their tax filers also may have been confused by or received inadequate education on the requirement to file and reconcile. HHS’ and the State Exchanges’ experiences with running FTR operations showed that Exchange enrollees often do not understand the requirement that their tax filer must file a Federal income tax return and reconcile their APTC or that they must also submit IRS Form 8962 to properly reconcile their APTC, even though both the single, streamlined application used by Exchanges on the Federal platform and the QHP enrollment process require a consumer to attest to understanding the requirement to file and reconcile. Note, the updated policy in the 2024 Payment Notice does not relieve tax filers from their requirement to reconcile each year nor any potential tax liability. By making these changes to the FTR processes in the 2024 Payment Notice and requiring Exchanges to determine an enrollee ineligible for APTC only after having an FTR status for two consecutive years (specifically, years for which tax data will be utilized for verification of household income and family size), Exchanges now have more opportunity to conduct outreach to tax filers for whom data indicate they have failed to file and reconcile and to prevent erroneous terminations of APTC, as well as to provide access to APTC for an additional year even when APTC would have been correctly terminated under the original FTR process.

There are limitations to these notices; notices that are sent directly to the tax filers and explicitly describe their FTR status must be compliant with IRS requirements for disclosing FTI, which can be a complex process and untenable with some Exchanges’ infrastructure.

Alternatively, combined notices, which do not contain FTI, have limitations in that they do not explicitly inform the recipients that they are at risk of losing APTC due to the household tax filer being found to have failed to file and reconcile. However, both types of notices will create an opportunity for State Exchanges to educate enrollees or their tax filers on the requirement to reconcile their PTC. This will address the consumer confusion and knowledge gaps that were identified by both HHS and State Exchanges, which were key considerations in making the changes to the FTR process described in the 2024 Payment Notice, wherein tax filers now must be identified as FTR for two years prior to having their APTC removed. With this additional year for tax filers to correct their FTR status, consumers will be better able to take appropriate action prior to losing their APTC and file and reconcile in response to these notices.

Under this proposal, Exchanges on the Federal platform would continue to send notices to tax filers for the year in which they have failed to reconcile APTC as an initial warning to inform and educate consumers that they need to file and reconcile, or risk being determined ineligible for APTC if they fail to file and reconcile for a second consecutive tax year. Our proposal to codify this practice and require it of all Exchanges, including the State Exchanges, would ensure that tax filers who have been determined to have FTR status for one year are adequately educated on the file and reconcile requirement, and have ample opportunity to address the issue and file and reconcile their APTC before they are determined to have FTR status for two consecutive years. This proposal would support compliance with the filing and reconciling requirement under section 36B(f) of the Code and its implementing regulations at 26 CFR 1.36B–4(a)(1)(i) and (a)(1)(ii)(A), minimize the potential for APTC recipients to incur large tax liabilities over time, and support eligible enrollees’ continuous enrollment in Exchange coverage with APTC by avoiding situations where enrollees become uninsured when their APTC is terminated. Additionally, this proposal would better align State Exchanges’ Failure to Reconcile processes with that of the Exchanges on the Federal platform.

We seek comment on this proposal.

#### 11. Verification Process Related to Eligibility for Enrollment in a QHP Through the Exchange (§ 155.315(e))

We are proposing to amend § 155.315(e) by revising paragraph (e)(1)

to permit all Exchanges to accept an applicant’s attestation of incarceration status and paragraph (e)(2) to allow Exchanges to electronically verify a consumer’s current incarceration status using an HHS-approved verification data source. We are also proposing to amend the reference in paragraph (e)(3) to reflect that if an Exchange verifies an applicant’s attestation of incarceration status using an approved data source and the attestation is not reasonably compatible with the information provided from the said data source or other information provided by the applicant or in the records of the Exchange, then the Exchange must follow the data matching issue (DMI) process set forth in § 155.315(f). If this proposed policy is finalized, Exchanges using the Federal eligibility and enrollment platform, including SBE-FPs, that currently use the incarceration verification data source offered through the Federal Data Services Hub (the “Hub”) would be able to accept consumer attestation of incarceration status without further verification of incarceration status.

As background, section 1312(f)(1)(B) of the ACA states that an individual shall not be treated as a qualified individual for enrollment in a QHP if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges. Sections 155.315(e) and (e)(1) currently state that Exchanges must verify incarceration status with a data source approved by HHS and deemed accurate, current, and offering less administrative complexity than paper verification. When an individual’s incarceration attestation conflicts with information from an approved data source or other information provided by the applicant or in the records of the Exchange, § 155.315(e)(3) requires Exchanges to create a DMI as outlined in § 155.315(f). However, if an approved data source is unavailable, an Exchange may accept attestation of incarceration without further verification under § 155.315(e)(2).

Under proposed paragraphs (e)(1) and (2), an Exchange would be able to accept a consumer’s attestation of incarceration status or propose an electronic data source for incarceration verification to HHS for approval and use that approved source to verify incarceration status. Should a State Exchange choose to propose use of an alternative electronic data source for verifying incarceration status, HHS would review such proposals in accordance with the process under § 155.315(h), through which HHS would make a determination based on the proposed



use of the alternative data source and whether it minimizes administrative costs and burdens on individuals while it maintains accuracy and minimizes delay. Proposed paragraph (e)(3) would provide that if an Exchange verifies an applicant's attestation of incarceration status using an approved data source as provided under proposed paragraph (e)(2), to the extent that the applicant's attestation is not reasonably compatible with information from the approved data source or other information provided by the applicant or in the records of the Exchange, the Exchange would be required to follow the DMI procedures at § 155.315(f).

In the Exchange Establishment Rule (77 FR 18362), we recognized that there may be challenges in the availability of electronic incarceration verification data but believed that so long as an incarceration verification data source existed that has been approved by HHS, it should be used to verify incarceration status. We also recognized that requesting consumer attestation of incarceration status and accepting such attestation without further verification when an accurate data source was unavailable is necessary since incarceration status is a statutory standard for eligibility to enroll in a QHP.

Exchanges using the Federal eligibility and enrollment platform, including SBE-FPs, currently verify whether an applicant is incarcerated through the Hub by using the Social Security Administration's (SSA) Prisoner Update Processing System (PUPS). PUPS is currently maintained by SSA and is the only national database that reflects information from Federal, State, and local correctional records. Our experience administering the Federal eligibility and enrollment platform, along with the experience from the State Exchanges that have used the PUPS data, have demonstrated that verifying incarceration data using PUPS has resulted in a high number of DMIs, few of which identify QHP applicants who are incarcerated. For example, we conducted an internal study and found that out of 110,802 incarceration DMIs generated between PYs 2018 to 2019, 96.5 percent of them were resolved in favor of the applicant. More importantly of those 3,878 applicants whose DMIs were not resolved in their favor (3.5 percent of 110,802), we found that only a total of 2,469 applied for QHP coverage during PYs 2018 and 2019. Of these 2,469 ineligible applicants, 950 applicants were released from either prison or jail within 90 days after the application submission date. Excluding these individuals leaves 1,519 QHP-

ineligible individuals, of which 921 applicants effectuated coverage (that is, made the binder payment), which is allowed while awaiting DMI clearance, thus resulting in an improper APTC payment. An average annual APTC per individual of \$1,569 was estimated for the 921 QHP ineligible applicants with effectuated policies.<sup>155</sup> This yields potential improper payments of approximately \$361,262.25 over 3 months. Because only a very small number of incarcerated individuals apply to enroll in QHPs, verifying incarceration status using PUPS and conducting the DMI process outlined at § 155.315(f) results in Exchanges saving only a fraction of improper overpayment of APTC, and those savings are dwarfed by the administrative costs imposed by using PUPS and conducting the DMI process.

We conducted a cost-benefit assessment and determined that the cost to verify incarceration status electronically far exceeds potential savings. Should the Exchange conduct an electronic incarceration verification check, such as a verification check of a consumer's attestation using PUPS data, it would cost more than \$4 million to operate yearly, along with a one-time implementation startup cost of approximately \$200,000. Furthermore, connecting to an alternative incarceration data source, such as PUPS, and conducting the DMI process outlined at § 155.315(f) can be very costly to Exchanges. In PY 2019, nearly 38,000 out of 78,000 applicants with an incarceration DMI submitted documents to attempt to resolve the incarceration DMI. To process DMIs, the Exchange incurs costs for the eligibility-verification contractor on a fixed-price basis totaling about \$0.57 million per year for verification of incarceration. This figure does not include other costs related to sending notices to consumers, processing appeals, and handling call center transactions. Our 2019 study concluded that those who receive an incarceration DMI are statistically likely to be eligible to enroll in a QHP as the

<sup>155</sup> This per-person per-year estimate was calculated by multiplying the monthly APTC benefit that each ineligible and effectuated applicant was estimated to receive in their FFE application by the maximum number of months the applicant could have been enrolled in a QHP while still incarcerated and pending DMI clearance. For open enrollment applications, an enrollment start date of January 1 was used (45 CFR 155.410). For special enrollment period applicants, the previous coverage effective date rules were used where if the applicant applied between the 1st and 15th of the month, an enrollment start date of the 1st of the following month was used. If the applicant applied after the 16th of the month, an enrollment start date of the 1st of the month 2 months following the application month was used. 45 CFR 155.420.

applicants were released from either prison or jail within 90 days after the application submission date. However, an unresolved incarcerated DMI can result in a complete loss of coverage.

The processes of notifying consumers of their DMIs and resolving them have been burdensome and has negatively impacted the consumer experience. When an incarceration DMI is generated, applicants are required to provide documentation to show that they are no longer incarcerated.<sup>156</sup> This creates a significant enrollment burden for formerly incarcerated individuals, a population comprised of a significant number of people with disabilities.<sup>157</sup> Many documents that can prove incarceration status cannot be obtained without an unexpired proof of identity document, and most cannot be obtained without submitting non-refundable payments. Incarceration may inhibit one's financial savings, and formerly incarcerated individuals are less likely to secure employment.<sup>158</sup>

These findings support our beliefs that incarcerated individuals apply for QHP coverage at very low rates, and that their applications are considered to be a very low program integrity risk for Exchanges, which do not warrant always conducting an extensive incarceration verification check. We also believe that previous guidance to conduct incarceration status verification<sup>159</sup> may have contributed to inequity in the Exchange population, as Black adults were imprisoned at five times the rate for White adults<sup>160</sup> and are more likely to face systemic obstacles hindering their ability to secure employment post incarceration.<sup>161</sup>

Given these concerns, we propose to amend § 155.315(e) by revising

<sup>156</sup> *HealthCare.gov*. (n.d.) How do I resolve a Data Matching Issue. Dept. of Health and Human Services. <https://www.healthcare.gov/help/how-do-i-resolve-an-inconsistency/#incarceration-status>.

<sup>157</sup> Apel, R., and Sweeten, G. (2010, Aug. 1). The Impact of Incarceration on Employment during the Transition to Adulthood. *Social Problems*, 57(3), 448–479. <https://doi.org/10.1525/sp.2010.57.3.448>.

<sup>158</sup> *Id.*

<sup>159</sup> 45 CFR 155.315(e).

<sup>160</sup> Nellis, A. (2021). *The Color of Justice: Racial and Ethnic Disparity in State Prisons*. The Sentencing Project. <https://www.sentencingproject.org/app/uploads/2022/08/The-Color-of-Justice-Racial-and-Ethnic-Disparity-in-State-Prisons.pdf>; Sabol, W.J., and Johnson, T.L. (2022). *Justice System Disparities: Black-White National Imprisonment Trends, 2000 to 2020*. Council on Criminal Justice. <https://secure.counciloncj.org/np/viewDocument?>

<sup>161</sup> Sirios, C., and Western, B. (2017, Feb.). *Racial Inequality in Employment and Earnings after Incarceration*. Harvard University. [https://scholar.harvard.edu/files/brucewestern/files/racial\\_inequality\\_in\\_employment\\_and\\_earnings\\_after\\_incarceration.pdf](https://scholar.harvard.edu/files/brucewestern/files/racial_inequality_in_employment_and_earnings_after_incarceration.pdf).



paragraph (e)(1) to permit all Exchanges to accept consumer attestation of incarceration status without further electronic verification. We also propose to revise paragraph (e)(2) to permit Exchanges to verify consumer incarceration status using an HHS-approved verification data source that is current, accurate, and minimizes administrative costs and burdens. We believe these proposed changes would improve the Exchange enrollment process, reduce operational challenges for Exchanges, and reduce burdens on applicants, all while maintaining program integrity and ensuring that the alternative incarceration verification data source that may be used by Exchanges is not unduly burdensome or costly to administer.

We also propose changes to paragraph (e)(3) to reflect that if an Exchange verifies an applicant's attestation of incarceration status using an approved data source, and the attestation is not reasonably compatible with the information from the approved data source or other information provided by the applicant or in the records of the Exchange, the Exchange must then follow the DMI process set forth in § 155.315(f).

We seek comment on this proposal, particularly from State Exchanges and other users of PUPS data through the Hub. We are also particularly interested in comments about whether State Exchanges intend to continue using PUPS data to verify incarceration status. We are also seeking input from any State Medicaid agency that uses PUPS data available through the Hub.

## 12. Verification Process Related to Eligibility for Insurance Affordability Programs (§ 155.320)

We propose to reinterpret State Exchange and State Medicaid and Children's Health Insurance Program (CHIP) agency use of the Federal Data Services Hub (Hub) to access and use the income data provided by the optional Verify Current Income (VCI) Hub service as a State Exchange or a State Medicaid and CHIP agency function, because these State entities use this optional service to implement eligibility verification requirements applicable to them. While we propose to redesignate use of the VCI Hub service by State Exchanges and State Medicaid and CHIP agencies as a State function, HHS would continue to maintain contracts that make this service available through the Hub for State Exchange and State Medicaid and CHIP agency use as part of its ongoing implementation of sections 1411 and 1413 of the ACA. We propose to amend

§ 155.320(c) to reflect this reinterpretation for the Exchanges. Under this proposal, States would pay annually in advance for the State Exchanges and Medicaid and CHIP agencies' anticipated utilization of the optional VCI Hub service. State Exchanges and Medicaid and CHIP agencies would be required to reconcile with HHS on an annual basis the anticipated utilization of CSI data provided by the VCI Hub service with the actual utilization. In the alternative, HHS would invoice States on a monthly basis for their actual utilization of CSI data provided by the VCI Hub service after that utilization occurs. State Medicaid and CHIP agencies would be eligible for Federal matching for the cost of this service, as described in this section.

To operationalize application and verification processes related to eligibility for health insurance affordability programs and to make eligibility determinations as accurate as possible, in accordance with sections 1411 and 1413 of the ACA, we developed the Hub, which is a secure, electronic interface that facilitates the exchange of information used by Exchanges and State Medicaid and CHIP agencies and provides access to authoritative, trusted data sources for various types of information, including income. The Hub serves as the mechanism described in 45 CFR 155.315 and 155.320 that Exchanges are required to use to perform eligibility verifications by transmitting applicant data to HHS, which then submits the data to specific trusted data sources for verification. For State Medicaid and CHIP agencies, the Hub serves as a mechanism for accessing both required and optional trusted data sources to verify eligibility at application or renewal as described at 42 CFR 435.949 and 42 CFR 457.380(g). These trusted data sources include Federal agencies, such as the IRS for Federal income tax data and the SSA for Social Security benefits.

For example, the ACA requires that Exchanges and State Medicaid and CHIP agencies use data from the SSA to verify applicants' U.S. Citizenship, Social Security number (SSN), and Social Security Disability Insurance (SSDI) income, if any, and data from the Department of Homeland Security to verify applicants' naturalized citizenship or immigration status, both available through the Hub. In addition to mandatory data to verify eligibility, Exchanges and State Medicaid and CHIP agencies may also use optional data available through the Hub, including Medicare enrollment data to verify an

applicant's eligibility for minimum essential coverage, and the VCI Hub service, which provides an access point for Exchanges and State Medicaid and CHIP agencies to request and receive an applicant's current income data from a private company, referred to as Current Sources of Income (CSI) data. Consistent with the requirements at sections 1411 and 1413 of the ACA (related to establishment and participation in a coordinated eligibility and enrollment system for all insurance affordability programs), in order to facilitate Exchange and State Medicaid and CHIP agency access to optional data, HHS will continue to provide free access to States for certain optional data, such as Medicare enrollment data, and will provide access to the CSI data to States that pay for their use of it in advance. However, we propose to re-interpret Exchange and State Medicaid and CHIP agency use of the Hub to access the optional data sources as an Exchange or a State Medicaid and CHIP agency function. We propose to amend § 155.320(c) to reflect this reinterpretation.

As additional background, the ACA requires the use of a single, streamlined application to determine Exchange eligibility and collect information.<sup>162</sup> The application is used to determine eligibility for enrollment in a QHP, and, as applicable, for insurance affordability programs such as APTC, CSR, Medicaid, CHIP, and, if applicable, the BHP. Eligibility for these programs is determined using an income standard based on an applicant's modified adjusted gross income (MAGI) and the process for verifying income depends on the insurance affordability program.<sup>163</sup> The income verification process that an Exchange uses to verify income depends on whether an applicant is being evaluated for eligibility for APTC and CSRs for a QHP or eligibility for Medicaid, CHIP, or the BHP. For example, Medicaid eligibility is determined using "point-in-time" income, or current monthly income, while eligibility for APTC and CSRs is determined using projected annual income.<sup>164</sup> An Exchange must follow a verification process for household income that includes requesting data

<sup>162</sup> See 42 U.S.C. 18083 and 45 CFR 155.405(a).

<sup>163</sup> Section 1902(e)(14)(A) of the Act requires that States determine financial eligibility for Medicaid based on MAGI except in the case of individuals identified in section 1902(e)(14)(D) of the Act. For example, States do not determine financial eligibility based on MAGI for individuals who are being evaluated for eligibility on the basis of living with a disability or blindness or being age 65 or older.

<sup>164</sup> See section 1902(e)(14)(H) of the Act, as added by section 2002 of the ACA.

through the Hub to verify income<sup>165</sup> using IRS and SSA income data.<sup>166</sup>

For these applications, regulations require that for any individual in the applicant's or enrollee's tax household (and for whom the Exchange has a SSN), the Exchange must request Federal income tax return data regarding income and family size from the IRS as well as data from SSA regarding Social Security Benefits.<sup>167</sup> When the Exchange requests tax return data from the IRS and the data indicates that attested projected annual household income represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the Exchange must determine eligibility for APTC and CSRs based on the IRS income tax data.<sup>168</sup> However, when the Exchange requests income tax return data from the IRS and the IRS returns data reflecting that the attested projected annual household income is not an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the applicant or enrollee is considered to have experienced a change in circumstances. This change in circumstance allows HHS to establish procedures for determining eligibility for APTC and CSRs on information other than the IRS income tax return data as described in § 155.320(c)(3)(iii)–(vi).<sup>169</sup>

In these situations, where government sources of income are unavailable, or the applicant(s)' attested income is significantly different from what the IRS returns, data on current income may be used for eligibility determinations and redeterminations for financial assistance, including the CSI data that HHS makes available to Exchanges and State Medicaid and CHIP agencies via the optional VCI Hub service. HHS holds a contract with a private, commercial company to provide the CSI data through the VCI Hub service. Exchanges and State Medicaid and CHIP agencies have been able to use the VCI Hub service as an optional secondary, trusted data source for income verification but are not required to do so and may use other data sources. The VCI Hub service provides current income data that is sourced from employer-reported income and job status data that is provided and updated for each employer payroll period (that

is, weekly, bi-weekly, monthly, etc.). Under § 155.315(h), State Exchanges may seek HHS approval to use other sources of additional income data for verification of applicant-attested annual household income.

For Medicaid and CHIP, section 2201 of the ACA, codified at section 1943 of the Act, requires State Medicaid and CHIP agencies to participate in and comply with the eligibility and enrollment system requirements under section 1413 of the ACA. This requires State Medicaid and CHIP agencies to use a single streamlined application and rely primarily on electronic data to verify income and other eligibility criteria. The ACA and the Act specify several data sources that State Medicaid and CHIP agencies must use in verifying eligibility. These agencies may also elect to use other optional electronic data sources to improve the efficiency and accuracy of the eligibility determination process. They may use the VCI Hub service for initial applications, redeterminations, changes in circumstance, and periodic data matching for their Medicaid and CHIP populations. State Medicaid agencies are required by 42 CFR 435.948(a) to verify financial eligibility with certain financial data sources. If a State does not accept self-attestation of income in determining eligibility for a separate CHIP, it similarly must verify financial eligibility with certain data sources in accordance with 42 CFR 435.948(a), which is incorporated into the CHIP regulations by cross reference at 42 CFR 457.380. CSI data is not among the data sources which State Medicaid agencies are required to access under this requirement. States also are given latitude to determine the usefulness of these data sources and must only access data sources determined to be useful to them. For initial applications and redeterminations for Medicaid or CHIP eligibility, income data accessed through the VCI Hub service provides real time, current income information for States to determine Medicaid or CHIP financial eligibility. Because other financial data sources, such as State quarterly wage data, provide data that is from a quarter to six months old, some States prefer to use the CSI income data available through the VCI Hub service, which is the only data source in the Hub used to verify and redetermine current and annual income outside of the IRS or SSA data, as their primary source of data to verify income prior to accessing other financial data sources. Some States also utilize the VCI Hub service to verify income information when a

beneficiary reports a change in circumstance for financial eligibility.

Under our proposal, Exchanges and State Medicaid and CHIP agencies may opt to continue to use the VCI Hub service to support their eligibility verification processes for Exchange QHP coverage or Medicaid and CHIP if they pay in advance for the cost of their use of the service. For instance, Exchanges would still be able to use this current income information to verify a tax household's annual income attestation if they are unable to verify income using SSA, IRS income tax data, or a combination of both SSA and IRS data, in determining eligibility for APTC. Because Exchanges and State Medicaid and CHIP agencies are permitted, but not required to use the VCI Hub service to fulfill the mandatory eligibility determination requirements imposed on them, accessing the CSI data via the VCI Hub service would be properly characterized as an Exchange or State Medicaid and CHIP agency function.

Consistent with section 1413 of the ACA, HHS would continue to provide access to optional data sources through the Hub to support the streamlined application processes. However, as these functions would be considered Exchange or State Medicaid and CHIP agency functions, and not HHS functions, HHS would no longer fund Exchange or State Medicaid and CHIP agency use of these sources and would only provide access to States who paid in advance for their use of the service. For all but one of the optional data sources available through the Hub, HHS does not bear a cost for Exchange or State Medicaid and CHIP agency use of the various Hub services that provide these data. However, HHS does bear a cost for Exchange and State Medicaid and CHIP agency use of the CSI data accessed through the VCI Hub service. If finalized as proposed, under this interpretation, State Exchanges and State Medicaid and CHIP agencies would be required to pay for their use of the VCI Hub service in advance of their usage of the service. However, where applicable, State costs for State Medicaid and CHIP agencies may be eligible for Federal matching funds, where HHS will match 75 percent of the cost of a State Medicaid agency's utilization of the VCI Hub service and match CHIP costs at a State's enhanced Federal Medical Assistance Percentage (FMAP).

Since the VCI Hub service was established in 2013 for use by both Exchanges and State Medicaid and CHIP agencies, utilization of the VCI Hub service has grown significantly over time, both in the number of State

<sup>165</sup> See § 155.320(c).

<sup>166</sup> See § 155.320(a)(1) and (c)(3)(ii)(B). Section 155.320(c)(2) outlines the verification process that Exchanges are also required to follow when evaluating eligibility for Medicaid or CHIP.

<sup>167</sup> See § 155.320(c)(i)(A).

<sup>168</sup> See § 155.320(c)(3)(ii)(C).

<sup>169</sup> See section 1412(b)(2) of the ACA.

Exchanges and State Medicaid and CHIP agencies using the service, and the number of applicants and beneficiaries that require income verification as Exchange populations have increased over time. During the first Open Enrollment in 2013, only the Exchanges on the Federal platform, two State Exchanges, and eight State Medicaid agencies used data from the VCI Hub service for eligibility determinations. In that first year, the Exchanges on the Federal platform initiated about 88 percent of all requests, or “pings” to the VCI Hub service for income verification. In the past decade, more State Medicaid agencies and State Exchanges have started using the VCI Hub service; as of June 2023, 34 States, including the District of Columbia and Puerto Rico, use the VCI Hub service for their State Medicaid and CHIP programs, and 10 of those States also use the service to verify QHP eligibility for their State Exchanges. Our analysis shows that as of March 2023, over 70 percent of monthly pings to the VCI Hub service were from State Medicaid applications, including renewals of eligibility for Medicaid or CHIP coverage, and the Exchanges on the Federal platform now account for less than 10 percent of the total volume.

If new State Medicaid agencies or State Exchanges are permitted to request access to the VCI Hub service, we forecast that in the next 5 years, transaction volume to the VCI Hub service would increase by over 17 percent. These trends in utilization have provided us with a clear picture of the primary uses and utilizers of the VCI Hub service. Specifically, we have learned that the queries submitted by States to the VCI Hub service have been for income verification by State Medicaid agencies to determine Medicaid and CHIP eligibility, and by State Exchanges to assess or determine Medicaid and CHIP eligibility and determine APTC eligibility. Accordingly, we now believe this activity that has been categorized as an HHS function would be better categorized as: (1) a State Medicaid and CHIP agency eligibility determination function under title XIX or title XXI of the Act when the determination is initiated by a State Medicaid or CHIP agency; and (2) as an Exchange function when the determination is initiated by an Exchange.

While we believe the utilization of this optional data source is an Exchange or State Medicaid and CHIP agency function, making the optional data sources available through the Hub is consistent with the requirements at sections 1411 and 1413 of the ACA

related to establishment and participation in a coordinated eligibility and enrollment system for all insurance affordability programs. As such, to facilitate Exchanges’ and States Medicaid and CHIP agencies’ access to this optional CSI data that is available through the VCI Hub service, HHS would continue to maintain contracts that make access to these resources available through the Hub for Exchange and State Medicaid and CHIP agency use.

In making this proposal, we note that while use of the VCI Hub service is an integral part of the eligibility determination process in most States, Exchanges and State Medicaid and CHIP agencies may have access to other data sources to verify income. As noted previously, we are aware that many States have access to other comprehensive data sources, such as State quarterly wage data. Generally, as dictated by individual State law, employers are required to report employee information such as payroll and unemployment insurance contribution data to a State department, such as the State Department of Labor or a similar office. In place of the optional VCI Hub service, State Exchanges continue to have flexibility under 45 CFR 155.315(h) and 155.320(c)(3)(iv) to use an alternative verification source, like State wage data, when income is not verified using IRS tax data or SSA title II data. We encourage State Exchanges, State Medicaid and CHIP agencies, and other interested parties, to submit comments regarding any operational burden, policy, or budget challenges regarding access to other State data sources of this proposal change.

As part of our consideration of these proposals in this rulemaking, we considered requiring State Medicaid agencies and State Exchanges to obtain their own contracts to administer their CSI data usage; however, we had concerns that these services cannot be procured reasonably and expeditiously, which would undermine the system we have implemented under section 1413 of the ACA. We also believe that there may be benefits to the State Medicaid agencies and State Exchanges that prefer to use the CSI data accessible through the VCI Hub service in their States. Therefore, we propose to retain optional access to the VCI Hub service on behalf of State Medicaid agencies and State Exchanges that prefer to continue to use this service and are willing to pay for their CSI data usage in advance. Under this proposal, State Medicaid agencies and State Exchanges can choose to

discontinue their use of the CSI data accessible through the VCI Hub service.

Given these considerations, we propose to amend 45 CFR 155.320(c)(1) to add new paragraph (c)(1)(iii) to require that beginning July 1, 2024, State Exchanges would be required to pay for 100 percent of their utilization of the CSI income data provided by the VCI Hub service.<sup>170</sup> To implement this proposal, States would be required to pay for their usage of the CSI data in advance of their use of the service in a timeline and manner established by HHS. HHS would use the State’s pre-payment to pay for the State’s access, with the amount of the pre-payment calculated as being equal to the product of the number of projected purchased transactions to be returned from the VCI Hub service, that is, the “number of pings,” and the price per transaction established under the contract maintained by HHS to provide the VCI Hub service. HHS is currently exploring the best mechanism to project States’ usage for their State Exchange’s use of the VCI Hub service. HHS anticipates leveraging lessons learned from its existing financial management processes.

Similarly, we propose to require that beginning July 1, 2024, States pay for their Medicaid and CHIP utilization of the VCI Hub service prior to obtaining information from data sources which these State entities choose, but are not required, to use in fulfilling Medicaid or CHIP eligibility determination requirements. As noted above, consistent with the requirements at section 1413 of the ACA (related to establishment and participation in a coordinated eligibility and enrollment system for all insurance affordability programs), which is incorporated into the Medicaid and CHIP statutes at sections 1943(b)(3) and 2107(e)(1), respectively, of the Act, in order to facilitate States’ access to this optional CSI data that is available through the VCI Hub service, we would continue to maintain contracts that enable States to efficiently access CSI data through the VCI Hub service. However, under our proposal, States would be required to pay the advance cost incurred by HHS when the State requests CSI data through the VCI service offered by the Hub.

In the alternative, HHS is also considering whether it could invoice States on a monthly basis for their actual utilization of CSI data provided by the VCI hub service after that

<sup>170</sup> The FFEs’ and SBE-FPs’ costs for accessing these services would be covered by the FFEs’ and SBE-FPs’ user fees.

utilization occurs. If appropriate, this alternative proposal could be adopted in the final rule. We are considering these mechanisms for implementing State Exchange and Medicaid and CHIP agency payments for use of the VCI Hub service and solicit comments on whether a different implementation approach would be more efficient or otherwise preferable.

To implement this proposal for the States to pay in advance for CSI data services, we would anticipate working with States to develop an estimate of their annual usage of the CSI data service and collecting those amounts from the States. Under this approach, each State would notify HHS that the State wants to continue to use the CSI data through the VCI Hub service and will pay in advance for its usage of services. In particular, HHS would estimate, based on historical utilization trends taking into consideration other reasonable assumptions about the State's usage, the anticipated annual number of each participating State's purchased transactions to the VCI Hub service returning usable CSI data, that is, the number of pings to the VCI Hub service returning usable CSI data. The estimate for each participating State would be multiplied by the fixed price set by the CSI contract HHS holds with its vendor. HHS would collect that amount from the State, which would be required to reconcile with HHS on an annual basis the anticipated utilization of CSI data provided by the VCI Hub service with the actual utilization.

Under this reconciliation process, HHS would offset payments for the next annual payment cycle for States<sup>171</sup> where actual utilization is less than the anticipated utilization for which they were invoiced. The offset amount would be equal to the difference in that State's anticipated number of pings multiplied by the fixed price, and its actual number of pings multiplied by the fixed price. States in which actual utilization is greater than the anticipated utilization for which they were invoiced would be assessed a charge for the difference in that State's actual number of pings multiplied by the fixed price, and the anticipated number of pings multiplied by the fixed price. We seek comment on how HHS should estimate States' future anticipated utilization of CSI data provided by the VCI Hub service. We also seek comment on whether HHS should estimate, collect, and reconcile these payments from States more frequently, such as biannually,

quarterly, or monthly, rather than annually, for their anticipated utilization.

Alternatively, we seek comment on HHS invoicing on a monthly basis for their actual utilization of CSI data provided by the VCI Hub service after that utilization occurs. To implement this alternative approach, we anticipate that each month, States would receive an invoice of the amount that must be paid to HHS for its usage in the prior month. This amount would total each respective State Exchange's and Medicaid and CHIP agencies' utilization in that month, specifically the number of purchased transactions to the VCI Hub service that returned usable CSI data, multiplied by the fixed price set by the CSI contract HHS holds with its vendor. Therefore, we, on behalf of HHS, would collect funds to cover the costs of these services from Medicaid and CHIP agencies after the use of the service and on a regular basis. State Medicaid and CHIP agencies would be eligible for Federal matching for the cost of this service under this alternative proposal we have opted to propose a July 1, 2024 effective, as described in this section. We seek comment on this alternative approach, including whether HHS should invoice States annually, biannually, or quarterly, rather than monthly, if this alternative is adopted in the final rule.

In accordance with section 1903(a)(3)(B) of the Act and 42 CFR 433.116, Federal Financial Participation (FFP) is available at 75 percent of State expenditures for operations of approved State Medicaid Enterprise Systems (MES) costs for data exchange between State systems and the VCI Hub service and including for State costs to access the VCI Hub service, as well as maintenance of associated State system functionality and automation. Additionally, per section 1903(a)(3)(A)(i) of the Act and 42 CFR 433.112, FFP is available at 90 percent of State expenditures for MES design, development, installation, or enhancement, including for such State costs as are necessary to use the VCI Hub service. In CHIP, administrative expenses, including those related to system operations, maintenance, design, development, installation, and enhancement, are matched at the regular CHIP enhanced FMAP. States that use a joint Medicaid and CHIP eligibility system should cost allocate VCI Hub service expenses between the programs. Prior to incurring MES development and operational costs for the VCI Hub service, the State must submit an Advance Planning Document requesting enhanced Federal match to us for

review and approval, in accordance with regulation at 45 CFR part 95, subpart F. We intend to provide States with operational guidance with options for how to comply with any new requirement finalized. We note that the VCI Hub service use is considered to be a State Medicaid and CHIP agency function, and therefore a cost for these agencies only when the eligibility determination is initiated by the State agency. Costs should be allocated to the requesting entity that is making the request to the VCI Hub service, such that States are only liable for the cost of the VCI Hub service responses for pings that originated from the State Medicaid and CHIP agency. For example, if an applicant initiates an application at *HealthCare.gov* or a State Exchange, but is then transferred to a State Medicaid agency, those costs would be the responsibility of HHS or the State Exchange and not the State Medicaid agency.

Finally, we propose that the interpretation characterizing use of the VCI Hub service as a function of State Exchanges and Medicaid and CHIP agencies and not an HHS function be effective on July 1, 2024. We recognize that this implementation date may be difficult for States, especially those with biennial budget cycles. However, given our determination that eligibility verifications using CSI data by State Exchanges and Medicaid and CHIP agencies is most appropriately characterized as a function of these agencies and not an HHS function, we believe it is appropriate to move forward with this change as expeditiously as possible, while giving States some time to plan for the change. For this reason, we have opted to propose a July 1, 2024 effective date for this provision.

We seek comment on these proposed changes, including whether we should make this interpretation effective as of July 1, 2024, or a different date. We are also interested in learning how this change may impact States' use of the VCI Hub service. Will State Exchanges and Medicaid and CHIP agencies seek to cease or restrict their use of the VCI Hub service, possibly using it as a last resort? What impact might these proposed changes have on the amount of time it takes applicants to verify their income or the time it takes for States to make an eligibility determination? We would also be interested in learning the extent to which States may be interested in potential avenues to reduce operational burdens or address budget challenges facing State Exchanges and Medicaid and CHIP agencies. Namely, we are interested in whether States would be

<sup>171</sup> Utilization of CSI data through the VCI Hub will be assessed for each relevant State Exchange, State Medicaid Agency, or CHIP agency.

interested in opportunities to pay an additional fee that would allow them to reuse VCI Hub service verification results across multiple Federally-funded and State-administered human service programs (with cost allocation across those programs); whether States have separate, direct access to the same or similar source of VCI Hub services, and the cost of such direct access; and whether States anticipate that reuse of verification data, coupled with cost allocation across program, would reduce operational burdens or address budget challenges facing State Exchanges and Medicaid and CHIP agencies.

### 13. Eligibility Redetermination During a Benefit Year (§ 155.330(d))

At § 155.330, we propose to redesignate paragraph (d)(3) as paragraph (d)(3)(i) and add paragraph (d)(3)(ii) to require Exchanges to conduct periodic checks for deceased enrollees twice yearly and subsequently end deceased enrollees' QHP coverage beginning with the 2025 calendar year. Additionally, we propose to add § 155.330(d)(3)(iii) to grant the Secretary the authority to temporarily suspend the periodic data-matching (PDM) requirement during certain situations or circumstances that lead to the unavailability of data needed to conduct PDM.

Under § 155.330(d), Exchanges are required to periodically examine available data sources, referred to as PDM, to identify whether enrollees become deceased, and to identify whether enrollees on whose behalf APTC or CSRs are being paid have been found eligible for or are enrolled in Medicare, Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange.

Currently, § 155.330(d)(3) defines "periodically" only for PDM activities that identify enrollment in Medicare, Medicaid, CHIP, and, if applicable, BHP, meaning that Exchanges must conduct Medicare PDM, Medicaid or CHIP PDM, and, if applicable, BHP PDM, twice a year. The current regulation does not specify the frequency by which PDM activities to identify deceased enrollees must occur, but the 2019 Program Integrity Rule requires that Death PDM be conducted once annually, and we noted that we intend to update the frequency for Death PDM in future rulemaking. As explained in the 2019 Program Integrity Rule, we did not require Exchanges to perform PDM for death at least twice in a calendar year so that Exchanges could prioritize the implementation of the new requirement to conduct PDM for Medicare, Medicaid, CHIP and, if

applicable, BHP eligibility or enrollment at least twice yearly. In this proposed rule, we are now proposing to add § 155.330(d)(3)(ii) to require Exchanges beginning with the 2025 calendar year to conduct periodic checks for deceased enrollees twice yearly and subsequently end deceased enrollees' QHP coverage after following the procedure specified in § 155.330(e)(2)(i).

Periodic checks for deceased enrollees help ensure Exchange program integrity. This proposal would not only align with current Federal Exchange policy and operations but would also prevent overpayment of QHP premiums and APTC/CSRs, and accurately capture household QHP eligibility based on household size. Additionally, by conducting Death PDMs twice a year, Exchanges can prevent future auto re-enrollments or policy effectuation for deceased enrollees for the next plan year.

Additionally, we propose to add § 155.330(d)(3)(iii) to grant the Secretary the authority to temporarily suspend the PDM requirement during certain situations or circumstances that lead to an unavailability of data needed to conduct PDM. PDMs are conducted as a program integrity measure where the prerequisite for conducting a proper PDM is assurance of data quality. We recognize that during certain circumstances data quality may be incomplete or lagging. During the COVID-19 Public Health Emergency, State and local agencies had to strain their resources to address backlogs due to job losses and other administrative gaps further slowing down response times,<sup>172</sup> thereby, increasing the risk of the Exchanges making inaccurate eligibility determinations due to potential data lags. In such cases, using such data could pose a risk of improper termination of coverage or APTC/CSRs for large numbers of enrollees. These improper terminations may be particularly harmful during situations such as a public health emergency. These potential harms can be even more likely to occur when the additional burdens of DMI resolution are imposed on Medicare and Medicaid beneficiaries, who can be vulnerable and underserved and more likely to encounter gaps in coverage or a complete lack of coverage as a result of failing to resolve the DMIs.<sup>173</sup> Allowing

the Secretary the flexibility to temporarily suspend the PDM requirement during certain situations may be able to prevent an inadvertent increase in the uninsured population, largely consisting of vulnerable consumers. We would notify Exchanges of such a suspension of PDM activities, and a resumption of PDM activities, through subregulatory guidance.

We anticipate most State Exchanges would be able to meet the proposed requirements for Death PDM based on operations already reported through the State-based Marketplace Annual Reporting Tool (SMART) as well as discussions we have had with the State Exchanges on PDM. We also anticipate that changes, including a suspension of the PDM requirement, would be well received by the Exchanges and issuers, as it is important that consumer information, such as eligibility for APTC or QHP coverage, be accurate to avoid expending administrative resources on complex processes to correct errors. Eleven State Exchanges reported in their 2022 SMART submissions that they curtailed PDM checks only due to the exigency resulting from the COVID-19 Public Health Emergency, which expired in May of 2023. Furthermore, we do not anticipate the new periodicity requirement for the Death PDM to result in a significant administrative burden for State Exchanges because States previously conducted PDM checks for deceased enrollees.

Under section 1313(a)(4) of the ACA, if HHS determines that an Exchange has engaged in serious misconduct with respect to compliance with Exchange requirements, it has the option to rescind up to 1 percent of payments due to a State under any program administered by HHS until such misconduct is resolved. These existing authorities would apply to the proposed PDM requirements in § 155.330(d). If HHS were to determine that it is necessary to apply this authority due to non-compliance by an Exchange with § 155.330(d), HHS would also determine the HHS-administered program from which it would rescind payments that are due to that State. However, if State Exchanges do not comply with the proposed PDM requirements, we would generally first direct a State Exchange to take corrective action. We utilize specific oversight tools (for example, the SMART, independent external programmatic & financial audits) to ensure compliance and that State Exchanges take appropriate corrective action. HHS also provides technical

<sup>172</sup> McDermott, D., Cox, C., Rudowitz, R., and Garfield, R. (2020, Dec. 9). *How Has the Pandemic Affected Health Coverage in the U.S.?* KFF. <https://www.kff.org/policy-watch/how-has-the-pandemic-affected-health-coverage-in-the-u-s/>.

<sup>173</sup> Hirsch, M. (1994). Health Care of Vulnerable Populations Covered by Medicare and Medicaid.

Health Care Finance Rev., 15(4):1-5. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193433/>.

assistance and ongoing monitoring to track those actions until the State Exchange remediates the issue fully.

We seek comment on this proposal.

#### 14. Incorporation of Catastrophic Coverage Into the Auto Re-Enrollment Hierarchy (§ 155.335(j))

We propose to amend § 155.335(j)(1) and (2) to require Exchanges to re-enroll individuals who are enrolled in catastrophic coverage as defined in section 1302(e) of the ACA into a new QHP for the coming plan year. We believe that some Exchanges already re-enroll these enrollees, including Exchanges on the Federal platform when issuers include plan crosswalk information for catastrophic plans when they submit the information as part of the annual QHP certification process. However, explicitly incorporating catastrophic plan enrollees into the rules at § 155.335(j) would help ensure continuity of coverage in cases where the issuer does not offer the catastrophic plan for the subsequent plan year, and individuals enrolled in catastrophic coverage do not actively select a different QHP. We also propose to add new § 155.335(j)(5) to establish that an Exchange may not newly auto re-enroll into catastrophic coverage an enrollee who is currently enrolled in coverage of a metal level as defined in section 1302(d) of the ACA. This is consistent with the practice of the Exchanges on the Federal platform, and we believe that State Exchanges likely also adhere to this practice, but that all interested parties would benefit from clear regulation on this aspect of the re-enrollment process.

If this proposal is finalized, we would also update the Federally-facilitated Exchange (FFE) Enrollment Manual to incorporate catastrophic coverage into the re-enrollment hierarchy for alternate enrollments, which we use to implement the regulation to crosswalk enrollees whose current issuer no longer offer plans available to them through the Exchanges on the Federal platform under § 155.335(j)(3).<sup>174</sup>

In the 2013 Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule (78 FR 12833), we set forth Exchange and issuer standards related to coverage of essential health benefits and actuarial value to reflect section 1302 of the ACA, which specifies levels of coverage or “actuarial values” that health plans in

the individual and small group markets, both inside and outside of an Exchange, must meet as part of the requirement to cover an EHB package beginning in 2014. Specifically, the final rule codified section 1302(d)(1) of the ACA, which specifies that actuarial values must be 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan.

In the 2013 Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review Final Rule (78 FR 13405), we established standards for catastrophic plans offered in the individual market, consistent with section 1302(e) of the ACA, and codified the statutory criteria identified in section 1302(e)(2) of the ACA listing the two categories of individuals eligible to enroll in a catastrophic plan. The first category includes individuals who are younger than age 30 before the beginning of the plan year. The second category includes individuals who have been certified as exempt from the individual responsibility payment because they cannot afford minimum essential coverage or because they are eligible for a hardship exemption. Section 1302(e) of the ACA does not specify an actuarial value requirement for a catastrophic plan, but states that a health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) for any plan year if it meets the requirements at section 1302(e)(1) of the ACA, providing an option for basic protections for young adults and people who cannot otherwise afford health insurance or have a hardship. However, section 36B(c)(3)(A) of the Code provides that PTC is not allowed for individuals who enroll in catastrophic coverage described in section 1302(e) of the ACA. Consequently, those individuals are not eligible for APTC.

In the 2014 Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the ACA, Including Standards Related to Exchanges (79 FR 52994, 52998 through 53001), we established the Exchange re-enrollment hierarchy at § 155.335(j) to help ensure continuous coverage for consumers who opt not to make an active plan selection for the upcoming year.<sup>175</sup> This final rule provided

standards that Exchanges must follow to place current enrollees whose current year plan is no longer available, and who do not terminate coverage or select a different QHP, into a new plan for the coming year based on their current product, and their current year plan’s metal level and plan network type. For example, an Exchange must place an enrollee whose current QHP is not available through the Exchange, in a QHP within the same product as their current year plan, and at the same metal level as the enrollee’s current QHP. The final rule also specified requirements at § 155.335(j)(2) for cases in which an enrollee’s current product is no longer available. For example, an Exchange must place an enrollee whose current product is no longer available in a QHP at the same metal level as the enrollee’s current QHP, in the product offered by the same issuer that is the most similar to the enrollee’s current product.<sup>176</sup>

In the 2017 Payment Notice (81 FR 12203), we amended § 155.335(j) to provide for automatic re-enrollment in a QHP offered by another issuer through the Exchange for enrollees whose current QHP issuer no longer offered a QHP through the Exchange in the enrollee’s service area. This policy helped ensure that enrollees could maintain coverage with APTC and income-based CSRs, as opposed to losing coverage or re-enrolling in a plan outside the Exchange in cases where their current issuer offered off-Exchange coverage. This rule at § 155.335(j)(3) provides that the Exchange may direct these re-enrollments, to the extent permitted by applicable State law, into a QHP from a different issuer as directed by the applicable State regulatory authority, or, if the applicable State regulatory authority declines to direct this activity, directed by the Exchange.

In the 2023 Payment Notice (87 FR 27273), we solicited comments on incorporating certain cost factors into the re-enrollment hierarchy, including net premium, maximum out-of-pocket amount (MOOP), deductible, and total

provides “no benefits” for any plan year (except for providing coverage for at least three primary care visits and preventive health services in accordance with section 2713 of the PHS Act) until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation on cost sharing in effect under section 1302(c)(1) of the ACA.

<sup>176</sup> “Product” means a discrete package of health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity) within a service area. 45 CFR 144.103.

<sup>174</sup> For the 2023 plan year, see CMS. (2023, July 12). *Federally-facilitated Exchange (FFE) Enrollment Manual*. CMS. Section 3.2.4, pp 29–30. <https://www.cms.gov/files/document/ffe-enrollment-manual-2023-5cr-071323.pdf>.

<sup>175</sup> This final rule also made a technical correction to catastrophic coverage regulation at § 156.155 to incorporate language in section 1302(e) of the ACA indicating that a catastrophic plan

out-of-pocket cost.<sup>177</sup> We also solicited comments on additional ways we could ensure that the Exchange hierarchy for re-enrollment aligns with plan generosity and consumer needs, such as re-enrolling a current bronze QHP enrollee into a silver QHP with a lower net premium and higher plan generosity offered by the same QHP issuer.

In the 2024 Payment Notice (87 FR 25740, 25821 through 25822), we added § 155.335(j)(4) to allow Exchanges to modify their re-enrollment hierarchies such that enrollees who are eligible for CSRs in accordance with § 155.305(g) and who would otherwise be automatically re-enrolled in a bronze-level QHP without CSRs, would instead be automatically re-enrolled in a silver-level QHP (with income-based CSRs) in the same product provided that certain conditions are met.<sup>178</sup> We also required Exchanges to ensure that enrollees whose QHPs are no longer available to them and enrollees who would be re-enrolled into a silver-level QHP to receive income-based CSRs are re-enrolled into plans with the most similar network to the plan they had in the previous year.

We propose to amend the regulations at § 155.335(j)(1) and (2) to require Exchanges to re-enroll individuals enrolled in catastrophic coverage as defined in section 1302(e) of the ACA into QHP coverage for the coming plan year. Section 155.335(j) currently specifies re-enrollment requirements for enrollees in coverage of a specific metal level as defined by section 1302(d) of the ACA, but does not address auto re-enrollment for catastrophic coverage enrollees nor does it address a scenario in which a catastrophic coverage enrollee would lose eligibility for catastrophic coverage in the coming plan year either because they exceed the 30-year age limit or lose eligibility for the exemption that allowed them to enroll in a catastrophic plan in spite of exceeding the age limit.<sup>179</sup>

To make this change, we propose to add new § 155.335(j)(1)(v) and (j)(2)(iv).

We propose paragraph (j)(1)(v) to specify that if the enrollee's current QHP is a catastrophic plan as described in section 1302(e) of the ACA, and the enrollee would no longer meet the criteria for enrollment in a catastrophic plan as described in section 1302(e)(2) of the ACA, the Exchange would re-enroll the enrollee into a bronze metal level QHP in the same product as the enrollee's current QHP that has the most similar network compared to the enrollee's current QHP; or if no bronze plan is available through this product, the Exchange would re-enroll the enrollee in the QHP with the lowest coverage level offered under the product in which the enrollee's current QHP is offered in which the enrollee is eligible to enroll and that has the most similar network compared to the enrollee's current QHP.

We propose paragraph (j)(2)(iv) to specify that if the enrollee's current QHP is a catastrophic plan as described in section 1302(e) of the ACA, and the enrollee would no longer meet the criteria for enrollment in a catastrophic plan as described in section 1302(e)(2) of the ACA, and if no bronze QHP is available in the same product as the enrollee's current QHP, the Exchange would re-enroll the enrollee into a bronze plan offered by the same issuer through the Exchange that has the most similar network compared to the enrollee's current QHP, in the product offered that is the most similar to the enrollee's current product.

We also propose to amend § 155.335(j)(1)(ii) to (iv) and (j)(2)(i) to (iii) to use the term "coverage level" instead of "metal level" so that the rules in this section are inclusive of catastrophic coverage enrollees to whom proposed paragraphs (j)(1)(v) and (j)(2)(iv) would not apply. For example, this change would ensure that paragraph (j)(1)(ii) requires an Exchange, if possible, to re-enroll a catastrophic coverage enrollee who would remain eligible for catastrophic coverage in the coming plan year into another catastrophic plan within the same product as their current QHP that has the most similar network compared to their current QHP.

In practice, we permit and encourage issuers as part of the annual QHP Certification process to submit a crosswalk option for enrollees in catastrophic coverage and for enrollees who would otherwise lose eligibility for their catastrophic plan. While most issuers submit this information, it is currently not required under the existing regulation. For PY 2023, one issuer on *HealthCare.gov* did not submit a crosswalk option for enrollees losing

catastrophic coverage eligibility, which resulted in the Exchanges not auto re-enrolling 37 people. By including catastrophic coverage and loss of eligibility for catastrophic coverage in regulation at § 155.335(j)(1) and (2), Exchanges would require issuers to submit crosswalk plans for the scenarios described in § 155.335(j) and ensure auto re-enrollment for all Exchange enrollees. It also improves transparency by incorporating the current practice of auto re-enrolling catastrophic enrollees in future year coverage to all issuers.

Finally, we propose adding a new § 155.335(j)(5) to establish that, for purposes of this section, catastrophic coverage is not a coverage level that is considered higher or lower than metal level coverage when moving an enrollee to a plan that is a metal level higher or lower than their current plan, and an Exchange may not re-enroll an enrollee that has coverage under section 1302(d) into catastrophic coverage. For example, when applying paragraphs (j)(1)(iii)(B), or (2)(ii), an Exchange may enroll bronze enrollees into silver level coverage but not catastrophic level coverage. When applying paragraphs (j)(1)(iv) or (2)(iii), an Exchange may enroll enrollees into a QHP other than catastrophic. This rule reflects our re-enrollment process for Exchanges on the Federal platform, and we believe it appropriately reflects enrollees' decision to enroll in coverage with benefits beyond those that catastrophic coverage provides, and the operational processes to determine catastrophic coverage eligibility for a coming plan year.

We solicit comment on these proposals, including from State Exchanges regarding whether the proposals reflect their current auto re-enrollment practices. If either or both of the policies proposed in paragraphs (j)(1)(v) and (j)(2)(iv) do not reflect current practices and would impose an implementation burden for State Exchanges or for other interested parties, we solicit comment on whether to provide flexibility on making this provision effective for plan years beginning on or after January 1, 2025. We solicit comment on strategies for helping enrollees who transition from catastrophic coverage into coverage through a metal level QHP on how to understand and apply APTC to their monthly premiums if they are eligible and wish to do so.

We also solicit comment on whether we should consider proposing changes to the auto re-enrollment hierarchy to prioritize re-enrollment in catastrophic coverage for enrollees who remain eligible for catastrophic coverage in a

<sup>177</sup> MOOP refers to the limit on cost sharing an enrollee must pay for covered services in a plan year. After the enrollee spends this amount on cost sharing for in-network essential health benefits, the health plan pays 100 percent of the costs of covered essential health benefits. For purposes of this section of preamble, the term total out-of-pocket costs refers to net premium and out-of-pocket costs attributable to cost sharing and excludes any costs attributable to balance billing.

<sup>178</sup> Additional conditions at § 155.335(j)(4) include that the silver plan must have the same provider network, and a lower or equivalent premium after the application of APTC, as the bronze level QHP into which the Exchange would otherwise re-enroll the enrollee under paragraph (j)(1) or (2) of this section.

<sup>179</sup> See § 155.305(h).



way that is similar to current prioritization of silver level coverage. That is, § 155.335(j)(1)(ii) specifies that if an enrollee's current QHP is a silver plan that will not be available for the coming plan year, and the enrollee's current product will no longer include a silver level QHP, then the Exchange will re-enroll the enrollee in a silver level QHP under a different product offered by the same QHP issuer that is most similar to the enrollee's current product. We seek comment on whether it would be appropriate to prioritize continuity of catastrophic coverage in a similar way. Finally, we solicit comment on additional strategies to help ensure continuity of coverage for enrollees in catastrophic QHPs, including those who lose eligibility for catastrophic coverage.

#### 15. Premium Payment Deadline Extensions (§ 155.400(e)(2))

We propose to amend § 155.400(e)(2) to codify that the flexibility for issuers experiencing billing or enrollment problems due to high volume or technical errors, or issuers directed to do so by applicable State or Federal authorities, is not limited to extensions of the binder payment.

Section 155.400(e) specifies that Exchanges may require, and the FFEs and SBE-FPs will require, enrollees to make a binder payment to effectuate enrollment, and paragraph (e)(1) specifies the range of dates within which an issuer may establish a deadline to pay binder, depending on whether coverage is being effectuated under regular, prospective, or retroactive effective dates. In the 2018 Payment Notice (81 FR 94058), we added paragraph (e)(2) to address situations in which an issuer is unable to timely process binder payments submitted by enrollees, which may impact an enrollee's ability to effectuate coverage. Specifically, we noted that based on our experience during several Open Enrollment Periods, issuers occasionally experience technical errors, or a processing backlog caused by an unusually high volume of enrollments. As a result, enrollees may be temporarily unable to submit premium payments, or the issuer may be unable to process payments in a timely manner. We thus established an option for issuers to implement a reasonable extension of binder payment deadlines,<sup>180</sup> which ensures that enrollees do not have coverage cancelled due to non-payment when the

enrollee did not have adequate time to pay the binder payment.

Although we only addressed extensions to the binder payment deadlines in § 155.400(e)(1), we did not intend to exclude other premium payment scenarios in which Exchanges could, and the Exchanges on the Federal platform would, provide similar flexibility. In published guidance, such as the 2023 *Federally-facilitated Exchange (FFE) Enrollment Manual*,<sup>181</sup> we stated that we will exercise enforcement discretion with regard to regulatory requirements such as the binder payment and the deadline for payment of premiums under grace periods if an issuer is complying with a State regulatory authority's request to extend premium payment deadlines and delay termination of coverage due to a natural disaster or other emergency within the State.

For example, in connection with the COVID-19 Public Health Emergency declared by the Secretary, HHS exercised enforcement discretion<sup>182</sup> regarding issuers extending premium payment deadlines and delaying cancellations or terminations of coverage with the permission of the applicable State regulatory authority. We propose to codify that Exchanges may, and Exchanges on the Federal platform would, provide flexibility in such circumstances, including circumstances in which an issuer is directed to do so by applicable State or Federal authorities.

Because current paragraph (e)(2) may be read to limit the flexibility Exchanges could provide issuers regarding payments other than the binder payment, we also propose to add the phrase "and other premium payment deadlines." Doing so would clarify for interested parties, particularly issuers, that Exchanges may, and Exchanges on the Federal platform would, provide flexibility regarding premium payment requirements other than the binder payment, such as the requirement to trigger a grace period to enrollees receiving APTC under § 156.270(d) if enrollees fail to pay premiums timely.

We request comments on this proposal.

<sup>181</sup> CMS. (2023, July 12). *2023 Federally-facilitated Exchange (FFE) Enrollment Manual*. CMS. Section 6.1.3, p. 89, and Section 6.10, p. 110. <https://www.cms.gov/files/document/ffe-enrollment-manual-2023-5cr-071323.pdf>.

<sup>182</sup> Pate, R. (2020, March 24). *Payment and Grace Period Flexibilities Associated with the COVID-19 National Emergency*. CMS. <https://www.cms.gov/files/document/faqs-payment-and-grace-period-covid-19.pdf>.

#### 16. Initial and Annual Open Enrollment Periods (§ 155.410)

At § 155.410, we propose to amend paragraph (e)(4)(ii) to revise parameters around the adoption of an alternative open enrollment period by a State Exchange. We propose to require that for benefit years beginning on or after January 1, 2025, State Exchanges must adopt an open enrollment period that begins on November 1 of the calendar year preceding the benefit year and ends no earlier than January 15 of the applicable benefit year, with the option to extend the open enrollment period beyond January 15 of the applicable benefit year.

In part 3 of the 2022 Payment Notice final rule (86 FR 53429 through 53432), where we extended the open enrollment period for the Exchanges on the Federal platform to January 15, we noted several observations regarding a 6-week open enrollment period ending on December 15. However, we also noted that for an open enrollment period ending in December, certain consumers may be subjected to unexpected plan cost increases that they may not be notified about until January, after open enrollment concludes. We also observed that extending the open enrollment period for the Exchanges on the Federal platform to January 15 would ensure ample time for Navigators, assisters, certified application counselors, agents, and brokers to fully assist all interested consumers. We further noted that ending open enrollment on January 15 would give consumers additional time to react to updated plan cost information and more time to seek enrollment assistance, which could improve access to health coverage, particularly for those in underserved communities who face additional barriers to accessing health coverage.

We believe these observations hold true as to State Exchanges and warrant requiring that their open enrollment periods also end no earlier than January 15. Since we extended the open enrollment period for Exchanges on the Federal platform in part 3 of the 2022 Payment Notice final rule, four States have transitioned to the State Exchange model, and we anticipate that there will be additional State Exchanges in future benefit years, which increases the potential for differing open enrollment periods. While most of the State Exchanges already hold an open enrollment period that ends on or after January 15 of the benefit year, we believe that the risk of shorter open enrollment periods in the future requires ensuring a minimum open enrollment period across all Exchanges,

<sup>180</sup> We also stated that we do not anticipate extensions to be greater than 45 calendar days.



including State Exchanges. Notably, this proposal would impose a minimal burden on most of the State Exchanges.

Additionally, we believe that ensuring State Exchanges' open enrollment periods begin on November 1 of the calendar year and continue through at least January 15 of the benefit year—thereby ensuring substantial overlap between all Exchange open enrollment periods—would reduce consumer confusion in States with State Exchanges that currently hold open enrollment periods that are shorter than the open enrollment period for the Exchanges on the Federal platform, or that begin before November 1 and end earlier than January 15. Consumers in these States would benefit from a longer open enrollment period by having an increased opportunity to enroll in coverage or reducing missed opportunities to enroll due to confusion about when open enrollment begins and ends. The combined benefits of this proposal in terms of reducing consumer confusion, building in additional time for consumers to enroll, and aligning open enrollment periods with Medicare and most employer open enrollment periods, could further increase Exchange enrollment and potentially have downstream impacts like improving the uninsured rate in States.

We seek comment on this proposal.

#### 17. Special Enrollment Periods

##### a. Effective Dates of Coverage (§ 155.420(b))

We propose amending § 155.420(b)(1) and (b)(3)(i) to align the effective dates of coverage after selecting a plan during certain special enrollment periods across all Exchanges, including State Exchanges. In order to consolidate and integrate the requirements in § 155.420(b)(3), without affecting any rights or obligations, we also propose to include the requirements currently in paragraph (b)(3)(ii) into proposed paragraph (b)(3)(i) and to delete paragraph (b)(3)(ii). For ease of consumer experience and to prevent coverage gaps, particularly for consumers transitioning between different Exchanges or from other insurance coverage, we propose amending § 155.420(b)(1) and (b)(3)(i) so that qualifying individuals or enrollees who select and enroll in a QHP during certain special enrollment periods receive coverage beginning the first day of the month after the consumer selects a QHP.

In accordance with § 155.420(b)(3)(i), in the FFEs, SBE-FPs, as well as several State Exchanges, during a special enrollment period, consumers who

select a QHP through the Exchange to which regular effective dates specified in § 155.420(b) apply have the plan's coverage begin on the first day of the month after the consumer's selection. For example, if a consumer selects a QHP on March 31, their QHP coverage would start April 1.

However, in some State Exchanges, a consumer's coverage is only made effective on the first day of the month after the consumer has selected a plan during a special enrollment period to which regular effective dates specified in § 155.420(b) apply if the consumer selects their plan between the 1st day and the 15th day of the previous month, per § 155.420(b)(1). In these State Exchanges, if a consumer selects a plan between the 16th day and the last day of the month, coverage will not become effective until the first day of the second month after plan selection. For example, for these State Exchanges, if a consumer selects a plan on March 1, Exchange QHP coverage would start April 1, but if that consumer selected a plan on March 16, their Exchange QHP coverage would start on May 1. This may result in a coverage gap of more than a month for these consumers.

As consumers typically qualify for special enrollment periods due to a life event that may disrupt their previous coverage (such as a move to a new State, or a change in household size due to birth or divorce, or a loss of other health insurance, such as a loss of Medicaid), these consumers are less likely to have health insurance coverage while they wait for their selected QHP coverage to begin.

In addition, when transitioning between Exchanges, such as from an Exchange in a State that operates on the Federal platform to a State Exchange that does not offer first-of-the-following-month coverage, consumers may expect that their coverage becomes effective on the first day of the month after selecting a QHP. These consumers might not be aware that the effective dates of coverage may differ between Exchanges, and they might not take appropriate steps to maintain or access alternate coverage while waiting for their QHP to become effective. As a result, these consumers may be at risk of coverage gaps due to the existing policies governing effective dates of coverage.

To address this, we propose amending § 155.420(b)(1) and (b)(3)(i) to align effective dates of coverage across all Exchanges under these special enrollment periods. The proposal would require all State Exchanges, beginning on January 1, 2025, or an earlier date at the option of the Exchange to provide coverage that is effective on the first day

of the month following plan selection, if a consumer enrolls in a QHP during a Special Enrollment Period to which regular effective dates specified in § 155.420(b) apply.

We seek comment on this proposal.

##### b. Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals With a Household Income *At or Below* 150 Percent of the Federal Poverty Level

At § 155.420, we propose to amend paragraph (d)(16) to revise the parameters around the availability of a special enrollment period (SEP) for APTC-eligible qualified individuals with a projected household income at or below 150 percent of the Federal Poverty Level (FPL) hereinafter referred to as the "150 percent FPL SEP." We are proposing to amend the current text from "no greater than" to "at or below" for improved readability and understanding. Specifically, we are proposing to remove the limitation that this SEP be only available during periods of time when APTC is available such that the applicable taxpayers' applicable percentage is set to zero.

As background, in part 3 of the 2022 Notice of Benefit and Payment Parameters (86 FR 53429 through 53432), we finalized, at the option of an Exchange, a monthly SEP for APTC-eligible qualified individuals with a projected household income at or below 150 percent of the FPL. We also finalized a provision stating that this SEP is available only during periods of time during which APTC is available such that the applicable taxpayers' applicable percentage is set at zero, such as during tax years 2021 through 2025, as provided by section 9661 of the American Rescue Plan (ARP) and extended by the Inflation Reduction Act (IRA).<sup>183</sup> We also amended § 147.104(b)(2)(i) to specify that issuers are not required to provide the SEP in the individual market with respect to coverage offered outside of an Exchange.

As a result of the enhanced financial assistance established by the ARP and extended by the IRA until December 31, 2025, many consumers with lower household incomes with a projected household income at or below 150 percent of the FPL, have the opportunity to enroll in a much wider range of affordable coverage. Specifically, as a result of the legislative changes passed by Congress in the ARP and IRA, more consumers have access to Exchange and QHP coverage with zero-dollar premiums after financial subsidies, including more opportunities to enroll in zero-dollar silver-level plans with

<sup>183</sup> Public Law 117–169.

significant levels of CSRs. To provide these consumers—many of whom might have had difficulty enrolling during standard SEP timelines due to lack of awareness or other logistical difficulties—with the chance to access this generous Exchange coverage, we finalized the 150 percent FPL SEP.

We remain committed to ensuring that affordable Exchange coverage is available for individuals with lower household incomes and who are uninsured, and we believe that the availability of the 150 percent FPL SEP has made significant strides in ensuring that this population has real opportunities to enroll in free or extremely low cost Exchange coverage.

Executive Order (E.O.) 14070, signed on April 5, 2022 (which expanded upon E.O. 15009 signed on January 28, 2021), directs Federal agencies to identify ways to continue to expand the availability of affordable health coverage, to improve the quality of coverage, to strengthen benefits, and to help more Americans enroll in quality health coverage. To that end, this proposed change may further ensure continued improved access to affordable coverage for this population.

Continuing to make this SEP available also may continue to help consumers who lose other MEC coverage, especially those disenrolling from Medicaid or CHIP coverage to regain health care coverage. We are aware of the challenges many consumers disenrolling from Medicaid or CHIP coverage have faced due to the end of the Medicaid continuous enrollment condition as of March 31, 2023. During this time period, we have observed, and expect to continue to observe, a higher than usual volume of individuals with lower household incomes transitioning from Medicaid or CHIP coverage to coverage through Exchanges due to the end of the Medicaid continuous enrollment condition. As discussed in our guidance released on January 27, 2023, consumers disenrolling from Medicaid or CHIP because of the Medicaid continuous enrollment condition are especially vulnerable and may face challenges with transitioning from Medicaid or CHIP into other forms of coverage, such as Exchange coverage.<sup>184</sup> These challenges may include consumers' confusion as to why their Medicaid coverage is ending due

to irregular or untimely communications from State Medicaid agencies about the termination of coverage or coverage options for individuals with lower household incomes. Due to these factors, consumers may be unable to make an informed decision about their coverage options within the 60-day window provided by the SEPs at § 155.420(c)(1) and (d)(1) or within the 90-day window provided at the option of the Exchange at § 155.420(c)(6) beginning on January 1, 2024. Given our observations of these challenges, we believe that the existence of the 150 percent FPL SEP provides an additional safety-net, particularly for consumers impacted by the Medicaid continuous enrollment condition, but also generally for those who have historically faced challenges transitioning from Medicaid or CHIP into other coverage, like Exchange coverage.

Finally, our experience with the 150 percent FPL SEP strongly suggests that the policy has been successful. Based on our analysis, between October 2022 and August 2023, about 1.3 million consumers who reside in States with Exchanges on the Federal platform were APTC-eligible, and had projected household incomes at or below 150 percent of the FPL, enrolled in Exchange coverage under the 150 percent FPL SEP. In 2022, 41.8 percent of enrollees on Exchanges on the Federal platform had a projected household income of less than 150 percent of the FPL, compared to 46.9 percent of Exchange enrollees in 2023, after the implementation of the 150 percent FPL SEP. We believe the current 150 percent FPL SEP is one factor that significantly contributed to the increase in the enrollees on the Federal platform with a projected household income at or below 150 percent of the FPL.

In previous rulemaking, we expressed concern about offering the 150 percent FPL SEP when APTC does not always reduce the applicable percentage of a taxpayer with projected annual household income at or below 150 percent FPL to zero. We were also receptive to concerns raised by issuers that this SEP would impact the Exchange risk pool, lead to higher premiums, and impact the population with household incomes above 400 percent FPL with higher premium contributions as the APTC phases out. The possible increasing premiums also present a risk of financial hardship for consumers who purchase insurance off Exchange including those who are not eligible for APTC due to immigration status, or any other consumers who would purchase unsubsidized plans, or

only receive small subsidies. At the time, we believed that the risk for adverse selection was mitigated because consumers would not have an incentive to drop their Exchange plans when healthy and resume coverage when sick using the 150 FPL SEP since they would be enrolled in zero-dollar premium plans due to the enhanced financial subsidies provided by the ARP and IRA. Previously, we estimated that the adverse selection risk may result in issuers increasing premiums by approximately 0.5 to 2 percent, and a corresponding increase in APTC outlays and decrease in income tax revenues of approximately \$250 million to \$1 billion annually, when the enhanced APTC provisions of the ARP (and later extended by the IRA) are in effect. While it is challenging to predict the future nature of the Exchanges in 2026, we estimate that some adverse selection, though unknowable at this time, may occur once enhanced subsidies sunset on December 31, 2025, and may result in issuers increasing premiums. We acknowledge that there is a wide range of predictions for an increase to premiums due to the adverse selection risk associated with this proposed change and discuss this further in the regulatory impact analysis section of this rule.

However, an analysis of the plans available to consumers in 2020, just before implementation of the enhanced subsidies, suggests that the risk of adverse selection we acknowledged may be lower than expected, and therefore downstream impacts of that risk may be mitigated. When consumers with household incomes at or below 150 percent of the FPL are no longer eligible for enhanced subsidies, these consumers may still be eligible for low-cost silver or bronze plans with zero-dollar premiums after regular subsidies. In 2020, before the ARP provided enhanced financial assistance in the form of enhanced subsidies, about 900,000 consumers were enrolled in bronze plans, which were fully subsidized by APTC and where the consumer portion of premium was zero dollars. Additionally, in 2020, 77 percent of the consumer population at or below 150 percent FPL had access to a zero-dollar bronze plan with 16 percent of the same population having access to a zero-dollar silver plan in addition to the zero-dollar bronze plan. We believe that if the majority of consumers with income at or below 150 percent FPL would be eligible for a zero-dollar premium plan absent the enhanced subsidies provided under the ARP and IRA, then such consumers

<sup>184</sup> CMS. (2023, Jan. 27). *Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition—Frequently Asked Questions (FAQ)*. CMS. <https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf>.

would be unlikely to use the proposed 150 FPL SEP in a way that caused adverse selection. In other words, we believe that the availability of these zero-dollar bronze plans for consumers at or below 150 percent FPL mitigates the risk pool impact this proposed change might cause in addition to mitigating downstream hardships for consumers who purchase insurance without subsidies or with only small subsidies. Therefore, we are proposing to make the 150 percent FPL SEP, at the option of an Exchange, permanent by amending § 155.420(d)(16) to remove the requirement that the SEP only be available during periods of time when the applicable taxpayer's applicable percentage for purposes of calculating the premium assistance amount, as defined in section 36B(b)(3)(A) of the Code, is set at zero.

We seek comment on this proposal.

#### 18. Termination of Exchange Enrollment or Coverage (§ 155.430)

We propose to add § 155.430(b)(1)(iv)(D) to permit enrollees on Exchanges using the Federal platform to retroactively terminate their enrollment in a QHP through the Exchange<sup>185</sup> when the enrollee enrolls in Medicare Parts A or B retroactively effective to the day before the date Medicare coverage begins. We also propose making implementation of this proposal optional for State Exchanges and request comment on whether it should instead be mandatory.

In the 2017 Payment Notice (81 FR 12203), we implemented regulations at § 155.430(b)(1)(iv) to permit Exchange enrollees to retroactively terminate coverage in the following circumstances: (1) the enrollee demonstrates to the Exchange that the enrollee attempted to terminate the enrollee's coverage or enrollment in a QHP and experienced a technical error that did not allow the enrollee to terminate the enrollee's coverage or enrollment through the Exchange; (2) the enrollee demonstrates to the Exchange that the enrollee's enrollment in a QHP through the Exchange was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities; and (3) the enrollee demonstrates to the Exchange that the enrollee was enrolled

in a QHP without the enrollee's knowledge or consent by any third party, including third parties who have no connection with the Exchange. Additionally, § 155.430(d)(2)(v) authorizes Exchanges to retroactively terminate QHP coverage effective the day before Medicaid, CHIP, or BHP eligibility begins, though the Exchanges on the Federal platform do not permit retroactive terminations in this scenario. While SBE-FPs generally are required to follow the Exchanges on the Federal platform in matters of enrollment and disenrollment policy and operations, because this regulation relates to Medicaid, CHIP, or BHP programs, with which States are more closely involved than we are, we have provided SBE-FPs the option to implement retroactive terminations in these circumstances, despite the Federal platform not doing so.

Currently, we do not permit enrollees in Exchanges on the Federal platform to retroactively terminate QHP coverage due to retroactive enrollment in other coverage, including Medicare. When coverage is retroactively terminated, claims submitted during the period of terminated coverage will be reversed by the QHP issuer and become the responsibility of the enrollee, who must ensure claims are submitted by the provider to the new insurance provider, if coverage is effective retroactively.<sup>186</sup> State law would generally require that QHP issuers refund the enrollee any premiums paid during the months in which coverage is retroactively terminated.

In the 2017 Payment Notice (81 FR 12203), we stated that retroactive terminations would be limited to situations in which an enrollee was prevented from terminating coverage due to error or misconduct, and was not intended for enrollees who did not understand the rules of their enrollment and wished to avoid tax liability for APTC for which they were ineligible, nor for enrollees who seek retroactive termination of coverage at the end of the plan year because they did not use the coverage. We continue to believe that it is important to limit the scenarios in

which enrollees can seek retroactive termination of coverage, in part to address concerns raised by issuers of adverse selection if healthy enrollees are able to retroactively terminate coverage they did not use. However, we regularly receive requests from Exchange enrollees through the Marketplace Call Center to retroactively terminate QHP coverage because they enrolled retroactively in Medicare, and these requests are denied because they are not currently authorized by regulation. Unlike enrollees who enroll in Medicare prospectively when they turn 65, individuals who enroll in Medicare retroactively did not have the opportunity to prospectively terminate Exchange coverage, and thus, did not merely fail to understand the terms of their QHP enrollment.

Generally, consumers who become eligible for Medicare once they turn 65 can enroll prospectively, and those who are enrolled in Exchange coverage can normally terminate coverage prospectively so that there is no overlap between the two. In accordance with § 155.430(d)(2)(iii), Exchange enrollees may request same-day or prospective termination of coverage,<sup>187</sup> and Exchange communications instruct enrollees to terminate coverage once they learn they will be enrolled in other coverage to avoid an overlap. Exchange enrollees approaching their 65th birthday also receive communications from the Exchange advising them that they will be ineligible for APTC if they enroll in Medicare and instructing them to terminate Exchange coverage if they do not wish to have an overlap between the two. However, there are scenarios in which a consumer may retroactively enroll in Medicare Parts A or B coverage. For example, consumers can become eligible for retroactive Medicare Parts A and B due to retroactive eligibility for SSDI benefits, in which case the consumer is entitled to Medicare Parts A and B beginning with the 25th month of SSDI entitlement (that is, receipt of the SSDI benefit). If the SSA determines the consumer to be eligible more than 25 months back, the consumer will receive Medicare Part A automatically beginning with the 25th month of SSDI entitlement and will have the option of enrolling in Part B Medicare retroactive to the 25th month of SSDI entitlement (though they also have the choice to enroll in Part B

<sup>185</sup> When an enrollee retroactively terminates QHP coverage, State law generally requires that the premiums paid in the months for which coverage is retroactively terminated be refunded by the QHP issuer.

<sup>186</sup> Providers are generally required to submit claims to Medicare no later than 12 months after the date of service. However, in situations where Medicare Part A or B entitlement did not exist at the time service was furnished, or the beneficiary receives notice of Medicare Part A or B entitlement after the date of service, the 12-month limit may be extended for 6 months following the month in which the beneficiary receives notice of Medicare Part A or Part B entitlement. CMS. (rev. 2023, Jan. 19). *Medicare Claims Processing Manual*, 100-04, Chapter 1, Section 70.7.2 "Retroactive Medicare Entitlement." <https://www.cms.gov/regulations-and-guidance/manuals/downloads/clm104c01.pdf>.

<sup>187</sup> Although this regulation permits QHP enrollees to request prospective terminations, limitations in operations in the Exchanges on the Federal platform prevent one enrollee in an enrollment group from ending coverage prospectively when the other enrollees in the group intend to remain enrolled.

prospectively). In addition, when a consumer has not been automatically enrolled in Medicare Part A and applies for Medicare Part A after their 65th birthday, their entitlement to Part A begins (that is, when coverage starts) up to six months prior to the date of the application but no sooner than the consumer's 65th birthday.

Because consumers who enroll retroactively in Medicare Parts A or B may not be able to avoid an overlap in coverage by prospectively terminating their Exchange coverage, we believe it is appropriate to allow them to retroactively terminate Exchange coverage back to the day before Medicare coverage begins. Allowing consumers to request retroactive terminations in these scenarios ensures they can avoid an overlap between Exchange and Medicare coverage and avoid paying premium unnecessarily (if the consumer owes premium after the application of APTC). However, we note that consumers would not be required to request a retroactive termination and could maintain both Exchange and Medicare coverage if they wish. Consumers who enroll in Medicare retroactively are not categorically excluded from PTC eligibility for the period of retroactive coverage, and thus may not be required to repay APTC for the months of overlap when they file their taxes, in accordance with 26 CFR 1.36B–2(c)(2)(iv); however, a QHP enrollee receiving APTC who is voluntarily requesting and is granted a retroactive QHP termination relieves the government of subsidizing two forms of coverage, as the APTC is recouped for the terminated QHP coverage months.

Although it is also possible for consumers to become retroactively eligible for Medicaid, and have an unavoidable overlap with Exchange coverage, we believe it is appropriate to limit the applicability of this provision in the Exchanges on the Federal platform to Medicare. We previously allowed retroactive terminations of Exchange coverage due to enrollment in Medicaid, CHIP, and the BHP, but removed this option for the FFEs in the 2019 Payment Notice (83 FR 16930). This option was retained for State Exchanges and SBE-FPs, which as previously mentioned are more closely integrated into their State-administered Medicaid programs. In response to commenters who opposed this change, we noted that although consumers in these cases may wish to recoup premiums paid during the period of overlapping coverage, there is significant risk that providers who participate in the consumer's Exchange coverage do not participate in Medicaid,

CHIP, or BHP, which would leave the consumer with unexpected out-of-pocket costs. However, because Medicare is accepted by many, if not most, providers, it is less likely that a retroactive QHP disenrollment would leave consumers responsible for claims made during the period of retroactive Medicare enrollment.

We note that in the FFEs and SBE-FPs, Marketplace Call Center workers and caseworkers have system-based evidence of both QHP and Medicare eligibility dates and would be able to verify that an enrollee requesting retroactive termination is enrolled in Medicare and approve retroactive requests. This would ensure that enrollees cannot retroactively terminate their QHP coverage for other, unauthorized reasons such as low utilization of coverage, which could create an adverse selection risk. We also note that, similar to retroactive Medicare enrollment, consumers who retroactively enroll in Medicaid coverage are not required to repay APTC for the months in which they retroactively enrolled when they file their taxes, consistent with 26 CFR 1.36B–2(c)(2)(iv).

Finally, in recognition of the challenges associated with retroactively adjusting coverage for preceding years, we propose to require that enrollees must request retroactive termination of coverage within 60 days of the date they retroactively enroll in Medicare (the date the enrollment occurs, not the Medicare coverage effective date). In the 2017 Payment Notice (81 FR 12203), we requested comment on and finalized a similar requirement for the other retroactive enrollment scenarios permitted under § 155.430(b)(1)(iv). We believe implementing this requirement would be appropriate here as well. Permitting retroactive enrollments too far in the past can be operationally burdensome for Exchanges, and for issuers that must reverse claims and refund premiums for the months of terminated coverage. We believe that a window of 60 days provides an appropriate amount of time for an enrollee who retroactively enrolls in Medicare coverage to request retroactive termination of Exchange coverage and is consistent with the limitation placed on requests for the other permissible retroactive termination scenarios at § 155.430(b)(1)(iv).

We request comments on this proposal. Specifically, we request comment on whether the public benefits of this proposal to honor an enrollee's choice, recoup APTC for duplicative coverage, and protect the individual market risk pool outweighs the risk that

an enrollee would be left with uncovered claims for the overlapping period. We also request comment on the best way to ensure that enrollees have the necessary information to make an informed decision about whether to retroactively terminate coverage. If this proposal is finalized, we intend to monitor the impact to minimize harm to consumers. We also seek comment on whether this provision should be mandatory for State Exchanges, rather than optional, and if so, how State Exchanges would verify retroactive Medicare enrollment dates.

#### 19. Establishment of Exchange Network Adequacy Standards (§ 155.1050)

We propose to require that State Exchanges and SBE-FPs establish and impose quantitative time and distance QHP network adequacy standards that are at least as stringent as the FFEs' time and distance standards established for QHPs under § 156.230. We also propose that State Exchanges and SBE-FPs be required to conduct quantitative network adequacy reviews prior to certifying any plan as a QHP, consistent with the reviews conducted by the FFEs under § 156.230. We further propose to require State Exchanges and SBE-FPs to permit issuers that are unable to meet the specified network adequacy standards to participate in a justification process after submitting their initial network adequacy data to account for variances and potentially earn QHP certification. Finally, we propose to mandate that State Exchanges and SBE-FPs require all issuers seeking QHP certification to submit information to the State Exchange or SBE-FP about whether network providers offer telehealth services.

Understanding that some State Exchanges or SBE-FPs may need to promulgate regulations to comply with the proposed provisions requiring State Exchanges and SBE-FPs to impose quantitative network adequacy standards and conduct quantitative network adequacy reviews, as well as the requirement related to QHP issuer submission of telehealth information, we propose that these provisions would be effective for plan years beginning on or after January 1, 2025, to accommodate the time it may take for a State Exchange or SBE-FP to come into compliance. We are of the view that strong network adequacy time and distance standards across all Exchanges would enhance consumer access to quality, affordable care through the Exchanges.

a. Federal Network Adequacy Policy Under the Affordable Care Act

Section 1311(c)(1)(B) of the ACA directs the Secretary of HHS to establish by regulation certification criteria for QHPs, including criteria that require QHPs to ensure a sufficient choice of providers (in a manner consistent with applicable provisions under section 2702(c) of the PHS Act) and provide information to current and prospective enrollees on the availability of in-network and out-of-network providers. Federal network adequacy standards were first detailed in the Exchange Establishment Rule (77 FR 18418) and codified at § 156.230.

In the Exchange Establishment Rule (77 FR 18418), we established the minimum network adequacy criteria that plans must meet 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 modified § 156.230(a) in part to specify that network adequacy requirements only apply to QHPs that use a provider network, and that a provider network includes only providers that are contracted as in-network. For PYs 2015 through 2017, the FFEs conducted network adequacy reviews of time and distance standards for QHP issuers.

The 2017 Market Stabilization final rule (82 FR 18371 through 18372) deferred reviews of network adequacy for QHPs to States that we determined to have a sufficient network adequacy review process, an approach that was expanded on in the 2019 Payment Notice (83 FR 17024 through 17026). In the 2019 Payment Notice (83 FR 17024 through 17026), we deferred reviews of network adequacy for QHPs to States that possessed sufficient legal authority to enforce 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 legal authority or means to assess and ensure network adequacy, we relied on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accreditation body to determine compliance with network adequacy requirements. For PYs 2018 through

2022, we determined that all States had sufficient legal authority and means to assess the adequacy of QHP provider networks.

In part 1 of the 2022 Payment Notice (86 FR 6154 through 6155), we provided a clarification to the network adequacy rules to reflect that § 156.230 does not apply to plans seeking QHP certification that do not differentiate benefits based on whether or not enrollees receive covered services from providers that are members of the plan's provider network.

The network adequacy review policy finalized in the 2019 Payment Notice was challenged in *City of Columbus, et al. v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021). Specifically, on March 4, 2021, the United States District Court for the District of Maryland vacated the 2019 Payment Notice's policy that deferred to States the Federal government's reviews of the network adequacy of QHPs and plans seeking QHP certification to be offered through the FFEs. With the FFE QHP certification cycle for PY 2022 beginning on April 22, 2021, we were not able to fully implement the aspects of the court's decision regarding network adequacy in time for issuers to design plans and for us to be prepared to consider whether to certify such plans as QHPs for PY 2022. However, we noted in part 2 of the 2022 Payment Notice (86 FR 24264 through 24265) that we planned to propose specific steps to address implementation of this aspect of the court's decision in future rulemaking.

In the 2023 Payment Notice (87 FR 27322), we finalized network adequacy standards for issuers in the FFEs that would apply for PYs 2023 and later. Specifically, in that rule (87 FR 27323 through 27328), we finalized that we would evaluate plans seeking certification as QHPs in all States served by an FFE, including conducting network adequacy reviews based on time and distance standards. In PY 2023,<sup>188</sup> we assessed time and distance standards at the county level and classified counties into five county type designations: Large Metro, Metro, Micro, Rural, and Counties with Extreme Access Considerations (CEAC). We used a county type designation method that is based upon the population size and density parameters of individual counties. To assess whether QHPs complied with these standards, we reviewed provider data for in network providers that QHP issuers submitted to

us via our ECP/NA template.<sup>189</sup> For each specialty and time and distance standard, we reviewed the issuer-submitted data to ensure that the plan provided access within specified times and distances to at least one provider in each of the provider type categories for at least 90 percent of enrollees. If a QHP did not meet one or more of the time and distance standards, the issuer could (1) add more contracted providers to the network to come into alignment with the standards and re-submit their updated ECP/NA template to us, and/or (2) submit a completed Network Adequacy Justification Form.<sup>190</sup> This justification process required issuers that did not yet meet the time and distance standards to detail: (1) the reasons that one or more time and distance standards were not met; (2) the mitigating measures the issuer is taking to ensure enrollee access to respective provider specialty types; (3) information regarding enrollee complaints regarding network adequacy; and (4) the issuer's efforts to recruit additional providers. We used the provider's data submitted on the ECP/NA template and the completed Network Adequacy Justification Form submitted as part of the certification process to assess whether the issuer met the regulatory requirement, prior to making the certification decision.

In the 2023 Payment Notice (87 FR 27328), we also finalized that, starting in PY 2025, we would also evaluate QHPs for compliance with appointment wait time standards. In the 2023 Payment Notice (87 FR 27323), we finalized that CMS would not evaluate network adequacy in States performing plan management functions that elect to perform their own reviews of plans seeking QHP certification in their State, provided that the State applies and enforces quantitative network adequacy standards that are at least as stringent as the federal network adequacy standards established for QHPs under 45 CFR 156.230, and that reviews are conducted prior to plan confirmation to support timely QHP certification.

In response to the network adequacy proposals proposed in the 2023 Payment Notice proposed rule, many commenters also requested that we extend Federal network adequacy standards to State Exchanges in future rulemaking (87 FR 27334). Several commenters suggested that State alignment with Federal standards would be ideal, and that Federal standards

<sup>188</sup> 2023 Final Letter to Issuers in the Federally-facilitated Exchanges. <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf>.

<sup>189</sup> Essential Community Providers and Network Adequacy. <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>.

<sup>190</sup> Id.

should offer minimum standards, or a “strong floor,” that all States must meet.

In the 2024 Payment Notice (87 FR 78285 through 78287), we finalized that all individual market QHPs, including individual market stand-alone dental plans (SADPs), and all SHOP QHPs across all Exchanges must use a network of providers that complies with the standards described in §§ 156.230 and 156.235 (with a limited exception for certain SADP issuers as specified under § 156.230(a)(4)). We also further deferred the imposition of appointment wait time standards to PY 2025.

#### b. Network Adequacy Standards and Reviews Across Exchanges

Network adequacy is a key factor affecting consumers’ access to care. While the FFEs impose uniform network adequacy standards across the States they serve that require QHP issuers to meet quantitative metrics, a similarly uniform network adequacy standard does not exist for States served by State Exchanges and SBE-FPs. Indeed, these circumstances prompted the National Association of Insurance Commissioners to develop the NAIC Health Benefit Plan Network Access and Adequacy Model Act (Model Act).<sup>191</sup> The Model Act includes recommendations for qualitative network adequacy standards to which States could hold their issuers accountable and that require submission of access plans. The Model Act, however, does not specify what constitutes network adequacy, and, currently, only a few State Exchanges and SBE-FPs have adopted the full Model Act, resulting in the lack of a strong floor for network adequacy standards among State Exchanges and SBE-FPs.

State Exchanges and SBE-FPs currently have a mix of network adequacy policies in place, and approximately 25 percent of those fail to impose any quantitative standard. Quantitative network adequacy standards can be monitored relatively easily and applied objectively and may include standards that measure provider-to-enrollee ratios, time and distance, or appointment wait times.<sup>192</sup> On the other hand, a qualitative approach to network adequacy typically articulates a broad, general standard of

adequacy and typically grants regulators or insurers discretion to determine how to measure compliance.<sup>193</sup> State regulators using this approach may require issuers to simply articulate how they determine and measure adequacy in their networks.<sup>194</sup> Once regulators approve an issuer’s network adequacy plan using this approach, they then typically let issuers self-monitor their own compliance.<sup>195</sup> As opposed to conducting routine audits or requiring periodic reports of compliance, State regulators usually rely on consumer complaints to highlight situations that might require investigation.<sup>196</sup>

Based on our experience conducting network adequacy reviews and regulating QHPs, as well as feedback from interested parties, including the many commenters who requested in the 2023 Payment Notice (87 FR 27334) that HHS extend Federal network adequacy standards to State Exchanges in future rulemaking, we are now of the view that no matter the State in which a QHP is offered, some quantitative analysis is necessary for an Exchange to objectively monitor network adequacy and determine whether a QHP provides enrollees in that State with access to an adequate network of providers.

Moreover, the proliferation in recent years of QHP issuers with narrower provider networks raises several consumer protection concerns. QHPs with narrower networks may lack access to specific provider specialties in-network, resulting in significant out-of-pocket expenses for consumers who must seek care out-of-network or resulting in consumers forgoing care to avoid these expenses. We have also been made aware, through communications with interested parties, of issues faced by consumers where in-network emergency physicians and mental health providers are in limited supply or, in the case of in-network emergency physicians, not available at in-network hospitals. Additionally, the proliferation of narrower networks risks consumers being enrolled in plans whose networks do not have sufficient capacity to serve them or whose providers are too geographically dispersed to be reasonably accessible.

Therefore, we propose to establish a national floor of quantitative network adequacy standards and network adequacy reviews. Although a number of State Exchanges and SBE-FPs have taken meaningful steps towards ensuring the adequacy of QHP

networks, we are of the view that every Exchange should apply quantitative network adequacy standards and conduct a thorough review and analysis of issuer compliance with these standards to effectively evaluate the adequacy of QHP networks in order to ensure that all consumers, regardless of which State they live in, have timely access to providers to manage their health care needs.

#### c. Proposals Related to State Exchange and SBE-FP Network Adequacy Standards and Reviews

We propose that for PY 2025 and future plan years, State Exchanges and SBE-FPs must (1) 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 (2) conduct reviews of a plan’s compliance with those quantitative network adequacy standards prior to certifying any plan as a QHP, consistent with the manner in which the FFEs review the network adequacy of plans under § 156.230.

#### i. Quantitative Network Adequacy Time and Distance Standards

For plans years beginning on or after January 1, 2025, we propose that State Exchanges and SBE-FPs establish and impose quantitative time and distance network adequacy standards that are at least as stringent as the FFEs’ time and distance standards established for QHPs under § 156.230.

For purposes of this proposal, “at least as stringent as” means time and distance standards that use a specialty list that includes at least the same specialties as our provider specialty lists and time and distance parameters that are at least as short as our parameters. States would be permitted to implement network adequacy standards that are more stringent than those performed by the FFEs under § 156.230. In other words, States could use a specialty list that is broader than our specialty lists, but it must include all the provider specialties included in our lists. Similarly, the time and distance parameters could also be narrower than our parameters, meaning they could require shorter time and/or distances, but they cannot be less demanding than our time and distance parameters.

Quantitative time and distance standards help strengthen QHP enrollees’ timely access to a variety of providers to meet their health care needs, which in turn helps ensure that enrollees can receive health care services without unreasonable delay. Additionally, quantitative time and

<sup>191</sup> Health Benefit Plan Network Access and Adequacy Model Act. (2015, 4th Quarter). [https://www.nh.gov/insurance/legal/documents/naic\\_model\\_act\\_network\\_adequacy.pdf](https://www.nh.gov/insurance/legal/documents/naic_model_act_network_adequacy.pdf).

<sup>192</sup> Hall, Ginsburg. (2017, Sep.). A Better Approach to Regulating Provider Network Adequacy. <https://www.brookings.edu/wp-content/uploads/2017/09/regulatory-options-for-provider-network-adequacy.pdf>.

<sup>193</sup> Id.

<sup>194</sup> Id.

<sup>195</sup> Id.

<sup>196</sup> Id.

distance standards, when varied by county type, provide a useful assessment of whether QHPs provide reasonable access to care and a more comprehensive evaluation of the adequacy of QHPs' networks.

In the 2023 Payment Notice (87 FR 27322), we adopted time and distance standards that the FFEs would use to assess whether plans to be certified as QHPs in the FFEs meet network adequacy standards. The proposed provider specialty lists for time and distance standards for PY 2023 were informed by prior HHS network adequacy requirements, consultation with interested parties, and other Federal and State health care programs, such as Medicare Advantage and Medicaid. The provider specialty lists that were finalized for PY 2023 covered more provider types than previously evaluated under FFE standards so that

QHP networks would be robust, comprehensive, and responsive to QHP enrollees' needs. We believe that these provider specialty lists promote access to a variety of provider types and as a result strengthen consumer access to health care services without unreasonable delay. To establish a national floor for quantitative network adequacy standards, we propose that the provider specialty list that State Exchanges and SBE-FPs use must include, at a minimum, the providers in the provider specialty lists for the FFEs that were applicable to PY 2023. Those lists are included in this preamble, as well.

Consistent with the standards for the FFEs and to strengthen QHP enrollees' timely access to a variety of providers to meet their health care needs, we propose that State Exchanges and SBE-FPs' time and distance standards would

be calculated at the county level and vary by county designation. State Exchanges and SBE-FPs would be required to use a county type designation method that is based on the population size and density parameters of individual counties. Under our proposal, the time and distance standards State Exchanges and SBE-FPs would establish and impose would apply to the provider specialty lists contained in Tables 10 and 11. To count towards meeting the time and distance standards, individual and facility providers listed on Tables 10 and 11 would have to be appropriately licensed, accredited, or certified to provide services in their State, as applicable, and would need to have in-person services available.

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**TABLE 10: Individual Provider Specialty List for Time and Distance Standards**

<b>Individual Specialty Types</b>
Allergy and Immunology
Cardiology
Cardiothoracic Surgery
Chiropractor
Dental
Dermatology
Emergency Medicine
Endocrinology
ENT/Otolaryngology
Gastroenterology
General Surgery
Gynecology, OB/GYN
Infectious Diseases
Nephrology
Neurology
Neurosurgery
Occupational Therapy
Oncology – Medical, Surgical
Oncology – Radiation
Ophthalmology
Orthopedic Surgery
Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals)
Physical Medicine and Rehabilitation
Physical Therapy
Plastic Surgery
Podiatry
Primary Care – Adult
Primary Care – Pediatric
Psychiatry
Pulmonology
Rheumatology
Speech Therapy
Urology
Vascular Surgery

**TABLE 11: Facility Specialty List for Time and Distance Standards**

<b>Facility Specialty Types</b>
Acute Inpatient Hospitals (Must have Emergency services available 24/7)
Cardiac Catheterization Services
Cardiac Surgery Program
Critical Care Services – Intensive Care Units (ICU)
Diagnostic Radiology (Free-standing; hospital outpatient; ambulatory health facilities with Diagnostic Radiology)
Inpatient or Residential Behavioral Health Facility Services
Mammography
Outpatient Infusion/Chemotherapy
Skilled Nursing Facilities
Surgical Services (Outpatient or ASC)
Urgent Care

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The county-specific time and distance parameters that QHPs would be

required to meet would be detailed in future guidance, in the annual CMS

Letter to Issuers in the Federally-facilitated Exchanges. We would



consider industry standards in developing these standards.

#### ii. Quantitative Network Adequacy Reviews

For plans years beginning on or after January 1, 2025, we propose that State Exchanges and SBE-FPs be required to conduct quantitative network adequacy reviews prior to QHP certification, and that they conduct them consistent with network adequacy reviews conducted by the FFEs under § 156.230. Specifically, when we refer to the review being consistent with the network adequacy reviews conducted by the FFEs under § 156.230, we propose that State Exchanges and SBE-FPs would be required to conduct, prior to QHP certification, quantitative network adequacy reviews to evaluate compliance with requirements under § 156.230(a)(1)(ii) and (iii), and (a)(2)(i)(A), while providing QHP certification applicants the flexibilities described under § 156.230(a)(2)(ii) and (a)(3) and (4). Under this proposal, State Exchanges and SBE-FPs would be prohibited from accepting an issuer's attestation as the only means for plan compliance with network adequacy standards. We further propose that State Exchanges and SBE-FPs would make available to SADP applicants the limited exception available to SADPs under § 156.230(a)(4), pursuant to which SADPs may not be required to meet FFE network adequacy standards under § 156.230(a)(4), for the same reasons we made this exception available in the FFEs in the 2024 Payment Notice (88 FR 25878 through 25879). This exception is not available to medical QHP issuers.

#### iii. Quantitative Network Adequacy Review Justification Process

We acknowledge that State-specific challenges may necessitate exceptions, and so we propose to require State Exchanges and SBE-FPs to permit issuers that are unable to meet the specified standards to participate in a justification process after submitting their initial data to account for variances, consistent with the processes specified under § 156.230(a)(2)(ii) and (a)(3) and (4). State-specific challenges could include barriers beyond an issuer's control, such as provider supply shortages or topographic barriers.

The issuer would include this justification as part of its QHP application and describe 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 would be required to provide information as requested by the State Exchange or SBE-FP to support this justification. State Exchanges and SBE-FPs would be required to review the issuer's justification to determine whether making such health plan available through the Exchange is in the interests of qualified individuals in the State or States in which such Exchange operates as specified under § 156.230(a)(3). In making this determination, the factors State Exchanges and SBE-FPs could consider include whether the exception is reasonable based on circumstances such as the local availability of providers and variables reflected in local patterns of care. If the State Exchange or SBE-FP determines that making such health plan available through its Exchange is in the interests of qualified individuals in the State or States in which such Exchange operates, it could then certify the plan as a QHP.

#### iv. Exception Process for State Exchanges and SBE-FPs

We are aware that some States Exchanges employ robust, quantitative network adequacy standards that differ from those used by the FFEs, but still ensure that QHPs provide consumers with reasonable, timely access to practitioners and facilities to manage their health care needs, consistent with the ultimate aim of these proposals. In light of this, we propose a framework for granting exceptions to the requirements that State Exchanges and SBE-FPs are required to establish and impose network adequacy time and distance standards for QHPs that are at least as stringent as the standards applicable to QHPs in FFEs and conduct quantitative network adequacy reviews that are consistent with those carried out by the FFEs under § 156.230. We propose that HHS could grant State Exchanges and SBE-FPs an exception if it determines that the Exchange applies and enforces quantitative network adequacy standards that are different from the FFEs' but ensure reasonable access as defined under § 156.230. The exception would be available only to State Exchanges and SBE-FPs that conduct quantitative reviews of network adequacy prior to certifying plans as QHPs. Exchanges seeking to employ alternative network adequacy standards would be required to submit an exception request, in a form and manner specified by HHS, and to support their exception request with evidence-based data demonstrating that such standards ensure access as defined under § 156.230.

For example, if a State were to provide quantitative evidence that their network adequacy time and distance standards that measure access by service types provide consumers with equal access to providers as the Federal network adequacy standards under § 156.230 that measure access by provider types, we may grant the respective State's request for an exception from measuring access by provider types. Additionally, if a State were to use different county type designations than the five county type designations that we use to assess QHP time and distance standards at the county level (that is, Large Metro, Metro, Micro, Rural, CEAC), we would consider the respective State's request for an exemption from using the same five county type designations only if the State were to provide evidence that their alternative county type designations provide consumers with equal access to providers as the Federal network adequacy standards under § 156.230. Alternative quantitative network adequacy standards that we would review for potentially qualifying for the exemption must be supported by evidence-based data, demonstrating that such standards provide enrollees with a level of access to providers that is equal to or greater than that ensured by the FFE network adequacy standards under § 156.230.

Although we propose to establish minimum standards related to network adequacy in this proposed rule, we solicit comment on how States may be able to develop a combination of data-driven quantitative and qualitative standards, developed with input from interested parties, to assess network adequacy. In the 2020 Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care final rule (85 FR 72754, 72802), we provided States the flexibility to develop quantitative network adequacy standards for determining network adequacy. In that rule, we noted that in some situations, time and distance may not be the most effective type of standard for determining network adequacy and that some States have found that the time and distance analysis produces results that may not accurately reflect provider availability. For example, a State that has a heavy reliance on telehealth in certain areas of the State may find that a health care provider-to-enrollee ratio is more useful in measuring meaningful access to all services without unreasonable delay, as the time it would take the enrollee, and the distance the enrollee would have to travel, to access

the provider in-person could be well beyond applicable time and distance standards, but the enrollee may still be able to easily and quickly access many different providers on a virtual basis. (85 FR 72802) We seek comment on how we should administer the process for Exchanges to apply for these exceptions, including the appropriate timelines, and the data that would be required to be submitted as part of this request. We also seek comment on how we should evaluate the provider access offered by QHP issuers in a State that requests an exception to establish and impose quantitative network adequacy standards that are different from the FFEs', whether and how to measure the access provided by those different standards over time, and how long an approved exemption should last.

To ensure compliance with these proposed quantitative time and distance QHP network adequacy standards and review requirements, we would coordinate with State Exchanges and SBE-FPs to provide technical assistance to support their compliance with the requirements of this proposal and work with them should it be necessary to remedy any gaps in compliance. However, if a State Exchange or SBE-FP fails to comply with these standards, HHS could seek to take remedial action under its authorities related to Exchange program integrity.

#### d. Proposal Related to QHP Reporting on Telehealth Services

We propose to require State Exchanges and SBE-FPs to require that all issuers seeking certification of plans to be offered as QHPs submit information to the respective State Exchanges or SBE-FPs about whether network providers offer telehealth services. We propose that this requirement would be applicable beginning with the QHP certification cycle for PY 2025. This data would be for informational purposes; it would be intended to help inform the future development of telehealth standards and would not be displayed to consumers. We believe this information could be relevant to State Exchange and SBE-FP analysis of whether a QHP meets network adequacy standards. We note that this proposal is not intended to suggest that telehealth services would be counted in place of in-person service access for the purpose of meeting network adequacy standards for PY 2025. While we acknowledge the growing importance of telehealth, we want to ensure that telehealth services do not reduce the availability of in-person care.

For this purpose, telehealth encompasses professional consultations, office visits, and office psychiatry services delivered through technology-based methods, including virtual check-ins, remote evaluation of pre-recorded patient data, and inter-professional internet consultations. Currently, for issuers in FFEs to comply with telehealth reporting standards, issuers must indicate whether each provider offers telehealth with the options "Yes," "No," or "Requested information from the provider, awaiting their response." We are proposing that State Exchanges and SBE-FPs also impose this same standard.

We seek comment on this proposal, including comments on how we might incorporate telehealth availability into network adequacy standards in future plan years.

#### f. Additional Network Adequacy Standards

To reduce burden on State Exchanges and SBE-FPs that are not yet conducting quantitative network adequacy reviews, we are not proposing at this time that State Exchanges and SBE-FPs enforce appointment wait time standards or that State Exchanges and SBE-FPs ensure that the provider network of each QHP meets applicable standards specified in § 156.230(b) through (e). However, we seek comment to inform any potential future enforcement of appointment wait time standards as well as the standards specified in § 156.230(b) through (e), and look forward to capturing a wide range of perspectives on these topics from various interested parties. We are especially interested in comments about how State Exchanges and SBE-FPs may enforce quantitative network adequacy standards for appointment wait times, as well as the impact enforcing these standards may have on issuers and consumers.

We also seek comment on our proposal for State Exchanges and SBE-FPs to establish and impose quantitative time and distance QHP network adequacy standards that are at least as stringent as the FFEs' time and distance standards established for QHPs under § 156.230 and to conduct quantitative network adequacy reviews, prior to QHP certification, that are consistent with the reviews conducted by the FFEs under § 156.230, including comment on whether we should amend § 156.230 in addition to § 155.1050 to directly apply the same standards applicable to issuers on FFEs to issuers in State Exchanges and SBE-FPs for plan years beginning on or after January 1, 2025.

#### E. 45 CFR 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 2025 Benefit Year (§ 156.50)

For the 2025 benefit year, we propose to retain the 2024 benefit year FFE user fee rate of 2.2 percent of total monthly premiums and an SBE-FP user fee rate of 1.8 percent of the total monthly premiums.

Section 1311(d)(5)(A) of the ACA permits an Exchange to charge assessments or user fees on participating health insurance issuers as a means of generating funding to support its operations. If a State does not elect to operate an Exchange or does not have an approved Exchange, section 1321(c)(1) of the ACA directs HHS to operate an Exchange within the State. Accordingly, in § 156.50(c), we state that a participating issuer offering a plan through an FFE or SBE-FP must remit a user fee to HHS each month that is equal to the product of the annual user fee rate specified in the annual HHS notice of benefit and payment parameters for FFEs and SBE-FPs for the applicable benefit year and the monthly premium charged by the issuer for each policy where enrollment is through an FFE or SBE-FP. OMB Circular A-25 established Federal policy regarding user fees and what the fees can be used for.<sup>197</sup> OMB Circular 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 Rates for the 2025 Benefit Year

Based on estimated costs, enrollment (including anticipated establishment of SBE-FPs or shifts to State Exchanges in certain States in which FFEs or SBE-FPs currently are operating), and premiums for the 2025 benefit year, we propose a 2025 user fee rate for all participating FFE issuers of 2.2 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

<sup>197</sup> See Circular No. A-25 Revised. <https://www.whitehouse.gov/wp-content/uploads/2017/11/Circular-025.pdf>.

charged by the issuer for each policy where enrollment is through an FFE. As in benefit years 2014 through 2024, issuers seeking to participate in an FFE in the 2025 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 2025 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 2025 benefit year of costs for operating the FFEs, premiums, enrollment, and transitions in Exchange 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 and may affect the FFE and SBE-FP rates and are considered as part of our calculation of our proposed user fee amounts.

To develop the proposed 2025 benefit year FFE user fee rates, we considered a range of costs, premiums, and enrollment projections.<sup>198</sup> For the proposed 2025 benefit year user fee rates, we estimated a reduction in contract costs partially or fully funded out of FFE and SBE-FP user fees from the 2024 benefit year due to the HHS

funding for Exchange outreach activities related to Medicaid unwinding ending in 2024. We took several factors into consideration in choosing which premium and enrollment projections would inform the proposed 2025 FFE user fee rates. The enhanced PTC subsidies in section 9661 of the ARP were extended in section 12001 of the IRA through the 2025 benefit year. The extension of enhanced PTC subsidies significantly influenced our development of the 2025 enrollment and premium projections. We expect this provision of the IRA to sustain the higher enrollment levels observed in the 2021 and 2022 benefit years after the ARP was established and, as a result, we expect the projected total premiums where the user fee applies to increase, thereby increasing the amount of user fees that will be collected. Our 2025 enrollment estimates also account for the projected transitions of States from FFEs or SBE-FPs to State Exchanges, the enrollment impacts of section 1332 waivers, and transitioning Medicaid Expansion States.<sup>199</sup> We project that 2025 benefit year premiums will generally increase at the rate of medical inflation. After considering the range of costs, premiums, and enrollment projections, we propose a 2025 user fee rate that will ensure adequate funding for Federal Exchange operations.

We note that if any events significantly change our estimates around costs, premiums, or enrollment projections between this proposed rule and the final rule, we may modify the FFE and SBE-FP user fee rates that are proposed in this rule. For example, if enrollment during the open enrollment period for the 2024 plan year is significantly larger or smaller than anticipated, we would revise our enrollment projections, which could result in a modification of the FFE and SBE-FP proposed rates. The proposed FFE user fee rate for 2025 is 2.2 percent of total monthly premiums and is the same user fee rate as for the 2024 benefit year. After accounting for the impact of the proposed user fee rate, we estimate that we would have sufficient funding available to fully fund user-fee-eligible FFE activities.

We seek comment on the proposed 2025 FFE user fee rate.

b. SBE-FP User Fee Rates for the 2025 Benefit Year

We propose to charge issuers offering QHPs through an SBE-FP a user fee rate of 1.8 percent of the monthly premium charged by the issuer for each policy under plans offered through an SBE-FP for the 2025 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 ACA, and QHP enrollment functions under 45 CFR part 155, subpart E. The user fee rate for SBE-FPs is calculated based on the proportion of 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 rates for the 2025 benefit year, we used the same assumptions related to contract costs, enrollment, and premiums as we used for the proposed FFE user fee rates. 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 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. Based on this methodology, the proposed 2025 SBE-FP user fee rate is the same user fee rate of 1.8 percent of

<sup>198</sup> We considered the most recent projections from the Congressional Budget Office (<https://www.cbo.gov/system/files/2023-05/51298-2023-05-healthinsurance.pdf>) and, as we have in prior rulemakings, our own internal data. See, for example, 88 FR 25845.

<sup>199</sup> In 2023, South Dakota implemented the Medicaid expansion provision of the ACA, extending Medicaid eligibility to adults in that State under the age of 65 with incomes up to 138 percent of the Federal poverty level. North Carolina is expected to implement Medicaid expansion in 2024.

premiums that we established for the 2024 benefit year. The proposed user fee rate for SBE–FP issuers for the 2025 benefit year also 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 2025 benefit year, which impacts the SBE–FP enrollment projections. As mentioned above, we also note that if any events significantly change our estimates around costs, premiums, or enrollment projections between this proposed rule and the final rule, we may modify the FFE and SBE–FP rates that are proposed in this rule.

We seek comment on the proposed 2025 SBE–FP user fee rate.

## 2. State Selection of EHB-Benchmark Plans for Plan Years Beginning on or After January 1, 2027 (§ 156.111)

For benefit years beginning on or after January 1, 2027, we propose to revise the standards for the State selection of EHB-benchmark plans at § 156.111 to: consolidate the options for States to change EHB-benchmark plans at § 156.111(a); revise the scope of benefit requirements at § 156.111(b)(2); and amend § 156.111(e)(3) to require States to submit a formulary drug list as part of its application to change EHB-benchmark plans only if the State is seeking to change its prescription drug EHB.

Section 1302 of the ACA provides for the establishment of an EHB package that includes coverage of EHBs (as defined by the Secretary of HHS), cost-sharing limits, and AV requirements. 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. In the 2023 Payment Notice (87 FR 27290), we revised § 156.111 to require States to

notify HHS of the selection of a new EHB-benchmark plan by the first Wednesday in May of the year that is 2 years before the effective date of the new EHB-benchmark plan, and stated that if a State did not provide such notification to HHS, the State's EHB-benchmark plan for the applicable plan year would be that State's EHB-benchmark plan applicable for the prior year. In the EHB RFI (87 FR 74097), we solicited public comment on a variety of topics related to the scope of benefits in health plans subject to the EHB requirements of the ACA, including the description of the EHB, the scope of benefits covered in typical employer plans, the review of EHB, coverage of prescription drugs, and substitution of EHB.

Section 156.111(a) describes three options for States to change their EHB-benchmark plan. States may: (1) select the EHB-benchmark plan that another State used for the 2017 plan year under §§ 156.100 and 156.110; (2) replace one or more categories of EHBs established at § 156.110(a) in the State's EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year under §§ 156.100 and 156.110; or (3) otherwise select a set of benefits that would become the State's EHB-benchmark plan.

Among other requirements, a State changing its EHB-benchmark plan must comply with two scope of benefit requirements at § 156.111(b)(2)(i) and (ii). The first scope of benefit requirement at § 156.111(b)(2)(i), also known as the typicality standard, requires the State's proposed EHB-benchmark plan to provide a scope of benefits equal to the scope of benefits provided under a typical employer plan,<sup>200</sup> in accordance with section 1302(b)(2) of the ACA. As defined at § 156.111(b)(2)(i)(A) and (B), a typical employer plan is either: one of the selecting State's 10 base-benchmark plan options established at § 156.100 and available for the selecting State's selection for the 2017 plan year or the largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State.<sup>201</sup> The

second scope of benefit requirement at § 156.111(b)(2)(ii), also known as the generosity standard, requires the State's proposed EHB-benchmark plan to provide a scope of benefits that does not exceed the generosity of the most generous among a set of comparison plans, including: the State's EHB-benchmark plan used for the 2017 plan year, and any of the State's base-benchmark plan options for the 2017 plan year described in § 156.100(a)(1), supplemented as necessary under § 156.110.

Under § 156.111(e)(3), if a State is selecting its EHB-benchmark plan by selecting a set of benefits that would become the State's EHB-benchmark plan under § 156.111(a)(3), the State must submit a formulary drug list in a format and manner specified by HHS.

Nine States have changed their EHB-benchmark plans since 2018 by complying with the requirements at § 156.111.<sup>202</sup> Based on interactions with these States and feedback received in response to the EHB RFI,<sup>203</sup> we understand that certain aspects of the process to change EHB-benchmark plans may impose unanticipated difficulty on and create confusion for States. We understand there are concerns that the typicality standard, as implemented, is a burdensome way to ensure a State's EHB-benchmark plan selection is equal in scope to a typical employer plan. In addition, in limiting EHB-benchmark plan selections, we understand that the generosity standard may also impede the ability of States to select an EHB-benchmark that is equal in scope to the benefits provided under a typical employer plan in the State, which we understand States often find have become more generous over time. We also understand that requiring States to submit a formulary drug list to HHS as part of the documentation required under § 156.111(e) can be particularly onerous when a State is not seeking to change its prescription drug EHBs.

As a result of that feedback, we are now proposing changes to § 156.111 to reduce State burden to change EHB-benchmark plans. For benefit years beginning on or after January 1, 2027, we propose three revisions to the

<sup>200</sup> § 156.145; the benefits are not excepted benefits, as established under § 146.145(b) and § 148.220; and the benefits in the plan are from a plan year beginning after December 31, 2013.

<sup>202</sup> For more information on the changes States have made to their EHB-benchmark plans, see <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb>.

<sup>203</sup> For example, see <https://www.regulations.gov/comment/CMS-2022-0186-0270>; <https://www.regulations.gov/comment/CMS-2022-0186-0412>; and <https://www.regulations.gov/comment/CMS-2022-0186-0559>.

<sup>200</sup> The scope of benefits of the State's new EHB-benchmark plan may exceed the scope of benefits of the typical employer-sponsored or other job-based plans only to the extent any supplementation is required to provide coverage within each EHB category at § 156.110(a).

<sup>201</sup> Provided that the product has at least 10 percent of the total enrollment of the five largest large group health insurance products in the State; the plan provides minimum value, as defined under

standards for State selection of EHB-benchmark plans at § 156.111. First, we propose to consolidate the options for States to change EHB-benchmark plans at § 156.111(a) to reduce the burden on States to decide between three functionally identical choices. Second, we propose to revise the typicality standard at § 156.111(b)(2) so that, in demonstrating that a State's new EHB-benchmark plan provides a scope of benefits that is equal to the scope of benefits of a typical employer plan in the State, the scope of benefits of a typical employer plan in the State would be defined as any scope of benefits that is as or more generous than the scope of benefits in the State's least generous typical employer plan (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)), and as or less generous than the scope of benefits in the State's most generous typical employer plan (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)), among the typical employer plans currently defined at § 156.111(b)(2)(i)(A) and (B). We also propose to remove the generosity standard at § 156.111(b)(2)(ii) and to make a technical revision to the language regarding supplementation at § 156.111(b)(2)(i). Third, we propose to revise § 156.111(e)(3) to require States to submit a formulary drug list as part of their documentation to change EHB-benchmark plans only if the State is seeking to change its prescription drug EHB.

#### a. Consolidating the State EHB-Benchmark Plan Options

First, we propose to consolidate the choices for States to change their EHB-benchmark plan by revising § 156.111(a) to add a new paragraph (a)(2) which would simply state that, subject to paragraphs (b), (c), (d), and (e) of § 156.111, for plan years beginning on or after January 1, 2027, a State may change its EHB-benchmark plan by selecting a set of benefits that would become the State's EHB-benchmark plan. The language at current § 156.111(a) would be redesignated as § 156.111(a)(1) and would be revised to provide that this paragraph applies to plan years beginning on or after January 1, 2020, through December 31, 2026. Further, the language currently at § 156.111(a)(1) through (3) would be redesignated as § 156.111(a)(1)(i) through (iii).

This proposal would not substantively change the options for States to change their EHB-benchmark plans, as current § 156.111(a)(3) already

allows States to select a set of benefits that would become the State's EHB-benchmark plan and this option functionally encompasses the options at current § 156.111(a)(1) and (a)(2), which allow States to select the EHB-benchmark plan that another State used for the 2017 plan year under §§ 156.100 and 156.110, in whole or in part. Under this proposal, a State selecting a set of benefits to become the State's EHB-benchmark plan that wants to use an EHB-benchmark plan from another State, either in whole or in part, could still do so. The flexibility that current § 156.111(a)(3) offers is why all nine States that have changed their EHB-benchmark plans since 2018 relied on § 156.111(a)(3) to do so, though they often made that decision after spending time and resources to deliberate on the differences between the three options. Therefore, we propose to revise § 156.111(a) to reduce this burden on States without substantively changing their options to select an EHB-benchmark plan.

Under 42 CFR 440.347, Medicaid ABPs authorized under section 1937 of the Act are required to meet EHB standards. Similarly, under 42 CFR 600.405, in States that elect to operate a BHP, the standard health plans must meet EHB standards. The changes to State EHB-benchmark plan options would also be applicable to States when choosing a benchmark plan used to define EHBs in a Medicaid ABP or BHP standard health plan.

We seek comment on the proposal to consolidate State EHB-benchmark plan options under § 156.111(a).

#### b. Scope of Benefit Requirements

Second, we propose to revise the scope of benefit requirements at § 156.111(b)(2) for plan years beginning on or after January 1, 2027, with corresponding proposed revisions to the actuarial requirements at § 156.111(e)(2). Specifically, we propose that a State's new EHB-benchmark plan would be required to provide a scope of benefits that is equal to the scope of benefits of a typical employer plan in the State, and that the scope of benefits of a typical employer plan in the State would be defined as any scope of benefits that is as or more generous than the scope of benefits in the State's least generous typical employer plan (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)), and as or less generous than the scope of benefits in the most generous typical employer plan in the State (supplemented by the State as necessary to provide coverage within each EHB category at

§ 156.110(a)), among the typical employer plans currently defined at § 156.111(b)(2)(i)(A) and (B). We also propose to remove the generosity standard at § 156.111(b)(2)(ii) and to make a technical revision to the language regarding supplementation at § 156.111(b)(2)(i).

Since the effective date of the 2019 Payment Notice, States have been required to perform detailed actuarial analyses to demonstrate that their EHB-benchmark plans offer a scope of benefits equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at § 156.110(a), the scope of benefits provided under a typical employer plan from among the typical employer plans identified in the regulation. To demonstrate this, a State must first assess the value of the current EHB-benchmark plan. Next, the State must determine how that valuation increases or decreases depending on their proposed plan modifications. Finally, the State must assess the value of each typical employer plan option to identify an exact match for the expected value offered by the proposed plan. To find such a match, the State may need to assess the value of many typical employer plan options, and determine whether supplementation is necessary, which requires both additional time and potentially additional costs for actuarial services. Additionally, the typical employer plan options available to the State may not yield an exact match to the benefit changes the State wishes to make, requiring the State to then modify its proposed benefit changes to be exactly equal in value to one of the available typical employer plan options. In this way, the existing typicality standard can inhibit the ability of States to innovate benefits in the State's EHB-benchmark plan by generally requiring an exact actuarial match. In contrast, under the proposed approach to typicality, each State would need to assess only two typical employer plan options (the most and least generous available) to establish a range of scopes of benefits that would be considered typical employer plans within which the State EHB-benchmark plan values could then match. We believe that requiring States to actuarially assess only two typical employer plan options would reduce both the time and cost to States of seeking to update their EHB-benchmark plans and support a wider range of possible benefit changes, thereby enabling States to more easily propose such updates if and when they deem it appropriate to do so.

As an example, a State seeks to add benefits to an existing EHB-benchmark

plan that currently provides a scope of benefits equivalent to the State's least generous typical employer plan. The benefits that the State seeks to add to the existing EHB-benchmark plan would make it no longer equivalent to the State's least generous typical employer plan. The additional benefits would also result in an EHB-benchmark plan that is still less generous than the State's most generous typical employer plan. Under the current rules, the State could not add these benefits to their existing EHB-benchmark unless there is another typical employer plan listed in the regulation that provides an equivalent scope of benefits that accounts for the State's proposed additions. This could mean that the State's proposed EHB-benchmark plan would be out of compliance with the typicality standard simply because it does not provide a scope of benefits equivalent to one of the remaining State's typical employer plans, even though the scope of benefits in the State's proposed EHB-benchmark plan is more generous than the State's least generous typical employer plan and less generous than the State's most generous typical employer plan. States have expressed frustration that this approach to the typicality standard is unnecessarily restrictive.

We agree with States that this approach to the typicality standard can lead to unnecessary burden for States to ensure compliance with section 1302(b)(2) of the ACA. Accordingly, we propose to revise the scope of benefits requirements at § 156.111(b)(2) to redesignate § 156.111(b)(2)(i) and (ii) as § 156.111(b)(2)(i)(A) and (B) and to specify at redesignated § 156.111(b)(2)(i) that these provisions would apply for plan years beginning on or after January 1, 2020, through December 31, 2026. We further propose to add new § 156.111(b)(2)(ii) to provide that, for plan years beginning on or after January 1, 2027, States may select an EHB-benchmark plan that provides a scope of benefits equal to that of a typical employer plan in the State, where the scope of benefits of a typical employer plan is any scope of benefits within a continuous range of the scope of benefits that is as or more generous than that provided by State's least generous typical employer plan (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)) and as or less generous than that provided by the State's most generous typical employer plan (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)), among the plans described at the proposed

§ 156.111(b)(2)(ii)(A) and (B). Under this proposal, at proposed § 156.111(b)(2)(ii)(A) and (B), a State would identify the least and most generous typical employer plans among the same typical employer plans currently defined at § 156.111(b)(2)(i)(A) and (B) to determine the permissible continuous range of the scope of benefits for a State's EHB-benchmark plan selection. We believe that this approach would significantly reduce State burden in changing EHB-benchmark plans while still ensuring that they provide a scope of benefits in accordance with section 1302(b)(2) of the ACA.

As noted above, we are not proposing to change the list of typical employer plans in this proposed rule. Under current § 156.111(b)(2)(i)(B) and proposed § 156.111(b)(2)(ii)(B), for purposes of complying with the proposed typicality standard, a State may use the largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State, provided that the benefits in the plan are from a plan year beginning after December 31, 2013.<sup>204</sup> Nonetheless, if the scope of benefits in these large group employer plans changes over time and such plans are among a State's most generous typical employer plans, the upper bound of that State's available scope of benefits could change accordingly.<sup>205</sup> We have received feedback from States that indicates that the scope of benefits in some of these large group plans has increased since 2017, so we believe it is appropriate to allow States to select an EHB-benchmark plan with a scope of benefit requirement that tracks with such changes to employer plans in the States, to the extent they exist.

We continue to believe that this list of plans appropriately represents the scope of benefits provided under typical employer plans. Based on our research on how the scope of benefits in employer-sponsored or other job-based coverage has changed since 2014, which

includes our review of the comments submitted in response to the EHB RFI, we believe that the scope of benefits in employer-sponsored or other job-based coverage has either remained the same or increased incrementally overall since 2014. To the extent it has increased in certain States or certain regions, we believe that the scope of benefits in employer-sponsored or other job-based coverage increasingly tends to provide coverage for telehealth services, gender-affirming care, bariatric surgery, hearing aids, infertility treatment, routine non-pediatric dental services, and travel-related benefits for certain conditions.<sup>206</sup>

When we finalized the addition of § 156.111 in the 2019 Payment Notice (83 FR 17009), we also included the generosity standard at § 156.111(b)(2)(ii) among the scope of benefit requirements for State EHB-benchmark plans. As described at § 156.111(b)(2)(ii), the generosity standard requires that the scope of benefits in a State's proposed new EHB-benchmark plan not exceed the generosity of the most generous among a set of comparison plans, including: the State's EHB-benchmark plan used for the 2017 plan year, and any of the State's base-benchmark plan options for the 2017 plan year described in § 156.100(a)(1), supplemented as necessary under § 156.110. In the 2019 Payment Notice (83 FR 17011), we supported the addition of the generosity standard by stating that it would appropriately limit the range of benefits that can be considered EHB. Ever since, we have received significant feedback from States and interested parties that the generosity standard "hinders the ability of States to add innovative benefits to their EHB-benchmark plans."<sup>207</sup> States have also shared that the generosity standard is not necessary to ensure the State EHB-benchmark plan selections are not unbounded given that the typicality standard can function as both a ceiling and floor to limit a State's EHB selections. Specifically, the typicality standard alone limits the

<sup>204</sup> In addition, the product must have at least 10 percent of the total enrollment of the five largest large group health insurance products in the State; the plan must provide minimum value, as defined under § 156.145; and the benefits must not be excepted benefits, as established under §§ 146.145(b) and 148.220. See § 156.111(b)(2)(i)(B)(1) through (3).

<sup>205</sup> It is our expectation that the changes to the scope of benefits in these large group plans would only impact the upper bound of EHB-benchmark plans' scope of benefits. We expect the small group typical employer-sponsored or other job-based plans at § 156.100(a)(1), which are only from PY 2017, to consistently be among the least generous typical employer-sponsored or other job-based plans.

<sup>206</sup> We emphasize that, under current § 156.111, States that change their EHB-benchmark plan are generally permitted to select a set of benefits as their EHB-benchmark plan without regard to the specific benefits that the State's selected typical employer-sponsored or other job-based plan covers. As implemented under § 156.111(b)(2)(i) and (e)(2)(i), the State is only required to provide an actuarial certification and an associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies, that affirms that the State's EHB-benchmark plan is actuarially equal to the scope of benefits under a typical employer-sponsored or other job-based plan.

<sup>207</sup> See, for example, <https://www.regulations.gov/comment/CMS-2022-0186-0412>.

potential generosity of a State's EHB-benchmark plan to be no greater than the generosity provided by the most generous typical employer plan, because a State would be unable to demonstrate that a more generous plan was equal in scope to any of the typical employer plans defined at § 156.111(b)(2)(i).

Based on this feedback and our experience working with the nine States that have changed their EHB-benchmark plans under § 156.111, we propose to remove the generosity standard from the scope of benefit requirements at § 156.111(b)(2), for plan years beginning on or after January 1, 2027. Under this proposal, the scope of benefits in the State's new EHB-benchmark plan would no longer be restricted by the generosity of the set of prescribed comparison plans at § 156.111(b)(2)(ii)(A) and (B), which should provide States with significant flexibility to more easily select a new EHB-benchmark plan and remove a burdensome step of the actuarial analysis that States are required to complete under the existing generosity standard when selecting a new EHB-benchmark plan. However, we still believe that it is appropriate to limit the range of benefits that can be considered EHB to ensure the affordability of the EHB, and believe that the proposal to revise the typicality standard so that States may select an EHB-benchmark plan that provides a scope of benefits along a continuous range of the scope of benefits provided by a State's least and most generous typical employer plans is a more appropriate way to limit State EHB-benchmark plan selections in accordance with section 1302(b)(2) of the ACA. The proposed revisions to the typicality standard and the proposed removal of the generosity standard would also establish an upper bound for State EHB-benchmark plan selections that better tracks with the scope of benefits in typical employer plans as they change over time.

When we finalized the addition of § 156.111 in the 2019 Payment Notice, we also published an acceptable methodology for States to comply with the scope of benefits requirements.<sup>208</sup> If the proposals contained in this proposed rule are finalized, this methodology would no longer be applicable after the May 1, 2024 deadline for States to notify us of a new EHB-benchmark plan selection for plans

effective beginning on or after January 1, 2027. Given that the proposed revisions to the scope of benefit requirements are designed to reduce State burden, we do not believe it is necessary to issue a new standalone methodology at this time. We believe States could more easily comply with these proposed requirements, if finalized, by identifying the least and most generous typical employer plans at § 156.111(b)(2) (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)) and assessing their scope of benefits in some quantitative manner in accordance with generally accepted actuarial principles and methodologies. The State would then assess the scope of benefits in its selected EHB-benchmark plan in the same manner. The State would be in compliance with the proposed scope of benefit requirement if the assessed scope of benefits in its proposed EHB-benchmark plan is as or more generous than the least generous typical employer plan in the State (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)) and as or less generous than the most generous typical employer plan in the State (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)). For a State adding benefits to its existing EHB-benchmark plan, an acceptable analysis under the proposed revisions to § 156.111 could involve the State calculating the expected premium for covering all the benefits in the State's proposed EHB-benchmark plan and in the State's least and most generous typical employer plans at § 156.111(b)(2) at 100 percent actuarial value, in accordance with generally accepted actuarial principles and methodologies. This analysis would allow the State to confirm, on an estimated premium basis, that the scope of benefits in the proposed EHB-benchmark plan is as or more generous than the scope of benefits in the least generous typical employer plan and as or less generous than the scope of benefits in the most generous typical employer plan in the State (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)). We anticipate that we would continue working closely with States to provide technical assistance to comply with the scope of benefit requirements at proposed § 156.111(b)(2).

In addition, we propose corresponding edits to § 156.111(e)(2) to require States to submit an actuarial

certification and an associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies, that affirms that the State's EHB-benchmark plan complies with the scope of benefits requirements at proposed § 156.111(b)(2).

We also propose a technical clarification to the language regarding supplementation at § 156.111(b)(2)(i), which currently states that a State's new EHB-benchmark plan must "provide a scope of benefits equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at § 156.110(a), the scope of benefits provided under a typical employer plan" (emphasis added). We have found that the language regarding supplementation is consistently misunderstood as allowing a State's EHB-benchmark plan to be greater than the scope of benefits under a typical employer plan for any reason. A State's EHB-benchmark plan may only exceed the scope of benefits in a typical employer plan when supplementation is required to provide coverage in the typical employer plan within each category at § 156.110(a). To address the confusion created by this provision, we propose to make a technical clarification at § 156.111(b)(2)(i) (which would apply to State selections of EHB-benchmark plans through plan year 2026) to state that a State's EHB-benchmark plan must provide a scope of benefits equal to the scope of benefits provided under a typical employer plan (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)). This proposed technical clarification would not substantively change the existing requirement regarding supplementation at § 156.111(b)(2)(i).

Under 42 CFR 440.347, Medicaid ABPs authorized under section 1937 of the Act are required to meet EHB standards. Under 42 CFR 600.405, in States that elect to operate a BHP, the standard health plans are required to meet EHB standards. The changes to State EHB-benchmark plan requirements would also be applicable to States when choosing a benchmark plan used to define EHBs in a Medicaid ABP or a BHP standard health plan.

We seek comment on the proposals to revise the typicality standard at § 156.111(b)(2)(i), remove the generosity standard at § 156.111(b)(2)(ii), make corresponding edits to § 156.111(e)(2), and make a technical revision to the language regarding supplementation at § 156.111(b)(2)(i).

<sup>208</sup> "Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii)". <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/final-example-acceptable-methodology-for-comparing-benefits.pdf>.



### c. Drug Formularies

We propose to revise § 156.111(e)(3) to require States to submit a formulary drug list as part of their documentation provided to change EHB-benchmark plans only if the State is seeking to change its prescription drug EHB. Currently, we require States to submit a formulary drug list if the State is selecting its EHB-benchmark plan using the option at current § 156.111(a)(3), even if the State is not seeking to change its prescription drug EHB. We understand that creation and submission of this formulary drug list creates a significant amount of burden for the State. Since we can carry over the State's existing prescription drug EHB, as defined under § 156.122, without substantial input from the State if the State is not seeking to change its prescription drug EHB, we propose to revise § 156.111(e)(3) as specified to reduce the burden on States.

We seek comment on this proposal.

### 3. Provision of EHB (§ 156.115)

We propose to remove the regulatory prohibition at § 156.115(d) on issuers from including routine non-pediatric dental services as an EHB.

In the EHB Rule, we finalized at § 156.115(d) that issuers of a plan offering EHB 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 ACA directs the Secretary, in defining the EHB, 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 prohibition at § 156.115(d), we stated that routine non-pediatric dental services are not typically included in the medical plans offered by employers and are often provided as excepted benefits by the employer. We now believe a more natural reading of this provision is one that considers all the benefits typically covered by employers, regardless of whether such benefit is historically considered a "health benefit" or whether such benefit is "typically covered" by an employer's major medical plan or, for example, by a limited scope excepted benefits plan. Given that oral health has a significant impact on overall health and quality of life,<sup>209</sup> and several commenters on the

EHB RFI<sup>210</sup> advocated for adult dental EHB coverage, we propose specifically to remove the regulatory prohibition on issuers including routine non-pediatric dental services as an EHB. We seek comment on whether similar changes should be proposed with regard to routine non-pediatric eye exam services and long-term/custodial nursing home care benefits as well.

In 2020, approximately 110 million Americans had private dental coverage.<sup>211</sup> Of the Americans that have private dental coverage, about 91 percent get their dental benefits through their employer or through affiliation with an entity such as the American Association of Retired Persons (AARP).<sup>212</sup> According to National Financial Partners (NFP)'s 2023 US Benefits Trend Report, approximately two out of every three employers offer at least one dental plan, with 46 percent offering one plan, 18 percent offering two plans, and 3 percent offering three or more plans.<sup>213</sup> Furthermore, according to KFF,<sup>214</sup> among firms offering health benefits in 2019 included in the report, 59 percent of small firms (3–199 workers) and 92 percent of large firms (200 or more workers) offered a dental insurance program to their workers separate from the health plan(s).<sup>215</sup> Therefore, it appears that routine non-pediatric dental services are commonly covered as an employer-sponsored or other job-based benefit to a degree that warrants removing the prohibition on their provision as an EHB. We solicit comment on this understanding of the inclusion of routine non-pediatric dental services in employer-sponsored or other job-based benefits.<sup>216</sup>

<sup>210</sup> For example, see <https://www.regulations.gov/comment/CMS-2022-0186-0567>; <https://www.regulations.gov/comment/CMS-2022-0186-0586>; and <https://www.regulations.gov/comment/CMS-2022-0186-0626>.

<sup>211</sup> National Association of Dental Plans (2023). *Understanding Dental Benefits*. <https://www.nadp.org/about-dental-plans-care/understanding-dental-benefits/>.

<sup>212</sup> See *supra* note 15. Also note that another 8.8 percent buy individual dental coverage, while less than 1 percent obtain dental benefits as part of a medical plan.

<sup>213</sup> National Financial Partners. (2023). *US Benefits Trend Report 2023*. <https://www.nfp.com/Portals/25/2023USBenefitsTrendReport.pdf?ver=H3zZlbZ5N2KDLhC0UjYiYA%3D%3D>.

<sup>214</sup> Formerly the Kaiser Family Foundation. See KFF "About Us." <https://www.kff.org/about-us/>.

<sup>215</sup> KFF (2019, September 25). *2019 Employer Health Benefits Survey*. <https://www.kff.org/report-section/ehbs-2019-section-2-health-benefits-offer-rates/#figure217>.

<sup>216</sup> Section 156.115(d) also currently prohibits routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and non-medically necessary orthodontia as EHB. We are not proposing to remove the prohibition on such services as EHB in this proposed rule; however, we

Additionally, we believe that prohibiting the inclusion of routine non-pediatric dental services as an EHB on the basis that they are not often covered by typical employer plans is a more restrictive reading of section 1302(b)(2) of the ACA than is warranted by a plain reading of the statute. Section 1302(b)(2) of the ACA states that, in defining the EHB, the Secretary shall ensure that the scope of the EHB is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary and as informed by a survey by the Secretary of Labor of employer-sponsored or other job-based coverage to determine the benefits typically covered by employers. In considering the benefits typically covered by employers, this statutory section does not require the Secretary to consider only those benefits provided in major medical plans. It also does not require the Secretary to consider only those benefits that are strictly "health benefits," if such a term excludes coverage of routine non-pediatric dental services. Therefore, we no longer believe that the prohibition on non-pediatric dental services as an EHB is warranted. Accordingly, we propose to remove the regulatory prohibition on including routine non-pediatric dental services as an EHB at § 156.115(d).

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 EHB. This would allow States to work to improve adult oral health and overall health outcomes, which are disproportionately low among marginalized communities such as people of color and people with low incomes.<sup>217</sup> Lack of dental insurance remains one of the primary barriers to accessing dental care,<sup>218</sup> and this proposed policy would help mitigate this barrier. Oral health and overall health are inextricably linked; untreated oral health conditions can increase risk for and complicate the management of

solicit comment on the extent to which employer-sponsored or other job-based benefits provide coverage for these services.

<sup>217</sup> 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>.

<sup>218</sup> Agency for Healthcare Research and Quality. (2022). *2022 National Healthcare Quality and Disparities Report*. <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhrdr/2022qdr.pdf>.

<sup>209</sup> Spanemberg, J.C., Cardoso, J.A., Slob, E.M.G.B., & López-López, 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>.



other chronic conditions.<sup>219</sup> For example, studies have shown that periodontal disease and tooth loss are strongly associated with heart health, and oral health care can reduce the risk for cardiovascular disease,<sup>220</sup> atrial fibrillation, and heart failure.<sup>221</sup> Additionally, research indicates that oral health care has implications for substance use disorder (SUD) treatment. Individuals who receive comprehensive oral health care during SUD treatment have been shown to remain in treatment longer and have improved treatment outcomes at discharge, including an increase in employment and drug abstinence, as well as a reduction in homelessness.<sup>222</sup> Furthermore, access to oral health care impacts employment prospects. Approximately 30 percent of low-income adults in the U.S. and nearly 60 percent of Medicaid beneficiaries without access to dental coverage report that the appearance of their mouth and teeth limits their ability to interview for a job.<sup>223</sup>

This proposed policy would also align with CMS' Oral Health Cross Cutting Initiative, which aims to implement policy changes and consider opportunities through existing authorities to expand access to oral health coverage.<sup>224</sup> Additionally, it

would align with the request of several commenters on the EHB RFI (87 FR 74097) for us to remove regulatory and coverage barriers to expanding access to routine non-pediatric dental care.

We emphasize that the removal of this prohibition would not, by itself, mean that routine non-pediatric dental services would be an EHB, even in States with an EHB-benchmark plan that currently describes routine non-pediatric dental services as a non-EHB covered benefit. We stress that this proposal would not require any State to add such services as an EHB, nor would we consider any existing language regarding routine non-pediatric dental services in any State's current EHB-benchmark plan to have the effect of adding such services as an EHB. Under this proposal, a State seeking to provide any routine non-pediatric dental services as an EHB would be required to update its EHB-benchmark plan to include such services as an EHB pursuant to § 156.111. If a State does not update its EHB-benchmark plan to add coverage of routine non-pediatric dental services as an EHB, then such services would not be an EHB, even if the current benchmark plan document includes routine non-pediatric dental services. However, we believe this proposal would incentivize States to add routine non-pediatric dental services as an EHB by updating their EHB-benchmark plans pursuant to § 156.111.

Under this proposal, we would expect States, in determining whether it is appropriate to update their EHB-benchmark plan to add routine non-pediatric dental services as an EHB, to weigh the advantages of expanded dental services against the challenges of providing such services. States should consider the ability of plans to add such services as an EHB, which, as with pediatric oral care, may require plans to establish new networks of dental providers. Alternatively, issuers could comply with this policy by contracting with issuers of SADPs to administer these services, as long as it is seamless to the enrollee. This contracting arrangement would not be required, but it could be permitted as an option. In addition, States should consider that some health plans may not currently have infrastructure or experience working with Current Dental Terminology (CDT) codes that report dental procedures to dental payers.

We note that while section 1302(b)(4)(F) of the ACA permits a medical QHP sold on the Exchange to omit coverage of pediatric dental EHB services if a SADP is offered through an

Exchange,<sup>225</sup> there is no statutory basis to extend this exception to routine non-pediatric dental services. Thus, plans subject to an EHB-benchmark plan that includes routine non-pediatric dental services as an EHB may not omit such coverage on the basis that a SADP already provides such coverage through an Exchange.

This proposal, if finalized, may impact plans that are not directly subject to the EHB requirements, such as self-insured group health plans and fully-insured group health plans in the large group market, that are required to comply with the annual limitation on cost sharing and restrictions on annual or lifetime dollar limits in accordance with applicable regulations with respect to such EHBs.<sup>226</sup> If a State updates its EHB-benchmark plan to add coverage of routine non-pediatric dental services as an EHB and the sponsor of a self-insured group health plan or fully-insured group health plan in the large group market selects that EHB-benchmark plan, any routine non-pediatric dental services covered by such a group health plan would generally be subject to the limitation on cost sharing and restrictions on annual or lifetime dollar limits. However, if the sponsors of such plans offer coverage of routine non-pediatric dental services through an excepted benefit under 26 CFR 54.9831-1(c)(3), 29 CFR 2590.732(c)(3), and 45 CFR 146.145(b)(3), including a limited-scope dental plan, that benefit is generally excepted from complying with the group market reforms, including the limitation on cost sharing and restrictions on annual or lifetime dollar limits.

Additionally, under 42 CFR 440.347, Medicaid ABPs authorized under section 1937 of the Act are required to meet EHB standards. Under 42 CFR 600.405, in States that elect to operate a BHP, the standard health plans are required to meet EHB standards. Under this proposal, States would be permitted to include routine non-pediatric dental services as EHB for purposes of their ABPs or BHP standard health plans.

We seek comment on the proposal to revise § 156.115(d) to remove the regulatory prohibition on issuers from including routine non-pediatric dental services as an EHB, including the impact this proposal would have, if

<sup>225</sup> See section 1311(d)(2)(B)(ii) of the ACA for more information on offering SADP benefits.

<sup>226</sup> See parallel requirements to § 147.126 at 26 CFR 54.9815-2711, and 29 CFR 2590.715-2711. Additionally, section 2707(b) of the PHS Act, as added by the ACA, was incorporated by reference into section 9815 of the Code and section 715 of ERISA.

<sup>219</sup> 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.

<sup>220</sup> Dietrich, T., Webb, I., Stenhouse, L., Pattni, A., Ready, D., Wanyonyi, K.L., White, S., & Gallagher, J.E. (2017). Evidence summary: the relationship between oral and cardiovascular disease. *British dental journal*, 222(5), 381–385. <https://doi.org/10.1038/sj.bdj.2017.224>.

<sup>221</sup> Chang, Y., Woo, H.G., Park, J., Lee, J.S., & Song, T.J. (2020). Improved oral hygiene care is associated with decreased risk of occurrence for atrial fibrillation and heart failure: A nationwide population-based cohort study. *European journal of preventive cardiology*, 27(17), 1835–1845. <https://doi.org/10.1177/2047487319886018>.

<sup>222</sup> Hanson, G.R., McMillan, S., Mower, K., Bruett, C.T., Duarte, L., Koduri, S., Pinzon, L., Warthen, M., Smith, K., Meeks, H., & Trump, B. (2019). Comprehensive oral care improves treatment outcomes in male and female patients with high-severity and chronic substance use disorders. *Journal of the American Dental Association* (1939), 150(7), 591–601. <https://doi.org/10.1016/j.adaj.2019.02.016>.

<sup>223</sup> Families USA in partnership with the American Dental Association (ADA), Health Policy Institute (HPI), and Community Catalyst. (2021, July). *Making the Case for Dental Coverage for Adults in All State Medicaid Programs*. [https://familiesusa.org/wp-content/uploads/2021/07/HPI-CC-FUSA-WhitePaper\\_0721.pdf](https://familiesusa.org/wp-content/uploads/2021/07/HPI-CC-FUSA-WhitePaper_0721.pdf).

<sup>224</sup> CMS. (n.d.) *Strategic Plan Cross-Cutting Initiatives*. <https://www.cms.gov/files/document/strategic-plan-overview-fact-sheet.pdf>.

finalized, on health insurance coverage in the individual, small group, and large group markets, as well as self-insured plans.

#### 4. Prescription Drug Benefits (§ 156.122)

We propose revisions to certain EHB prescription drug benefit requirements at § 156.122, including proposals to revise the minimum membership standards for pharmacy & therapeutics (P&T) committees and to codify EHB policy related to prescription drugs in excess of the benchmark. We seek comment on these proposals as well as a possible future policy proposal to replace the United States Pharmacopeia (USP) Medicare Model Guidelines (MMG) with the USP Drug Classification system (DC) to classify the prescription drugs required to be covered as EHB under § 156.122(a)(1).

##### a. Classifying the Prescription Drug EHB

We seek public comment to confirm or further expand our understanding of the risks and benefits associated with replacing the reference to the USP MMG with a reference to the USP DC as a means of classifying the drugs required to be covered as EHB under § 156.122(a)(1). As finalized in the EHB Rule (78 FR 12845 through 12846), to provide EHB, a plan must comply with § 156.122(a)(1) and cover at least the same number of prescription drugs in every USP category and class as covered by the State's EHB-benchmark plan, or one drug in every category and class, whichever is greater. We stated in the EHB Rule (78 FR 12845 through 12846) that plans could exceed the minimum number of drugs required to be covered and that additional drugs would still be considered EHB. In that final rule, we chose to use USP MMG Version 5.0 (USP Guidelines) to classify the drugs required to be covered as EHB under § 156.122(a)(1). In so doing, we noted in the EHB Rule (78 FR 12845 through 12846) that “[w]hile there was concern among commenters on the use of USP as the system, there was no universal system identified as a potential alternative. We chose the current version of USP Medicare Model Guidelines (version 5) because it is publicly available, and many pharmacy benefit managers are familiar with it. We believe the USP model best fits the needs for the years 2014 and 2015 during the transitional EHB policy.”

In the 2016 Payment Notice (80 FR 10814), we solicited comments on whether to replace the USP Guidelines with a standard based on the American Hospital Formulary Service (AHFS) or another drug classification system. We ultimately decided in the 2016 Payment

Notice (80 FR 10815) to retain the USP Guidelines classification system because “[i]ssuers have already developed 2 years of formularies based on it, States have already developed systems to review those formularies, and interested parties are familiar with the system. Thus, while AHFS had the benefit of being updated more frequently and incorporating a broader set of classes and subclasses, commenters did not uniformly support its use because of several issues, including a lack of transparency, the need to supplement certain classes when compared with USP, and the complexity of the AHFS system.” In 2017, the USP developed a second drug classification system, the USP DC, an independent drug classification system “developed in response to input from interested parties that it would be helpful to have a classification system beyond the MMG to assist with formulary support outside of Medicare Part D.”<sup>227</sup>

In the EHB RFI (87 FR 74097 through 74102), we sought input from the public regarding a variety of topics related to the scope of benefits in health plans subject to the EHB requirements of the ACA, including whether we should consider using an alternative prescription drug classification standard for defining the EHB prescription drug category, such as the USP DC or others. Most commenters supported the transition from the USP MMG, as currently used for EHB purposes and for Medicare Part D, to USP DC as the standard for defining the EHB prescription drug category. Commenters noted that USP DC is more inclusive of drug classes relevant to the private insurance patient base and is updated annually, while USP MMG is only updated once every three years. In particular, advocacy groups and provider groups stated that USP DC was developed to support formularies outside of the Medicare Part D population, which is another advantage over the current classification system designed specifically with Medicare beneficiaries in mind. They noted that USP MMG inappropriately limits access to FDA-approved therapies such as anti-obesity medications (AOMs), resulting in fewer treatment options. A few commenters encouraged us to consider implementing an annual review and update process that includes input from consumers and other interested parties, to ensure USP DC continues to remain current with the prescription drug landscape. Some commenters

recommended that we retain the USP MMG drug classification system. These same commenters expressed concern regarding the potential administrative burden with changing drug classification systems, explained that both government and commercial plans have broad experience with USP MMG, and stated that issuers would need to undertake potentially significant information technology work and expense to remap their data warehouses to include the new drug categories. A few commenters also noted that changing to a new classification standard could have negative consequences for patients as issuers could be required to cover high-cost drugs with low clinical value, increasing the total cost of care and potentially increasing premiums for members.

Additionally, some commenters stated that new and expanded categories and classes under USP DC include anti-obesity agents, infertility agents, and several new classes of combination products, the latter of which often are comprised of brand name drugs paired with other drugs or devices and are more expensive coverage options than the individual generic products. Some commenters recommended that we retain the USP MMG drug classification system but noted that we should consider adoption of a new classification system, while a few commenters urged us to develop our own prescription drug classification standards rather than relying on those developed by private entities stating that our continued reliance on the USP does not address substantial gaps in coverage of medically necessary drugs. Lastly, a few commenters noted that replacement of USP MMG with the AHFS or USP DC would not address certain prescription drug access issues and instead recommended that the protected classes policy utilized in the Medicare Part D prescription drug program be incorporated into the prescription drug benefit.

After reviewing these comments, we agree that using the USP DC to categorize the drugs provided as EHB would assist in strengthening the drug benefit due to its inclusion of additional drug categories and classes relevant to enrollees within the private insurance market. The USP MMG was created for use by prescription drug plans for the Medicare Part D population (eligibility for Medicare enrollment is 65) and not designed with the health needs of the population covered by plans subject to the requirement to cover EHB, which includes those receiving coverage through the Exchanges, such as women

<sup>227</sup> USP Drug Classification. <https://www.usp.org/health-quality-safety/usp-drug-classification-system>.

of reproductive age and children whose health needs are significantly different than those of Medicare Part D beneficiaries, in mind. In addition, the USP MMG includes notable gaps in coverage related to the treatment of chronic conditions such as obesity, infertility agents, and sexual disorder agents. We also note that inclusion of additional categories and classes of drugs used to manage chronic conditions would assist in mitigating future risks and complications associated with a lack of access to these therapies, particularly for vulnerable populations.

In addition, USP DC is updated annually instead of every three years, allowing for a more rapid incorporation of new prescription drugs, drugs that are newly or no longer used for a particular indication, or discontinued drugs. While we are aware that the USP DC system has many features that may be beneficial to consumers and meet evolving public health challenges, we recognize the concerns as noted by commenters to the EHB RFI regarding the potential challenges of switching drug classification systems from USP MMG to USP DC for defining EHB, including the administrative burdens to issuers and negative premium impacts to patients. We seek public comment to confirm or further expand our understanding of the risks and benefits associated with potentially replacing USP MMG with USP DC.

Further, we seek comment regarding concerns noted by interested parties in response to the EHB RFI related to the challenges that issuers may experience transitioning from USP MMG to USP DC to include administrative burdens, particularly relating to disruptive impacts to issuer operations and systems to incorporate new drug categories and classes into their formulary review process. Lastly, we seek comment on a reasonable timeline for impacted entities to potentially migrate from USP MMG to USP DC.

CMS and the USP developed the USP Guidelines in 2004 to implement the Medicare Part D Prescription Drug Program,<sup>228</sup> and as such, the system was designed for the Medicare population. Section 1860D–2(e) of the Act defines a “covered part D drug” for purposes of the Medicare Part D program, and the statutory definition excludes drugs used for anorexia, weight loss, weight gain, fertility, cosmetic purposes or hair growth, symptomatic relief of cough and colds, smoking cessation, prescription

vitamins and mineral products, nonprescription drugs, certain covered outpatient drugs, barbiturates, benzodiazepines, and drugs for the treatment of sexual or erectile dysfunction.<sup>229</sup> Consequently, the USP Guidelines do not include categories and classes to classify these excluded drugs, and as a result, these drugs are not required to be covered as EHB under § 156.122(a)(1), though there may be coverage requirements for a limited subset of these drugs based on other requirements such as the requirement to cover preventive services under section 2713 of the PHS Act. However, certain types of AOMs may still be covered as EHB but under a different drug category (for example, AOMs classified and covered under the category for central nervous system drugs). Additionally, nothing prevents issuers from voluntarily covering these drugs as EHB. However, the variation in classification for these drugs leads to potential coverage gaps for consumers.

We recognize that there could be formulary challenges if we were to change drug classification systems, particularly as it relates to issuers’ coverage and issuers’ affordability of AOMs through the formulary benefit design. Specifically, although issuers would not necessarily be required to cover one of the more expensive AOMs looking solely at the policy at § 156.122(a)(1), under § 156.122(a)(3)(iii)(H)(2), P&T committees are required to ensure that issuer formulary drug lists provide appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time. We have included a review of current guidelines on pharmacological interventions for adults with obesity to highlight some of the issues that issuers and P&T committees would need to consider should we move from USP MMG to USP DC. We solicit comment on the data summarized as well on additional clinical data that we should review as we continue to consider possible future policy proposals related to the EHB prescription drug benefit requirements.

Two guidelines, one by the American College of Cardiology/American Heart

Association/The Obesity Society, and the other by the American Association of Clinical Endocrinologists/American College of Endocrinology are considered the standard of care in the management of overweight and obesity in adults.<sup>231</sup> In November 2022, the American Gastroenterological Association (AGA) issued a new clinical practice guideline on pharmacological interventions for adults with obesity.<sup>232</sup> This guideline advances those evidence-based recommendations from the American College of Cardiology/American Heart Association/The Obesity Society, the American Association of Clinical Endocrinologists/American College of Endocrinology, and the Endocrine Society. These guidelines note that AOMs used with lifestyle modifications produce greater and more sustained weight loss when compared with lifestyle modifications alone. Further, the authors of the AGA guideline reiterate that AOM selection should be based on each patient’s needs and highlight that AOMs are generally used chronically to treat the chronic disease of obesity. In addition, the AGA guidelines note that Wegovy, Saxenda, Qsymia, and Contrave, which are classified in USP DC 2023 as anti-obesity agents had a balance of weight loss over harm that favored their use. The guidelines further state, “given the magnitude of net benefit, Wegovy may be prioritized over other approved [anti-obesity medications] for the long-term treatment of obesity for most patients.”<sup>233</sup> Additionally, the guidelines recommend against the use of Xenical. Four drugs are currently available in the United States for short-term weight loss: phentermine, benzphetamine, diethylpropion, and phendimetrazine. Although the American Association of Clinical Endocrinologists/American College of Endocrinology guidelines recommend against use of these treatments, the Endocrine Society guideline endorses the use of long-term treatment with phentermine that is contingent upon several conditions being met. The AGA guideline also provides a qualified endorsement of long-term use of phentermine, noting a low quality of evidence for this recommendation.

<sup>231</sup> Cornier, M. (2002). A Review of Current Guidelines for the Treatment of Obesity. *Am J Manag Care*, 28(15), S288–S296. doi:10.37765/ajmc.2022.89292.

<sup>232</sup> Grunwald, E., Shah, R., Hernaez, R., Chandar, A.K., Pickett-Blakely, O., Teigen, L.M., Harindhanavudhi, T., Sultan, S., Singh, S., Davitkov, P. (2022). AGA Clinical Practice Guideline on Pharmacological Interventions for Adults With Obesity. *Gastroenterology*, 163(5), 1198–1225. doi:10.1053/j.gastro.2022.08.045.

<sup>233</sup> [Id.]

<sup>228</sup> USP Medicare Model Guidelines. <https://www.usp.org/health-quality-safety/usp-medicare-model-guidelines>.

<sup>229</sup> See section 1860D–2(e)(2) of the Act.

<sup>230</sup> See section 1927(d)(2) of the Act. The list of drugs subject to restriction include drugs used for anorexia, weight loss, weight gain, fertility, cosmetic purposes or hair growth, symptomatic relief of cough and colds, smoking cessation, prescription vitamins and mineral products, nonprescription drugs, certain covered outpatient drugs, barbiturates, benzodiazepines, and drugs for the treatment of sexual or erectile dysfunction.

Phentermine is not FDA-approved for long-term treatment of obesity.

Although some issuers may cover AOMs, we are aware that demand for effective AOMs is high and expected to increase.<sup>234</sup> We seek comment on the potential financial effects of covering AOMs by issuers should we adopt the USP DC classification system to define EHB; in particular, we are interested in understanding estimated enrollee medication uptake within plans, associated total spending cost, overall impact to the medical and prescription drug benefit as well as premium impact to patients. Further, we seek comment on the estimated premium impact to patients if issuers were required to cover drugs in additional categories/classes of the USP DC such as infertility drugs, sexual disorder agents and combination drugs as part of the transition from USP MMG. Additionally, we seek comment on how issuers would try to balance prescription benefit costs of these newly added categories and classes within the USP DC with providing members access to affordable, clinically proven medications. For example, if an issuer were to employ utilization management strategies (for example, step therapy, prior authorization, and quantity limits) to ensure that the appropriate patient populations receive and benefit from these treatments, we are interested in understanding how issuers determine which of these newly added medications would require the implementation of utilization management strategies and what would be included in the clinical coverage criteria developed for prior authorization or step therapy as well as quantity limit guidelines.

#### b. Coverage of Prescription Drugs as EHB

We propose to amend § 156.122 to codify that prescription drugs in excess of those covered by a State's EHB-benchmark plan are considered EHB. As a result, they would be subject to requirements including the annual limitation on cost sharing and the restriction on annual and lifetime dollar limits, consistent with § 156.130, unless the coverage of the drug is mandated by State action and is in addition to EHB pursuant to § 155.170, in which case the drug would not be considered EHB.

In the EHB Rule (78 FR 12845), in response to commenter concerns regarding how plans must address new prescription drugs that come onto the

market during the course of a plan year pursuant to § 156.122, we stated that while plans must offer at least the greater of one drug for each USP category and class or the number of drugs in the EHB-benchmark plan, plans are permitted to go beyond the number of drugs offered by the benchmark plan without exceeding EHB. Therefore, if the plan is covering drugs beyond the number of drugs covered by the benchmark, all drugs in excess of the drug count standard at § 156.122(a) are considered EHB, such that they are subject to EHB protections and must count towards the annual limitation on cost sharing. Additionally, we noted this policy in the preamble of the 2016 Payment Notice (80 FR 10749) during a discussion of requirements related to § 156.122(c).

We believed that this policy as noted in both the EHB Rule and preamble of the 2016 Payment Notice was clearly understood by issuers until we received comments in response to the EHB RFI that included a significant number of requests from interested parties to clarify this policy in rulemaking. In addition, a small number of commenters noted concerns regarding some plans in the individual, small group, and large group markets that have stated that some drugs in excess of the drug count standard at § 156.122(a) are not EHB and have developed programs to provide some drugs as "non-EHB," outside of the terms of the rest of the coverage. We seek comment regarding how widespread these practices are.

To resolve these concerns, we propose to amend § 156.122 to add paragraph (f), which would explicitly state that drugs in excess of the benchmark are considered EHB. To the extent that a health plan covers drugs, in any circumstance, in excess of the benchmark, these drugs would be considered an EHB and would be required to count towards the annual limitation on cost sharing. This policy would apply unless the coverage of the drug is mandated by State action and is in addition to EHB pursuant to § 155.170, in which case the drug would not be considered EHB.

We have been made aware of a few plans within the individual and small group markets that have either developed or are offering programs that provide some drugs as "non-EHB." As we have only recently begun receiving comments from interested parties regarding this issue, we do not believe that there are a large number of plans that offer these types of programs; however, we seek comment regarding how widespread these programs are.

We seek comment on this proposal.

#### c. Pharmacy and Therapeutics Committee Standards

For plan years beginning on or after January 1, 2026, we propose to amend § 156.122 to provide that the P&T committee must include a consumer representative.

In the 2016 Payment Notice (80 FR 10749), we required plans providing EHB to establish P&T committees to review and update plan formularies in conjunction with the USP MMG. At § 156.122(a)(3)(i), we require P&T committees to: (a) have members that represent a sufficient number of clinical specialties to adequately meet the needs of enrollees; (b) consist of a majority of individuals who are practicing physicians, practicing pharmacists, and other practicing healthcare professionals who are licensed to prescribe drugs; (c) prohibit any member with a conflict of interest with respect to the issuer or a pharmaceutical manufacturer from voting on any matters for which the conflict exists; and (d) require at least 20 percent of its membership to have no conflict of interest with respect to the issuer and any pharmaceutical manufacturer.

Many of the P&T committee requirements are also found in the Principles of a Sound Drug Formulary System, which was first developed in September 1999 by a coalition of national organizations representing healthcare professionals, government, and business leaders and later adopted in 2000 by the Academy of Managed Care Pharmacy (AMCP), Alliance of Community Health Plans, American Medical Association, American Society of Health-Systems Pharmacists, Department of Veterans Affairs, Pharmacy Benefits Management Strategic Healthcare Group, National Business Coalition on Health, and U.S. Pharmacopeia.<sup>235</sup> Since that time, best practices for P&T committees have matured throughout the healthcare system. In 2019, AMCP convened a group of thought leaders, clinicians, academics, patient advocacy organizations, payer organizations, and members of the pharmaceutical industry to consider P&T committee best practices in today's evolving healthcare system.<sup>236</sup> Specifically, the group

<sup>235</sup> Hawkins, B., ed. (2011). Principles of a sound drug formulary system. Best Practices for Hospital and Health System Pharmacy: Positions and Guidance Documents of ASHP. American Society of Health-System Pharmacists. <https://www.ashp.org/-/media/assets/policy-guidelines/docs/endorsed-documents/endorsed-documents-principles-sound-drug-formulary-system.pdf>.

<sup>236</sup> AMCP Partnership Forum: Principles for Sound Pharmacy and Therapeutics (P&T)

<sup>234</sup> Duncan, I., Kerr, D., Aggarwal R., & Huynh, N. New Drugs for Obesity, Is the Excitement Affordable? *Population Health Management*. Oct 2023. 356–357. <http://doi.org/10.1089/pop.2023.0086>.

provided perspectives on: (a) P&T committee composition and relevant interested parties, (b) evaluation of emerging evidence for formulary decisions and recommendations around training of P&T committee members, and (c) characteristics and best practices of successful committees.

While a P&T committee is usually composed of actively practicing physicians, pharmacists, and other healthcare professionals, forum participants stated that a well-structured committee should also include patient representation since it provides additional insight into the patient perspective regarding the practical use of therapies and effect on quality-of-life outcomes which can be a helpful component of the formulary evaluation process. Additionally, participants noted that the patient perspective should be considered a key voice in formulary decisions as they are directly affected by P&T committee decisions and can assist the committee in better understanding the value of different treatments and medications for patients.

While we are aware that the inclusion of consumers in the P&T committee process is not common, it has been observed in different healthcare systems. One example of this practice includes the Uniform Formulary Beneficiary Advisory Panel (UFBAP), which provides independent advice and recommendation on the development of the TRICARE Uniform formulary.<sup>237</sup> Members of the UFBAP include nongovernmental organizations and associations that represent the views and interests of a large number of eligible covered beneficiaries, contractors responsible for the TRICARE retail pharmacy program, contractors responsible for the national mail-order pharmacy program, and TRICARE network providers. Additional examples of States that include clinicians such as physicians, pharmacists, and other specialists along with consumer or patient representatives as members within their respective P&T committees

include Pennsylvania,<sup>238</sup> Connecticut,<sup>239</sup> and New York.<sup>240</sup>

P&T committee decisions have the power to impact a consumer's overall quality of life and encompass important elements of care and cost for the consumer. Therefore, we propose to add paragraph (a)(3)(i)(E) to § 156.122 to update P&T membership standards to require the P&T committee to include a consumer representative as part of its membership for plan years beginning on or after January 1, 2026. In addition, we propose to specify at § 156.122(a)(3)(E)(1) through (4) membership standards for consumer representatives. Specifically, the consumer representative would be required to represent the consumer perspective as a member of the P&T committee and would be required to have an affiliation with and/or demonstrate active participation in consumer or community-based organizations. Some examples of these types of organizations include those that are representative of a community or significant segments of a community that provide educational or related direct services to individuals in the community as well as organizations that protect consumer rights via advocacy, research, or outreach efforts. As a P&T committee member, the consumer representative would assume responsibility for highlighting and addressing any potential risks and benefits observed that could have a direct impact on consumers as a result of issues and actions before the P&T committee. In addition, an affiliation with and/or active participation in a consumer or community-based organization would provide the consumer representative with the necessary background to represent consumers' perspectives. If this rule is finalized as proposed, issuers would also be required to select a consumer representative who has experience in the analysis and interpretation of complex data and is able to understand its public health significance, bearing in mind that one of the duties as a member of a P&T committee includes thoughtful

consideration of clinical criteria, such as drug safety and efficacy data, when making a recommendation regarding products under review. This individual would also be required to have no fiduciary obligation to a health facility or other health agency and have no material financial interest in the rendering of health care services. This conflict-of-interest standard is intended to ensure that, as a member of the P&T committee, the consumer representative is free from financial interests or other relationships that could compromise the objectivity of the members of the committee as they perform their duties. Nothing in this proposal would prevent the P&T committee from defining additional membership standards pertaining to the position of consumer representative.

We believe that proposed § 156.122(a)(3)(i)(E) would ensure that the consumer experience with a disease or condition is considered in the design of formulary benefits. Consumer representatives would be able to offer insight into real consumer experiences that P&T committees may be unaware of that would help the committee better understand consumer challenges related to medication use as well as assist them in exploring solutions to these challenges during the formulary development process. We also note that broader inclusion of perspectives on the P&T committee would align with other groups, including the AMCP.

We seek comment on these proposals. The consumer representative, as a member of the P&T committee, would be subject to the conflict-of-interest standards as specified in § 156.122(a)(3); however, we are interested in comments regarding whether we should further define additional membership standards for the consumer representative. In particular, we seek comments on the qualifications necessary to serve as a consumer representative on a P&T committee, to include if the representative should have a clinical background, have served as a representative of organizations with a regional or Statewide constituency, or have been involved in activities related to health care consumer advocacy, including issues affecting individual and small group market enrollees. We also seek comment on whether the current conflict-of-interest provision is sufficient as applied to this proposed role, or whether the consumer representative role should be subject to additional conflict-of-interest standards. We seek comment on whether a consumer representative should have a background for more than one condition or disease to sufficiently represent the

Committee Practices: What's Next? (2020). *J Manag Care Spec Pharm*, 26(1), 48–53. <https://doi.org/10.18553/jmcp.2020.26.1.48>.

<sup>237</sup> Charter: Uniform Formulary Beneficiary Advisory Panel. <https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Pharmacy-Operations/BAP>.

<sup>238</sup> The Pennsylvania Department of Human Services Pharmacy and Therapeutics Committee. See: <https://www.dhs.pa.gov/about/DHS-Information/Pages/Stakeholders/Pharmacy-Committee.aspx>.

<sup>239</sup> The Connecticut Medical Assistance Program Pharmaceutical and Therapeutics Committee. See: [https://www.cga.ct.gov/current/pub/chap\\_319v.htm#sec\\_17b-274d](https://www.cga.ct.gov/current/pub/chap_319v.htm#sec_17b-274d) and [https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/CT\\_PT\\_COMMITTEE\\_BYLAWS\\_v2.pdf](https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/CT_PT_COMMITTEE_BYLAWS_v2.pdf).

<sup>240</sup> New York State Department of Health Drug Utilization Review (DUR). See: [https://www.health.ny.gov/health\\_care/medicaid/program/dur/docs/board\\_membership.pdf](https://www.health.ny.gov/health_care/medicaid/program/dur/docs/board_membership.pdf).

concerns of a diverse population. Additionally, we seek comment on the number of consumer representatives who should be included on a committee and if that number should be directly proportional to the size of the committee. We also recognize that a requirement to develop additional P&T committee standards, solicit for applicants for this new position, and provide any necessary training to new members would require lead time for States, issuers, and pharmacy benefit managers to implement and we seek comment on the proposed timing for implementation.

5. Publication of the 2025 Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage in Guidance (§ 156.130)

As established in part 2 of the 2022 Payment Notice (86 FR 24238), we will publish the premium adjustment percentage, the required contribution percentage, and maximum annual limitations on cost sharing and reduced maximum annual limitation on cost sharing, in guidance annually starting with the 2023 benefit year. We note that these parameters are not included in this rulemaking, as we do not propose changing the methodology for these parameters for the 2025 benefit year. Therefore, we will publish these parameters in guidance no later than January 2024.

6. Standardized Plan Options (§ 156.201)

HHS proposes to exercise its authority under sections 1311(c)(1) and 1321(a)(1)(B) of the ACA to make minor updates to the standardized plan options for PY 2025. Specifically, we propose to make minor updates to the plan designs for PY 2025 to ensure these plans have AVs within the permissible *de minimis* range for each metal level, and we propose to maintain a high degree of continuity with the approach to standardized plan options finalized in the 2023 and 2024 Payment Notices. We do not propose to amend § 156.201.

Section 1311(c)(1) of the ACA directs the Secretary to establish criteria for the certification of health plans as QHPs. Section 1321(a)(1)(B) of the ACA directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the ACA for, among other things, the offering of QHPs through such Exchanges.

In the 2024 Payment Notice (88 FR 25847 through 25855), we maintained a large degree of continuity with the

approach to standardized plan options finalized in the 2023 Payment Notice, aside from several minor changes to the plan designs. Specifically, in contrast to the policy finalized in the 2023 Payment Notice, 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 severe AV constraints. Thus, for PY 2024 and subsequent PYs, we finalized standardized plan options for the following metal levels: one bronze plan that meets the requirement to have an AV up to five points above the 60 percent standard, as specified in § 156.140(c)(2) (known as an expanded bronze plan), one standard silver plan, one version of each of the three income-based silver CSR plan variations, one gold plan, and one platinum plan.

Consistent with our approach in the 2023 Payment Notice, in the 2024 Payment Notice (88 FR 25847 through 25848), 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. However, we continued requiring issuers to offer these plan variations for all standardized plan options offered, and we removed the regulation text language that stated that standardized plan options for these plan variations were not required to be offered. In the 2024 Payment Notice (88 FR 25847 through 25848), we further clarified that while issuers must continue to offer AI/AN CSR plan variations based on standardized plan options under § 156.420(b), those plan variations will themselves not be standardized plan options based on designs specified in that rulemaking.<sup>241</sup> Instead, similar to how all the cost sharing values for income-based silver CSR plan variations are automatically imputed based on the corresponding standard silver plan when an issuer enters required data into the Plans and Benefits Template as part of QHP certification, all the cost sharing values for standardized plan option AI/AN CSR plan variations will be automatically imputed based on the corresponding standardized plan option standard silver plan.

Similar to the approach taken in the 2023 Payment Notice, in the 2024 Payment Notice (88 FR 25848), we finalized standardized plan options that once again resembled the most popular QHP offerings that millions were

already enrolled in by taking the following steps: selecting the most popular cost-sharing type for each benefit category; selecting enrollee-weighted median values for each of these benefit categories based on refreshed PY 2023 cost sharing and enrollment data; modifying these plans to ensure they comply with State cost-sharing laws; and decreasing the AVs for these plan designs to be at the floor of each AV *de minimis* range, primarily by increasing deductibles.

Furthermore, in the 2024 Payment Notice (88 FR 25848), we finalized two sets of standardized plan options at the aforementioned metal levels, with the same sets of designs applying to issuers in the same sets of States as in the 2023 Payment Notice. Specifically, the first set of standardized plan options continued applying to FFE and SBE-FP issuers in all FFE and SBE-FP States, excluding those in Delaware, Louisiana, and Oregon, and the second set of standardized plan options continued applying to Exchange issuers in Delaware and Louisiana.

Also consistent with our approach in PY 2023, in the 2024 Payment Notice (88 FR 25848), we continued requiring issuers in the individual market Exchanges on the Federal platform to offer the standardized plan options specified in the 2023 Payment Notice, but we did not apply this requirement to issuers in the small group market SHOPS. We also continued exempting issuers offering QHPs through 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,<sup>242</sup> from the requirement to offer the standardized plan options included in the 2024 Payment Notice. We also continued not requiring State Exchange issuers to offer the standardized plan options included in the 2024 Payment Notice.

Furthermore, consistent with the policy finalized in the 2023 Payment Notice, in the 2024 Payment Notice (88 FR 25848), we stated that we would continue differentially displaying standardized plan options on *HealthCare.gov* pursuant to § 155.205(b)(1), including those standardized plan options required under State action taking place on or before January 1, 2020. We also stated that we would continue enforcing the standardized plan options display requirements for approved web-brokers and QHP issuers using a direct

<sup>241</sup> See also QHP Certification Standardized Plan Options FAQs, <https://www.qhpcertification.cms.gov/s/Standardized%20Plan%20Options%20FAQs>.

<sup>242</sup> See Or. Admin. R. 836–053–0009, <https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=3778>.

enrollment pathway to facilitate enrollment through an FFE or SBE-FP—including both the Classic DE and EDE Pathways—at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv), respectively.

As such, web-brokers and QHP issuers were required to differentially display the PY 2024 standardized plan options in accordance with the requirements under § 155.205(b)(1) in a manner consistent with how standardized plan options are displayed on *HealthCare.gov*, unless we approved a deviation, beginning with the 2024 benefit year open enrollment period. Consistent with the PY 2023 policy, the 2024 Payment Notice (88 FR 25848) provided that any requests from web-brokers and QHP issuers seeking approval for an alternate differentiation format will continue to be reviewed based on whether the same or similar level of differentiation and clarity would be provided under the requested deviation as is provided on *HealthCare.gov*.

Consistent with the approach to plan designs in the 2023 Payment Notice, in the 2024 Payment Notice (88 FR 25848), we continued using the following four tiers of prescription drug cost sharing in the standardized plan options: generic drugs, preferred brand drugs, non-preferred brand drugs, and specialty drugs. We explained that we believed that continued use of four tiers of prescription drug cost sharing in standardized plan options would result in more predictable and understandable drug coverage. We also explained that we believed that continuing to use four tiers of prescription drug cost sharing would play an important role in helping consumers make informed QHP selections by allowing consumers to more easily compare formularies between plans and make year-to-year comparisons with their current plan. We also explained that the continued use of four tiers would minimize issuer burden since, for PY 2023, issuers had already created standardized plan options with formularies that included only four tiers of prescription drug cost sharing.

We refer readers to the preambles to the 2023 and 2024 Payment Notices discussing § 156.201 (87 FR 27310 through 27322 and 88 FR 25847 through 25855, respectively) for more detailed discussion regarding approaches to standardized plan options in PY 2024 and previous PYs.

For PY 2025, we propose to follow the approach finalized in the 2024 Payment Notice concerning standardized plan option metal levels, and to otherwise maintain continuity with our approach to standardized plan options finalized in the 2023 and 2024 Payment Notices.

We propose to make only minor updates to the plan designs for PY 2025 to ensure these plans have AVs within the permissible *de minimis* range for each metal level. Our proposed updates to plan designs for PY 2025 are detailed in Tables 12 and 13, later in this section. We propose to maintain a high degree of continuity with the approach to standardized plan options finalized in the 2023 and 2024 Payment Notices for several reasons.

We are continuing to require FFE and SBE-FP issuers to offer standardized plan options in large part due to continued plan proliferation, which has only increased since the standardized plan option requirements were finalized in the 2023 Payment Notice. In light of this continued plan proliferation, it is increasingly important to continue to attempt to streamline and simplify the plan selection process for consumers on the Exchanges. We believe these standardized plan options continue to play a meaningful role in that simplification by reducing the number of variables that consumers must consider when selecting a plan option, making it easier for consumers to compare available plan options.

More specifically, with these standardized plan options, consumers continue to be able to more quickly and more easily consider meaningful factors, such as networks, formularies, and premiums, when selecting a plan. We further believe these standardized plan options include several distinctive features, such as enhanced pre-deductible coverage for several benefit categories and copayments instead of coinsurance rates for a greater number of benefit categories, that will continue to play an important role in reducing barriers to access, combatting discriminatory benefit designs, and advancing health equity. Including enhanced pre-deductible coverage for these benefit categories (specifically, primary care visits, specialist visits, speech therapy, occupational and physical therapy, and generic drugs at all metal levels, with an increasing number of benefit categories exempt at higher metal levels) ensures consumers are more easily able to access these services without first meeting their deductibles. Furthermore, using copayments instead of coinsurance rates for a greater number of benefit categories reduces the risk of unexpected financial expenses sometimes associated with coinsurance rates.

Additionally, we propose to maintain a high degree of continuity with many of the standardized plan option policies previously finalized in the 2024

Payment Notice in order to reduce the risk of disruption for all involved interested parties, including issuers, agents, brokers, States, and enrollees. We believe making major departures from the methodology used to create the standardized plan options finalized in the 2023 and 2024 Payment Notices could result in drastic changes in these plan designs that may create undue burden for interested parties. For example, if the standardized plan options that we create vary significantly from year to year, those enrolled in these plans could experience unexpected financial harm if the cost sharing for services they rely upon differs substantially from the previous year. Ultimately, we believe consistency in standardized plan options is important to allow issuers and enrollees to become accustomed to these plan designs.

We seek comment on our proposed approach to standardized plan options for PY 2025. Additionally, we seek comment on requiring issuers offering QHPs in individual market State Exchanges to offer, in a future plan year, some version of standardized plan options, while not necessarily subjecting them to the full scope of standardized plan option requirements applicable to issuers on the FFEs or SBE-FPs under § 156.201. In particular, we seek comment on requiring issuers offering QHPs in individual market State Exchanges that are not already required to offer standardized plan options under State requirements to offer some version of standardized plan options, even if these plan designs differ from the requirements of those included in the applicable Payment Notice for that plan year. We also seek comment on requiring States that intend to transition their Exchange model type from an FFE or SBE-FP to a State Exchange to require their issuers to offer standardized plan options as one condition of this transition. As such, we are particularly interested in comments from individual market State Exchanges that do not currently require QHP issuers to offer standardized plan options, States with an FFE or SBE-FP Exchange model type that intend to transition their Exchange model type to a State Exchanges, and issuers offering QHPs through State Exchanges.

While we recognize that State Exchanges are best positioned to set requirements that serve the nuances of their respective individual markets, we underscore the benefits of offering at least some version of standardized plan options, which we discussed in greater detail in the preamble discussion of § 156.201 in the 2023 Payment Notice



(87 FR 27316). We also believe that the fact that over half of State Exchanges currently require issuers to offer

standardized plan options in one form

or another suggests that they, too, see value in standardized plan options.

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**TABLE 12: 2025 Proposed Standardized Options Set One (For All FFE and SBE-FP Issuers, Excluding Issuers in Delaware, Louisiana, and Oregon)**

	<b>Expanded Bronze</b>	<b>Standard Silver</b>	<b>Silver 73 CSR</b>	<b>Silver 87 CSR</b>	<b>Silver 94 CSR</b>	<b>Gold</b>	<b>Platinum</b>
Actuarial Value	63.81%	70.01%	73.09%	87.33%	94.14%	78.06%	88.04%
Deductible	\$7,500	\$5,000	\$3,000	\$500	\$0	\$1,500	\$0
Annual Limitation on Cost Sharing	\$9,200	\$8,000	\$6,400	\$3,000	\$2,000	\$7,800	\$4,300
Emergency Room Services	50%	40%	40%	30%	25%*	25%	\$100*
Inpatient Hospital Services (Including Mental Health & Substance Use Disorder)	50%	40%	40%	30%	25%*	25%	\$350*
Primary Care Visit	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Urgent Care	\$75*	\$60*	\$60*	\$30*	\$5*	\$45*	\$15*
Specialist Visit	\$100*	\$80*	\$80*	\$40*	\$10*	\$60*	\$20*
Mental Health & Substance Use Disorder Outpatient Office Visit	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Imaging (CT/PET Scans, MRIs)	50%	40%	40%	30%	25%*	25%	\$100*
Speech Therapy	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Occupational, Physical Therapy	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Laboratory Services	50%	40%	40%	30%	25%*	25%	\$30*
X-rays/Diagnostic Imaging	50%	40%	40%	30%	25%*	25%	\$30*
Skilled Nursing Facility	50%	40%	40%	30%	25%*	25%	\$150*
Outpatient Facility Fee (Ambulatory Surgery Center)	50%	40%	40%	30%	25%*	25%	\$150*
Outpatient Surgery Physician & Services	50%	40%	40%	30%	25%*	25%	\$150*
Generic Drugs	\$25*	\$20*	\$20*	\$10*	\$0*	\$15*	\$5*
Preferred Brand Drugs	\$50	\$40*	\$40*	\$20*	\$15*	\$30*	\$10*
Non-Preferred Brand Drugs	\$100	\$80	\$80	\$60	\$50*	\$60*	\$50*
Specialty Drugs	\$500	\$350	\$350	\$250	\$150*	\$250*	\$150*

\*Benefit category not subject to the deductible.



**TABLE 13: 2025 Proposed Standardized Options Set Two (For Issuers in Delaware and Louisiana)**

	<b>Expanded Bronze</b>	<b>Standard Silver</b>	<b>Silver 73 CSR</b>	<b>Silver 87 CSR</b>	<b>Silver 94 CSR</b>	<b>Gold</b>	<b>Platinum</b>
Actuarial Value	63.81%	70.01%	73.10%	87.36%	94.37%	78.10%	88.07%
Deductible	\$7,500	\$5,000	\$3,000	\$500	\$0	\$1,500	\$0
Annual Limitation on Cost Sharing	\$9,200	\$8,000	\$6,400	\$3,000	\$2,000	\$7,800	\$4,300
Emergency Room Services	50%	40%	40%	30%	25%*	25%	\$100*
Inpatient Hospital Services (Including Mental Health & Substance Use Disorder)	50%	40%	40%	30%	25%*	25%	\$350*
Primary Care Visit	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Urgent Care	\$75*	\$60*	\$60*	\$30*	\$5*	\$45*	\$15*
Specialist Visit	\$100*	\$80*	\$80*	\$40*	\$10*	\$60*	\$20*
Mental Health & Substance Use Disorder Outpatient Office Visit	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Imaging (CT/PET Scans, MRIs)	50%	40%	40%	30%	25%*	25%	\$100*
Speech Therapy	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Occupational, Physical Therapy	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Laboratory Services	50%	40%	40%	30%	25%*	25%	\$30*
X-rays/Diagnostic Imaging	50%	40%	40%	30%	25%*	25%	\$30*
Skilled Nursing Facility	50%	40%	40%	30%	25%*	25%	\$150*
Outpatient Facility Fee (Ambulatory Surgery Center)	50%	40%	40%	30%	25%*	25%	\$150*
Outpatient Surgery Physician & Services	50%	40%	40%	30%	25%*	25%	\$150*
Generic Drugs	\$25*	\$20*	\$20*	\$10*	\$0*	\$15*	\$5*
Preferred Brand Drugs	\$50	\$40*	\$40*	\$20*	\$5*	\$30*	\$10*
Non-Preferred Brand Drugs	\$100	\$80	\$80	\$60	\$10*	\$60*	\$50*
Specialty Drugs	\$150	\$125	\$125	\$100	\$20*	\$100*	\$75*

\*Benefit category not subject to the deductible.

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#### 7. Non-Standardized Plan Option Limits (§ 156.202)

HHS proposes to exercise its authority under sections 1311(c)(1) and 1321(a)(1)(B) of the ACA to amend § 156.202 by adding paragraphs (d) and (e) to introduce an exceptions process that would allow issuers to offer additional non-standardized plan options (in excess of the limit of two) per product network type, metal level, inclusion of dental and/or 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. Under this proposal, issuers

would not be limited in the number of exceptions permitted per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area, so long as they meet specified criteria. Section 1311(c)(1) of the ACA directs the Secretary to establish criteria for the certification of health plans as QHPs. Section 1321(a)(1)(B) of the ACA directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the ACA for, among other things, the offering of QHPs through such Exchanges.

In the 2024 Payment Notice (88 FR 25855 through 25865), we finalized requirements limiting 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), inclusion of dental and/or vision benefit coverage, and service area for PY 2024, and two for PY 2025 and subsequent plan years.

We explained that we phased in this limit over 2 plan years (instead of adopting the limit of two in PY 2024) primarily to decrease the risk of disruption for both issuers and enrollees, and to provide increased flexibility to issuers. Many commenters supported adopting a more gradual approach in which the number of non-standardized plan options that issuers can offer is incrementally decreased over a span of 2 plan years, instead of

adopting a limit of two for PY 2024. Additionally, regarding the modification to factor the inclusion of dental and vision benefits into this limit, issuers have frequently offered these specific benefit categories as additional benefits in otherwise identical plan options, accounting for the vast majority of product ID-based variations (approximately 84 percent of such variation) offered by issuers within a given metal level, network type, and service area in PY 2022. We refer readers to the preamble of the 2024 Payment Notice discussing § 156.202 (88 FR 25855 through 25865) for more detailed discussion of our approach to non-standardized plan option limits for PY 2024 and related background.

As a result of the limit on the number of non-standardized plan options that issuers can offer through the Exchanges being reduced from four in PY 2024 to two in PY 2025, we estimate (based on current PY 2024 plan offering data) that the weighted average number of non-standardized plan options available to each consumer will be reduced from 67.3 in PY 2024 to approximately 41.7 in PY 2025. Furthermore, we estimate that the weighted average total number of plans, including standardized and non-standardized plan options, available to each consumer will be reduced from 91.8 in PY 2024 to approximately 66.2 in PY 2025.<sup>243</sup>

Furthermore, based on current QHP submission data for PY 2024, we estimate that approximately 28,275 of the total 109,229 non-standardized plan option plan-county combinations<sup>244</sup> (25.9 percent) will be discontinued as a result of this limit in PY 2025. Relatedly, based on trended enrollment data from PY 2023 (which we rely on for purposes of this estimate because PY 2024 enrollment data is currently unavailable), we estimate that approximately 1.78 million of the 14.94 million enrollees on the FFEs and SBE-FPs (11.9 percent) will be affected by these discontinuations in PY 2025.

In the 2024 Payment Notice (88 FR 25858 through 25859), we also

announced our intent to propose an exceptions process in the 2025 Payment Notice proposed rule that would allow issuers to offer non-standardized plan options in excess of the limit of two per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area for PY 2025 and subsequent plan years.

As such, in this proposed rule, we propose an exceptions process at new § 156.202(d) and (e) that would permit FFE and SBE-FP issuers to offer more than two non-standardized plan options per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area for PY 2025 and subsequent plan years, if issuers demonstrate that these additional non-standardized plans beyond the limit at § 156.202(b) have specific design features that would substantially benefit consumers with chronic and high-cost conditions. Issuers would not be limited in the number of exceptions permitted per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area, so long as they meet specified criteria.

Specifically, pursuant to proposed § 156.202(d), issuers would be permitted to offer more than two non-standardized plan options if these additional plans' cost sharing for benefits pertaining to the treatment of chronic and high-cost conditions (including benefits in the form of prescription drugs, if pertaining to the treatment of the condition(s)) is at least 25 percent lower, as applied without restriction in scope throughout the plan year, than the cost sharing for the same corresponding benefits in an issuer's other non-standardized plan option offerings in the same product network type, metal level, and service area. The reduction could not be limited to a part of the year, or an otherwise limited scope of benefits. Instead, issuers would be required to apply the reduced cost sharing for these benefits any time the covered item or service is furnished. For example, an issuer could not reduce cost sharing for the first three office visits or drug fills and then increase it for remaining visits or drug fills. Furthermore, issuers would be prohibited from conditioning reduced cost sharing for these benefits on a particular diagnosis. That is, although the benefit design would have reduced cost sharing to address one or more articulated conditions, the reduced cost sharing must be available to all enrolled in the plan who receive the service(s) covered by the benefit.

Under this proposal, no other plan design features (such as the inclusion of additional benefit coverage, different provider networks, different

formularies, or reduced cost sharing for benefits provided through the telehealth modality) would be evaluated under this exceptions process, meaning no other differences in plan design features would allow issuers to be excepted from the limit to the number of non-standardized plan options offered per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area.

Additionally, as part of this exceptions process, at proposed § 156.202(e), issuers would be required to submit a written justification in a form and manner and at a time prescribed by HHS that provides additional details and explains how the particular plan design the issuer desires to offer above the non-standardized plan option limit of two satisfies the proposed standards for receiving an exception to this limit—namely, how the particular plan would substantially benefit consumers with chronic and high-cost conditions. We would provide issuers with a justification form upon publication of the final rule and when the QHP templates for the applicable plan year are released.

This justification form would ask the issuer to (1) identify the specific condition(s) for which cost sharing is reduced, (2) explain which benefits would have reduced annual enrollee cost sharing (as opposed to reduced cost sharing for a limited number of visits) for the treatment of the specified condition(s) by 25 percent or more relative to the cost sharing for the same corresponding benefits in an issuer's other non-standardized plan offerings in the same product network type, metal level, and service area, and (3) explain how the reduced cost sharing for these services pertains to clinically indicated guidelines for treatment of the specified chronic and high-cost condition(s). Additionally, to allow the Exchange adequate time to review these justification forms, issuers would need to submit their QHP application in a form and manner and at a time specified by us. We anticipate requesting that issuers submit QHP applications for non-standardized plan options that exceed the two-plan limit by the QHP certification Early Bird deadline.

We propose for PY 2025 to allow exceptions only for plans that meet the previously described requirements for benefits pertaining to the treatment of conditions that are chronic and high-cost in nature. We clarify that, for purposes of this standard, chronic conditions are those that have an average duration of one year or more and require ongoing medical attention or limit activities of daily living, or

<sup>243</sup> The weighted average total number of plans available to each consumer was 107.8 in PY 2022, prior to the introduction of standardized plan option requirements, and 113.6 in PY 2023, the first year that standardized plan option requirements were introduced.

<sup>244</sup> Plan-county combinations are the count of unique plan ID and FIPS code combinations. This measure was used because a single plan may be available in multiple counties, and specific limits on non-standardized plan options or specific dollar deductible difference thresholds may have different impacts on one county where there are four plans of the same product network type and metal level versus another county where there are only two plans of the same product network type and metal level, for example.

both.<sup>245</sup> We also clarify that, for purposes of this standard, high-cost conditions are those that account for a disproportionately high portion of total Federal health expenditures. We note that the four chronic and high-cost conditions included in the prescription drug adverse tiering for PY 2025 (specifically, hepatitis C virus, HIV, multiple sclerosis, and rheumatoid arthritis) are examples of conditions that we would consider to be chronic and high-cost in nature for purposes of this standard. However, for purposes of this standard, we clarify that we would also consider additional conditions to be chronic and high-cost in nature. Additional representative examples of conditions that we would consider to be chronic and high-cost in nature for purposes of this proposal include Alzheimer's disease, kidney disease, osteoporosis, heart disease, diabetes, and all kinds of cancer. Examples of conditions that we would not consider chronic and high-cost in nature would be those that are generally acute in nature, including bronchitis, the flu, pneumonia, strep throat, and respiratory infections.

We propose this approach for several reasons. Considering that chronic and high-cost conditions (including the examples previously discussed) affect a comparatively low number of consumers, we anticipate that a significant portion of the non-standardized plan options that may be discontinued due to having comparatively lower rates of enrollment among each issuer's portfolio of offerings could potentially be those that have plan design features that benefit consumers with these chronic and high-cost conditions (such as plans with some combination of enhanced pre-deductible coverage for relevant services, reduced cost sharing for relevant services, lower MOOPs, lower deductibles, more comprehensive provider networks with more specialized providers, more generous formularies with more specialized medications, higher AVs, and higher premiums).

Even with comparatively lower rates of enrollment, we believe that these non-standardized plan options can still fulfill an important role in addressing chronic and high-cost conditions, which are responsible for a disproportionate amount of health care expenditures.<sup>246</sup>

Thus, we believe this proposed exceptions process could play an important role in enhancing the quality of life for those affected by these conditions, combatting health disparities, advancing health equity, and reducing health care expenditures. We further believe that introducing such an exceptions process while also reducing the non-standardized plan option limit to two for PY 2025 would balance the dual aims of reducing the risk of plan choice overload while simultaneously ensuring that truly innovative plan designs that may benefit consumers with chronic and high-cost conditions can continue to be offered.

We further believe that not limiting the number of permitted exceptions per issuer, product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area (instead of allowing exceptions for only two such plans, for example) would ensure that issuers are not restricted in the number of innovative plans they can offer. This would in turn help ensure that a greater portion of consumers with chronic and high-cost conditions have access to plans that reduce barriers to access to care for services critical to the treatment of their conditions.

Although issuers would not be limited in the number of exceptions they may be granted under this proposal, we anticipate that most issuers would determine that the burden of creating and certifying additional non-standardized plans intended to benefit a comparatively small population of consumers would outweigh the benefit of doing so. We also previously solicited comments on innovative plan designs, such as in the 2024 Payment Notice proposed rule. In response to this comment solicitation, we received only two examples of plan designs that commenters considered to be innovative in nature: plan designs that have reduced cost sharing for benefits provided through telehealth, and plan designs that have reduced cost sharing for services and medications related to the treatment of diabetes (such as in the form of insulin). We clarify that the former example (reduced cost sharing for benefits provided through the telehealth) would not qualify for this exceptions process, while the latter example (reduced cost sharing for benefits related to the treatment of diabetes) could potentially qualify for this exceptions process, if the specified criteria are met.

Regardless, given that we only received two examples of plan designs

that particular issuers considered to be innovative in nature, we do not anticipate that issuers will seek to have a substantial number of non-standardized plan options excepted from the non-standardized plan option limit. As a result, we do not anticipate this proposal would result in an increased risk of plan choice overload for consumers interested in plans with better benefits for qualifying conditions.

We further believe that permitting exceptions solely based on whether a non-standardized plan option has reduced cost sharing of 25 percent or more for benefits pertaining to the treatment of chronic and high-cost conditions, as opposed to considering other factors (such as specialized networks, specialized formularies, or specialized benefit packages), is appropriate since the current standardized plan option requirements do not limit issuers in the number of standardized plan options they can offer per product network type, metal level, or service area. Standardized plan option requirements do not permit issuers to deviate from the specified cost sharing parameters for standardized plan options—meaning issuers would not be able to offer standardized plan options with reduced cost sharing of 25 percent or more for the treatment of specific conditions if the benefit category's cost sharing does not comply with the specified standards.

As a result, issuers already have the flexibility to offer specialized networks, formularies, and benefit packages (including those that decrease barriers to access for the treatment of chronic and high-cost conditions—such as by including additional specialized providers, prescription drugs, or benefits) as standardized plan options. We further believe that the cost sharing difference threshold of 25 percent or more is appropriate since we have observed that cost sharing differences below this threshold represent normal variation within a particular metal level, while differences at or above this threshold are more often associated with cost sharing differences between different metal levels. Altogether, we do not believe that a difference in a cost sharing amount that is of the same magnitude as normal variation within a particular metal level (specifically, less than 25 percent) would warrant being excepted from the non-standardized plan option limit.

We note that under this proposed exceptions process, if additional plans were permitted to be offered in excess of the limit of two non-standardized plan options, in accordance with the guaranteed availability requirements at

<sup>245</sup> National Center for Chronic Disease Prevention and Health Promotion. *About Chronic Diseases*, July 21, 2022, <https://www.cdc.gov/chronicdisease/about/index.htm>.

<sup>246</sup> Waters, H, & Graf, M. (2018). *The Cost of Chronic Disease in the U.S.* Milken Institute.

<https://milkeninstitute.org/sites/default/files/reports-pdf/ChronicDiseases-HighRes-FINAL2.pdf>.

§ 147.104(a), these plans would also be required to be made available on the same basis to consumers without these chronic and high-cost conditions. Further, we emphasize that these plans would be prohibited from discriminating in accordance with the nondiscrimination requirements at §§ 147.104(e), 156.125, and 156.200(e).<sup>247</sup> To meet these non-discrimination requirements, these plans would be required to apply preferential cost sharing to all enrolled in the plan, without regard to diagnosis. Furthermore, although we acknowledge that non-standardized plan options excepted under this proposal would primarily benefit consumers with chronic and high-cost conditions, we believe that a sufficiently satisfactory range of both non-standardized and standardized plan options currently exist that are primarily intended for consumers without chronic and high-cost conditions. As a result, we are not concerned that any risk of discrimination created by this exceptions process would negatively impact consumers, including but not limited to consumers with chronic and high-cost conditions.

We seek comment on this proposed approach. Specifically, we seek comment on the proposed exceptions process, and whether there should be any exceptions at all to the limit on the number of non-standardized plan options that issuers can offer through the Exchanges. In addition, we are particularly interested in comments on the following topics: whether exceptions should be permitted only for a specific set of chronic and high-cost conditions as opposed to any chronic and high-cost condition; whether there are other plan attributes we should consider outside of sufficiently differentiated cost sharing, such as the inclusion of alternative payment models or sufficiently differentiated benefits, networks, or formularies; the specific difference threshold for these cost-sharing amounts, including whether a threshold higher or lower than 25 percent would be more appropriate; the specific components of the justification form that issuers would be required to submit; the deadline for issuers to submit the materials necessary for us to consider whether non-standardized plan

options should be excepted from the limit; and whether we should require that non-standardized plan options excepted from the limit be visually differentiated from other non-standardized plan options not excepted from the limit—such as by differentially displaying these excepted plans on *HealthCare.gov*, or by requiring these excepted plans to adopt a particular plan marketing name that accurately conveys how these plans would substantially benefit consumers with chronic and high-cost conditions (for example, by requiring that an excepted plan that reduces cost sharing for the treatment of diabetes have a corresponding plan marketing name related to diabetes).

We also seek comment on other ways to balance the dual aims of reducing the risk of plan choice overload while simultaneously ensuring that truly innovative plan designs that may benefit consumers with chronic and high-cost conditions can continue to be offered. Specifically, we seek comment on whether we should limit the number of exceptions available such that issuers are only permitted to offer one or several additional plans pursuant to the proposed exceptions process above the limit of two non-standardized plans—as opposed to not limiting the number of exceptions permitted per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area.

#### 8. CO-OP Loan Terms (§ 156.520)

We propose to amend § 156.520(f) to enable CMS to approve requests by CO-OP borrowers to voluntarily terminate their loan agreement with CMS, and thereby cease to constitute a qualified non-profit health insurance issuer (QNHII),<sup>248</sup> for the purpose of permitting the loan recipient to pursue innovative business plans that are not otherwise consistent with the governance requirements and business standards applicable to a CO-OP borrower, provided certain conditions are met as described in this section.

Section 1322 of the ACA requires a CO-OP loan recipient, or QNHII, to be, among other things, an entity “substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans.”<sup>249</sup> This requirement is set forth in regulations which require that at least two-thirds of the policies or contracts

for health insurance coverage issued by a CO-OP in each State in which it is licensed be qualified health plans offered in the individual and small group markets.<sup>250</sup>

The ACA also mandates that a QNHII be subject to governance by “a majority vote of its members.”<sup>251</sup> Accordingly, § 156.515(b) imposes governance requirements for each CO-OP that include a requirement that the entity remain under member control, such that a majority of its directors are elected by a majority vote of the CO-OP’s members. A CO-OP “member” is an individual covered by a health insurance policy issued by a CO-OP.<sup>252</sup> A CO-OP’s voting members consist of all persons covered by health insurance policies issued by the CO-OP who are 18 years of age or older.<sup>253</sup>

Section 1322 of the ACA mandates that the Secretary require an entity receiving a CO-OP loan to enter into a loan agreement with the Secretary. The required loan agreement must obligate the borrower to “meet, and to continue to meet” the requirements of a QNHII, and “any other requirements contained in the agreement.”<sup>254</sup> No more is specified concerning the required contents of the loan agreement.<sup>255</sup> The requirement that a CO-OP be subject to a majority vote of its members is, accordingly, imposed by regulation, at § 156.515(b), as well as the CO-OP loan agreement. Specifically, Section 18.2 of the CO-OP loan agreement prohibits any “[o]rganizational [c]hange . . . that would result in . . . implementing a governance structure that does not meet the governance standards codified at 45 CFR 156.515(b).”

As a result of these requirements, a CO-OP cannot pursue new business arrangements that would impose a governance structure under which it is possible for a majority of directors to be elected by a majority vote of persons who are not covered by health insurance policies issued by the CO-OP. A CO-OP also cannot enter into new business arrangements under which voting members need not be individuals covered by policies issued by the CO-OP. It is also not possible for a CO-OP to enter into a business plan under which less than two-thirds (“substantially all”) of the company’s

<sup>247</sup> The nondiscrimination requirements at § 147.104(e) apply to health insurance issuers offering non-grandfathered group or individual health insurance coverage, and their officials, employees, agents, and representatives. The nondiscrimination requirements at § 156.200(e) apply to QHPs in the individual and small-group markets, and the nondiscrimination requirements at § 156.125(b) apply to issuers providing EHB.

<sup>248</sup> Section 1322(c)(1)(B) of the ACA and 42 U.S.C. 18042(c)(1)(B) define a QNHII.

<sup>249</sup> 42 U.S.C. 18042(c)(1)(B).

<sup>250</sup> See § 156.515(c)(1).

<sup>251</sup> ACA section 1322(c)(3)(A); 42 U.S.C. 18042(c)(3)(A).

<sup>252</sup> See § 156.505.

<sup>253</sup> See § 156.515(b)(1).

<sup>254</sup> 42 U.S.C. 18042(b)(2)(C).

<sup>255</sup> 42 U.S.C. 18042(b)(2)(C)(iii) contains specific prohibitions, and concomitant penalty, that are not relevant here.

activities potentially may not consist of issuing qualified health plans.

The loan agreements currently in force only permit a CO-OP to initiate voluntary termination of its loan agreement on grounds that the loan recipient believes that it cannot create a viable and sustainable CO-OP.<sup>256</sup> The inability to create a viable or sustainable CO-OP would consist of a failure to become or remain licensed as a health insurance company, a failure to qualify as a QHP issuer, or a failure to become or remain financially solvent. There is no avenue currently for a CO-OP to request to terminate its loan agreement for the purpose of pursuing new business ventures that involve a governance structure or business model inconsistent with CO-OP governance or operational standards.

Informed by 8 years of experience with business operations for the CO-OP program, we have become aware of opportunities that may be available to CO-OPs to terminate their loan agreement, cease to constitute a QNHII, and thus become able pursue new opportunities that appear well-calculated to expand operations from regional areas within a State to Statewide operations, and also improve consumer access to other health insurance products, while remaining a non-profit, member-focused entity.

We therefore propose to amend § 156.520(f) to add § 156.520(f)(2) which would enable CMS, in its sole discretion, to approve requests by CO-OP borrowers to voluntarily terminate their loan agreement with CMS, and thereby cease to constitute a QNHII, for the purpose of permitting the loan recipient to pursue innovative business plans that are not otherwise consistent with the governance requirements and business standards of a CO-OP borrower, provided that (1) all outstanding CO-OP loans issued to the loan recipient are repaid in full prior to termination of the loan agreement, and (2) we believe granting the request would meaningfully enhance consumer access to quality, affordable, member-focused, non-profit health care options in affected markets. We propose to move the current regulation text at § 156.520(f) to new § 156.520(f)(1).

As a general matter, we anticipate that plans could be deemed innovative and likely to enhance consumer access to quality, affordable, member-focused health care if they appear to be well-calculated to lead directly to marketing non-profit, member-focused health plans in new regions of a State, or to offer health plans on a Statewide basis

for the first time, or to expand operations into new States, or to enhance consumer access to new non-profit products that are not qualified health plans. These examples of innovative business plans are illustrative, and not exclusive.

#### 9. Conforming Amendment to Netting Regulation To Include Federal IDR Administrative Fees (§ 156.1215)

We propose conforming amendments to the payment and collections process set forth at § 156.1215 to align with the policies and regulations proposed in the Federal Independent Dispute Resolution Operations proposed rules (88 FR 75744). If finalized, these amendments would provide that the administrative fees for utilizing the No Surprises Act<sup>257</sup> Federal IDR process for health insurance issuers that participate in financial programs under the Patient Protection and Affordable Care Act would be subject to netting as part of HHS' integrated monthly payment and collections cycle.<sup>258</sup>

To implement this policy, we propose to amend § 156.1215(b) to allow HHS to net payments owed to issuers and their affiliates<sup>259</sup> operating under the same tax identification number (TIN) against amounts due to the Federal Government from the issuers and their affiliates operating under the same TIN for APTC, advance payments of and reconciliation of CSRs, payment of FFE user fees, payment of SBE-FP user fees, HHS risk adjustment, reinsurance, and risk corridors payments and charges, and administrative fees from these issuers and their affiliates for utilizing the Federal IDR process in accordance with § 149.510(d)(2). Additionally, we propose to amend § 156.1215(c) to provide that any amount owed to the Federal Government by an issuer and its

<sup>257</sup> The Consolidated Appropriations Act, 2021 (CAA) was enacted on December 27, 2020. Title I, also known as the No Surprises Act, and title II (Transparency) of Division BB of the CAA amended chapter 100 of the Code, Part 7 of ERISA, and title XXVII of the PHS Act. Administrative fees are charged in accordance with 45 CFR 149.510(d)(2), 26 CFR 54.9816-8T(d)(2), and 29 CFR 2590.716-8(d)(2).

<sup>258</sup> 88 FR 75798. The effective date of any finalized proposal related to netting of amounts owed to the Federal government from health insurance issuers for administrative fees for utilizing the No Surprises Act Federal IDR process would be no earlier than a time at which both the proposals related to netting proposed in the Federal Independent Dispute Resolution Operations proposed rule and the proposed amendments to § 156.1215 in this proposed rule are finalized.

<sup>259</sup> "Affiliate" refers to any affiliated issuer that operates under the same taxpayer identification number as an issuer, such as when there are multiple Health Insurance Oversight System (HIOS) identifiers operating under the same taxpayer identification number. See the 2015 Payment Notice proposed rule (78 FR 72371).

affiliates for unpaid administrative fees due to the Federal Government from these issuers and their affiliates for utilizing the Federal IDR process in accordance with § 149.510(d)(2), after HHS nets amounts owed by the Federal Government under these programs, would be the basis for calculating a debt owed to the Federal Government.

We seek comment on the proposed amendments to § 156.1215(b) and (c).

#### IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of the agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs).

##### A. Wage Estimates

To derive wage estimates, we generally use data from the Bureau of Labor Statistics to derive average labor costs (including a 100 percent increase for the cost of fringe benefits and overhead) for estimating the burden associated with the ICRs.<sup>260</sup> Table 14 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

<sup>260</sup> See May 2022 Bureau of Labor Statistics, Occupational Employment Statistics, National Occupational Employment and Wage Estimates. [https://www.bls.gov/oes/current/oes\\_stru.htm](https://www.bls.gov/oes/current/oes_stru.htm).

<sup>256</sup> CO-OP loan agreement, section 16.1.1(a).

doubling the hourly wage to estimate

total cost is a reasonably accurate estimation method.

**TABLE 14: Adjusted Hourly Wages Used in Burden Estimates**

Occupation Title	Occupational Code	Median Hourly Wage (\$/hr.)	Fringe Benefits and Overhead (\$/hr.)	Adjusted Hourly Wage (\$/hr.)
Business Operations Specialist	13-1000	\$36.56	\$36.56	\$73.12
Web and Digital Interface Designer	15-1255	\$40.02	\$40.02	\$80.04
Web Developer	15-1254	\$37.78	\$37.78	\$75.56
Compliance Officer	13-1041	\$34.47	\$34.47	\$68.94
Accountant and Auditor	13-2011	\$37.50	\$37.50	\$75.00
Management Analyst	13-1111	\$45.81	\$45.81	\$91.62
Chief Executive	11-1011	\$91.12	\$91.12	\$182.24
Computer Systems Analyst	15-1211	\$49.15	\$49.15	\$98.30
Financial Examiners (State Government, excluding schools and hospitals)	13-2061	\$39.52	\$39.52	\$79.04
Actuary (Member of American Academy of Actuaries)	15-2011	\$54.80	\$54.80	\$109.60
General and Operations Manager	11-1021	\$47.16	\$47.16	\$94.32
General Internal Medicine Physician	29-1216	\$103.11	\$10.113	\$206.22
Computer Programmers	15-1251	\$47.02	\$47.02	\$94.04

*B. ICRs Regarding Proposed Amendments to Normal Public Notice Requirements (31 CFR 33.112, 31 CFR 33.120 and 45 CFR Part 155.1312, and 45 CFR 155.1320)*

The Departments propose amendments to the section 1332 waiver implementing regulations to set forth flexibilities related to State public notice requirements and post-award public participation requirements. Current regulations at 31 CFR 33.112 and 45 CFR 155.1312 specify State public notice and comment period and participation requirements for proposed section 1332 waiver requests, and 31 CFR 33.116(b) and 45 CFR 155.1316(b) specify the public notice and comment period and approval requirements under the accompanying Federal process.

However, this proposed rule does not propose to alter any of the requirements related to section 1332 waiver applications, compliance and

monitoring, or evaluation in a way that would impose any additional costs or burdens for States seeking waiver approval or those States with approved waiver plans that have not already been captured in prior burden estimates. The Departments anticipate that implementing these provisions, if finalized, would not significantly change or decrease the associated burden currently approved under OMB control number: 0938–1389, expiration date: February 29, 2024.

*C. ICRs Regarding Basic Health Program Regulations (42 CFR 600.320)*

We propose at 42 CFR 600.320(c)(1) through (3) that a State operating a BHP must establish a uniform method of determining the effective date of eligibility for enrollment in a standard health plan which follows: (1) the Exchange effective date standards at 45 CFR 155.420(b)(1); (2) the Medicaid effective date standards at 42 CFR

435.915 exclusive of § 435.915(a); or (3) an effective date of eligibility of the first day of the month following the month in which BHP eligibility is determined. We note that only 42 CFR 600.320(c)(3) is a new proposal. The options under 42 CFR 600.320(c)(1) and (2) exist.

We estimate that the proposal under 42 CFR 600.320(c)(3) would have no impact on the information collection burden. We note that any cost would be incurred 100 percent by the State, as Federal BHP funds cannot be used for program administration. We seek comment on these assumptions.

*D. ICRs Regarding Election To Operate an Exchange After 2014 (45 CFR 155.106)*

We propose amending § 155.106(a)(2) to add new paragraphs (a)(2)(i) and (ii) to require that, as part of a State's activities for its establishment of a State Exchange, the State provide supporting documentation demonstrating progress

toward meeting State Exchange Blueprint requirements, or documentation that details a State's plans for how it intends to implement and meet the Exchange functional requirements as laid out in the State Exchange Blueprint. This could include a State submitting detailed plans regarding its State Exchange consumer assistance programs and activities, such as information on its direct-to-consumer outreach plans, for HHS to assess comparability to the FFEs' consumer assistance programs and activities while allowing for State flexibility in its approach to best serve the State's consumers. Additionally, we are proposing to require that when a State submits its State Exchange Blueprint application to HHS for approval, the State must provide the public with notice and a copy of its State Exchange Blueprint application. Further, at some point following a State's submission of its State Exchange Blueprint application to HHS, a State must conduct at least one public engagement (such as a townhall meeting or public hearing), in a timeline and manner considered effective by the State, with concurrence from HHS, at which interested parties can learn about the State's intent to establish a State Exchange and the State's progress toward executing that transition. We also propose to require that while a State is in the process of establishing a State Exchange and until HHS has approved or conditionally approved the State Exchange Blueprint application, a State conduct periodic public engagements at which interested parties can continue to learn about the State's progress towards establishing a State Exchange, in a timeline and manner considered effective by the State, with concurrence from HHS. These proposals, if finalized, would impact States that are considering, or are in the process of, establishing a State Exchange for PY 2025 and subsequent years. However, if finalized, we anticipate minimal burden on these States, as we believe they would have sufficient time to plan for such public-facing State Exchange engagements and activities if not already in their plans.

*E. ICRs Regarding Adding and Amending Language To Ensure Web-Brokers Operating in State Exchanges Meet Certain Requirements Applicable in the FFEs and SBE-FPs (45 CFR 155.220)*

The following proposed changes will be submitted to OMB for review under OMB control number 0938–New (CMS–#####). We seek comment on these burden estimates.

We propose to amend § 155.220 to apply to web-brokers operating in State Exchanges, and consequently in State Exchanges, for both the State Exchange's Individual Exchange and SHOP, certain existing Federal standards governing web-brokers use of non-Exchange website to assist consumers with enrolling in QHPs and applying for APTC/CSRs in a manner that constitutes enrollment through the Exchange. The burden associated with these proposed changes includes costs for web-brokers participating in States with State Exchanges to meet the requirements described in new proposed § 155.220(n) and for State Exchanges related to the development and oversight of web-broker programs within their State. We anticipate that the same number of web-brokers operating in the Exchanges on the Federal platform (20) would also operate in the 5 State Exchanges and would be required to incur this burden for each of the 5 State Exchanges they may operate in. We estimate the relevant costs based on current Federal costs. These estimates are described below.

These proposals would impose burdens on web-brokers participating in State Exchanges for costs related to web-development to meet the website display requirements proposed to be extended to web-brokers operating in these State Exchanges and costs associated with creating and submitting audit documentation for the applicable Exchange's review. Although we have allowed States certain flexibility for State Exchanges with regards to establishing procedures and requirements for website displays and demonstration of operational readiness, we expect the costs can be reasonably estimated based on the Federal costs as follows. We also solicit feedback from State Exchanges regarding these burden estimates and the number of web-brokers expected to participate in State Exchanges pursuant to this proposal.

We estimate it would take 15 hours for a Business Operations Specialist at an hourly rate of \$73.12 to implement the standardized disclaimers required under § 155.220(c)(3)(i)(A) and (G), along with 45 hours at an hourly rate of \$80.04 for a Web and Digital Interface Designer to modify the website to implement the standardized disclaimers across 5 State Exchanges. Therefore, for the standardized disclaimers under § 155.220(c)(3)(i)(A) and (G), we estimate each web-broker operating in State Exchanges that operate their own eligibility and enrollment platform would incur a cost of \$4,698.60 (15 hours × \$73.12 per hour + 45 hours × \$80.04 per hour). We estimate a

cumulative burden of \$93,972 for the anticipated 20 web-brokers operating across the State Exchanges (\$4,698.60 × 20 web-brokers). Additionally, proposed new paragraph § 155.220(n)(1) allows State Exchanges the flexibility to add State-specific information to the standardized disclaimers that does not conflict with the HHS-provided language. We solicit feedback from State Exchanges regarding how these flexibilities would impact these burden estimates.

Additionally, we anticipate it would take up to 100 hours at an hourly rate of \$80.04 for a Web and Digital Interface Designer to modify the website to implement and display the standardized QHP comparative information required under § 155.220(c)(3)(i)(A) (including the quality ratings assigned by HHS and enrollee satisfaction survey) across 5 State Exchanges. Therefore, for the display of the QHP comparative information on web-broker non-Exchange websites, we estimate each web-broker operating in State Exchanges would incur a cost of \$8,004 (100 hours × \$80.04 per hour). We estimate a cumulative burden of \$160,080 for the anticipated 20 web-brokers operating across the State Exchanges (\$8,004 × 20 web-brokers).

We anticipate it would take 50 hours for a Web and Digital Interface Designer at an hourly rate of \$80.04 to modify the website to display the APTC and CSR eligibility information required under § 155.220(c)(3)(i)(I) across 5 State Exchanges. Therefore, for changes related to implementation of the Federal minimum web-broker standards related to display of consumer APTC and CSR eligibility information, we estimate each web-broker operating in States with State Exchanges would incur a cost of \$4,002 (50 hours × \$80.04). We therefore estimate a cumulative burden of \$80,040 for the anticipated 20 web-brokers operating across the 5 State Exchanges (\$4,002 × 20 web-brokers). Additionally, proposed new paragraph § 155.220(n)(1) allows State Exchanges the flexibility to add State-specific information to the standardized disclaimers that does not conflict with the HHS-provided language and to define and review how consumer education information about the State Exchange is customized and presented on web-brokers websites. We solicit feedback from State Exchanges regarding how these flexibilities would impact these burden estimates.

New proposed paragraph (c)(4)(iii) would extend certain downstream agent and broker requirements at § 155.220(c)(4)(i) that currently apply to web-brokers in FFE and SBE-FP States and govern the use of the web-broker's



non-Exchange website by other agents or brokers assisting Exchange consumers to also apply to web-brokers, and their downstream agents and brokers in State Exchanges. Under the proposed new provision, web-brokers that permit other agents or brokers, through a contract or other arrangement, to use the web-broker's non-Exchange website to help and applicant or enrollee complete a QHP selection or complete the Exchange eligibility application would be required to meet the standards at § 155.220(c)(4)(i)(A), (B), (D), and (F) when assisting consumers in States with State Exchanges. This includes extension of requirements for web-brokers to verify that any agent or broker accessing or using the website is licensed in the State in which the consumer is selecting the QHP and has completed training and registration and has signed all required agreements with the applicable State Exchange. It would also require web-brokers to terminate the agent or broker's access to its website if the applicable State Exchange determines the agent or broker is in violation of the provisions described in this section and/or if the applicable State Exchange terminates any required agreement with the agent or broker. In addition, it would also extend a requirement for web-brokers to provide State Exchanges with a list of agents and brokers who enter into such a contract or other arrangement to use the web-broker's non-Exchange website, in a form and manner to be specified by the State Exchanges similar to the requirement in § 155.220(c)(4)(i)(A) for web-brokers in FFE and SBE-FP States to report the same information to HHS. We understand that web-brokers who work with and allow other agents and brokers to use the web-brokers' non-Exchange websites to assist Exchange consumers typically obtain and manage information on each of their downstream agents or brokers as part of an onboarding process. As a result, we expect web-brokers would already have the necessary data to provide a list to the applicable State Exchange of each of the other agents or brokers that allows to use the web-brokers' non-Exchange websites to assist Exchange consumers. We estimate that it would take up to 240 hours at an hourly cost of \$94.04 for a computer programmer to perform the necessary programming to comply with these requirements in § 155.220(c)(4)(i)(A), (B), and (D), and 20 hours at an hourly cost of \$118.30 for a senior manager to develop a listing of affiliated third-party agents and brokers across all 5 State Exchanges. Therefore,

for changes related to implementation of these Federal minimum web-broker standards related to downstream agents or brokers, we estimate each web-broker operating in State Exchanges would incur a cost of \$24,935.60 per web-broker ( $(\$94.04 \times 240 \text{ hours}) + (\$118.30 \times 20 \text{ hours})$ ). We estimate a cumulative burden of \$598,454.40 for an anticipated 24 web-brokers operating across the State Exchanges ( $\$24,935.60 \times 24 \text{ web-brokers}$ ).

We estimate it would take 95 hours for a Business Operations Specialist at an hourly rate of \$73.12 to oversee and monitor compliance with the operational readiness requirements established by State Exchange, as required by new § 155.220(n)(2) across 5 State Exchanges. Therefore, for compliance requirements, we estimate each web-broker operating in States with State Exchanges would incur a cost of \$6,946.40 (95 hours  $\times$  \$73.12) for the proposed operational readiness requirements. We estimate a cumulative burden of \$138,928 for the anticipated 20 web-brokers operating across the 5 State Exchanges ( $\$6,946.40 \times 20 \text{ web-brokers}$ ). These burden estimates are provided based on the estimates of the cost for DE entities to comply with the operational readiness requirements established by HHS. Proposed new paragraph § 155.220(n)(2) would allow State Exchanges to define and establish the form and manner for their web-brokers to establish operational readiness. Although we anticipate State Exchanges would establish requirements similar to the requirements for demonstrating operational readiness to operate in the FFE or SBE-FPs, we solicit feedback from State Exchanges regarding how well these burden estimates reflect their anticipated requirements.

Therefore, we estimate each web-broker operating in all 5 State Exchanges would incur a one-time burden in PY 2025 of 565 hours at a cost of \$48,586.60. We estimate a cumulative burden of 11,300 hours at an estimated cost of \$1,071,474.40 for all 20 web-brokers operating across the 5 State Exchanges. We seek comment on the number of State Exchanges that would be interested in establishing a web-broker program to allow web-brokers to host non-Exchange websites to assist Exchange consumers in their State and on the number of web-brokers interested in operating in those State Exchanges.

New proposed paragraph 155.220(n) requires State Exchanges to comply with the Federally-facilitated Exchange standards described above and in the preamble. Proposed paragraph 155.220(n)(1) allows State Exchanges

the flexibility to add State-specific information to the standardized disclaimers that does not conflict with the HHS-provided language and provides flexibility for the State Exchanges to define how consumer educational information is displayed on websites by web-brokers in State Exchanges. Proposed paragraph (2) under this new section also requires State Exchanges to establish the form and manner for their web-brokers to demonstrate operational readiness and compliance with applicable requirements, in the form and manner specified by the Exchange. The burden associated with these proposed changes includes costs for existing and future State Exchanges related to drafting new policy, updating standards, and potentially hiring additional staff to perform functions not currently being performed by the State Exchange, such as for drafting web-broker disclaimer language, drafting consumer-facing educational content, and engaging web-brokers in operational readiness, that would now incur new costs related to establishment of a web-broker program and ongoing monitoring of web-brokers to enforce the minimum Federal standards and any additional State-specific requirements.

We estimate the relevant costs based on current Federal costs as follows. We estimate that 5 States will opt to host a web-broker program for their State Exchanges. We anticipate the total burden associated with the State Exchanges developing the associated policies and procedures, including providing web-brokers with examples and technical assistance (including technical implementation guidance such as providing the quality ratings assigned and enrollee satisfaction survey data) to be up to 528 hours per State. This assumes 480 hours for a GS-13, Step 5 employee at an hourly rate of \$121.66 (the hourly wage rate for a GS-13, Step 5 employee in the Washington, DC area,<sup>261</sup> doubled to account for fringe benefits and overhead) and 48 hours for a GS-15, Step 5 employee at an hourly rate of \$169.10 (the hourly wage rate for a GS-15, Step 5 employee in the Washington, DC area,<sup>262</sup> doubled to account for fringe benefits and overhead). In total, for the 5 State Exchanges anticipated to participate, we estimate a burden of 2,640 hours (5

<sup>261</sup> OPM. (2023, January). *Salary Table 2023–DCB Incorporating the 4.1% General Schedule Increase and a Locality Payment of 32.49% For the Locality Pay Area of Washington-Baltimore-Arlington, DC-MD-VA-WV-PA Total Increase: 4.86%*. [https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2023/DCB\\_h.pdf](https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2023/DCB_h.pdf).

<sup>262</sup> *Id.*



State Exchanges  $\times$  528 hours per State Exchange) at a cost of \$332,568 (2,400 hours  $\times$  \$121.66 + 240  $\times$  \$169.10).

We estimate it would take 40 hours each for the State Exchange equivalent of 2 GS–13, Step 5 employees at an hourly rate of \$121.66 (the hourly wage rate for a GS–13, Step 5 employee in the Washington, DC area,<sup>263</sup> doubled to account for fringe benefits and overhead) to complete initial documentation review related to all web-broker requirements pursuant to this proposal, for a total cost to State governments of \$9,732.8 (2  $\times$  40 hours  $\times$  \$121.66) per State Exchange. We estimate it would take 8 hours for the equivalent of 1 GS–15, Step 5 employee at an hourly rate of \$169.10 (the hourly wage rate for a GS–15, Step 5 employee in the Washington, DC area,<sup>264</sup> doubled to account for fringe benefits and overhead) to provide managerial review and oversight, for a total cost to State governments of \$1,352.8 (1  $\times$  8 hours  $\times$  \$169.10) per State Exchange. *Additionally, we estimate* the total burden for each State government for State contract and contractors ongoing reviews for oversight would include 1,087 hours at GS–12, Step 5 with an hourly rate of \$102.30 (the hourly wage rate for a GS–12, Step 5 employee in the Washington, DC area,<sup>265</sup> doubled to account for fringe benefits and overhead) and 2,305 hours at GS–13, Step 5 with an hourly rate of \$121.66 (the hourly wage rate for a GS–13, Step 5 employee in the Washington, DC area,<sup>266</sup> doubled to account for fringe benefits and overhead), and the total burden across all 5 States to be 16,960 hours. Therefore, we estimate a cost to each State governments of \$469,225.60, with a total estimated cost to State governments of \$2,346,128 (5 States  $\times$  \$469,225.60). We seek comment from State Exchanges on these burden estimates.

We recognize that some State Exchanges may utilize web-brokers already participating in the FFEs and SBE–FPs, and encourage State Exchanges to leverage web-broker operational readiness demonstrated to participate in the FFEs or SBE–FPs when possible, as to minimize both burden on the State Exchanges and their web-brokers.

*F. ICRs Regarding Establishing Requirements for DE Entities Mandating HealthCare.gov Changes To Be Reflected on DE Entity Non-Exchange Websites Within a Notice Period Set by HHS (45 CFR 155.221(b))*

The following proposed changes will be submitted to OMB for review under OMB control number 0938–New (CMS–#####). We seek comment on these burden estimates.

As discussed in the preamble of this proposed rule, we propose to add language to § 155.221 requiring that display changes adopted by *HealthCare.gov* be reflected on DE entity non-Exchange websites within a time period specified by HHS, unless HHS approves a deviation.

Based on our experience with operating the DE program on the FFEs and SBE–FPs over the past several years, we estimate that approximately three or fewer display changes would be required annually. We estimate that a total of 100 web-brokers and QHP issuers participating in DE in FFE and SBE–FP States would be required to comply with these requirements. These display changes may range from changes such as, but not limited to, relatively simple text-based updates to more complex display changes involving the website’s backend display methodology or algorithms. We estimate approximately two simpler and one more complex display change annually. We estimate that it would take a Web and Digital Interface Designer 30 hours annually, at a cost of \$80.04 per hour, to implement these changes, at a total annual cost of approximately \$2,401.20 (\$80.04  $\times$  30 hours) per web-broker or QHP issuer. We therefore estimate a total annual burden of 3,000 hours (30  $\times$  100) at a cost of \$240,120 (3,000 hours  $\times$  \$80.04 per hour) for all applicable web-brokers and QHP issuers.

We recognize that system constraints may prevent DE entity websites from conforming to the minimum standards defined by HHS for certain *HealthCare.gov* display changes, and that DE entities may have an idea for implementation that does not meet the standards but would effectively communicate the same information to consumers. We propose DE entities participating in FFE and SBE–FPs that intend to deviate from the standards defined by HHS would be required to submit a deviation request. Those requests would be subject to review by HHS in advance of implementation of any alternative website displays.

Based on internal data, we estimate that 25 web-brokers and QHP issuers participating in FFE or SBE–FP States

would submit a request to deviate from the standards defined by HHS annually. We estimate it would take a compliance officer approximately 3 hours annually, at a rate of \$68.94 per hour, to prepare and submit the request to deviate from the communicated standards, including preparing the rationale explaining for the request. We therefore estimate the total annual burden for all web-brokers and issuers in completing and submitting a request to deviate to be approximately \$5,170.50 annually.

We do not expect this proposal to impose a new burden on EDE entities, if finalized, as EDE entities are already following the process outlined in this proposal through the change request processes described in the Third Party Auditor Guidelines.

If the proposal to add and amend language to ensure DE entities participating in Exchanges, at proposed new § 155.221(j), is finalized, we estimate that DE entities may incur burden related to the website development needed to implement changes made to State Exchange websites per the standards defined by the State Exchange. We anticipate that the web-development costs cited above would apply for each DE entity assisting consumers in State Exchanges. As described in the preamble, there may be burden associated with maintaining DE environments tailored to each States’ display requirements. However, based on our experience conducting oversight of DE entity websites, it is our understanding that DE entities are familiar with and capable of tailoring website displays based on specific criteria and, as such, we anticipate entities are capable of tailoring website displays to the requirements of the State the consumer is seeking assistance in. We anticipate a total annual burden of \$1,226,452.50 for DE entities participating in States with State Exchanges associated with implementing display changes and submitting requests to deviate from the standards defined by the State Exchange across 5 State Exchanges (\$245,290.50  $\times$  5 State Exchanges). Deviation requests would be subject to review by the State Exchange in advance of implementation of any alternative website displays. We seek comment on the burden of this proposal on DE entities planning to operate in State Exchanges.

*G. ICRs Regarding Adding and Amending Language To Ensure DE Entities Operating in State Exchanges Meet Certain Standards Applicable in the FFEs and SBE–FPs (45 CFR 155.221)*

The following proposed changes will be submitted to OMB for review under

<sup>263</sup> *Id.*

<sup>264</sup> *Id.*

<sup>265</sup> *Id.*

<sup>266</sup> *Id.*

OMB control number 0938–New (CMS–#####). We seek comment on these burden estimates.

We propose to amend § 155.221 to apply to DE entities operating in State Exchanges, and consequently State Exchanges that choose to implement a DE program, certain existing Federal standards regarding DE entities assisting consumers with enrolling in QHPs and applying for APTC/CSRs, both for the State Exchange's Individual Exchange and SHOP program. We anticipate that the same number of DE entities operating in the Exchanges on the Federal platform (100) would also operate in the 5 State Exchanges and would be required to incur this burden for each of the 5 State Exchanges they may operate in. The burden associated with these proposed changes includes costs for DE entities participating in State Exchanges to meet the requirements described in new proposed § 155.221(j) and for State Exchanges related to the development and oversight of DE programs within their State. We estimate relevant costs based on current Federal costs. These estimates are described below.

The burden associated with operating a DE program includes costs for DE entities related to web-development to meet the website display requirements being applied to DE entities operating in States with State Exchanges and costs for creating, storing, and submitting operational readiness documentation for Exchange review. Although these proposals allow States certain flexibility for State Exchanges with regards to establishing procedures and requirements for website displays and demonstration of operational readiness, we expect the costs to reasonably be estimated based on the Federal costs as follows.

We estimate it would take 15 hours for a DE entity's Business Operations Specialist at an hourly rate of \$73.12 to implement the standardized disclaimer required under § 155.221(b)(2), along with 20 hours at an hourly rate of \$80.04 for a Web and Digital Interface Designer to modify the DE entity non-Exchange website to implement the standardized disclaimer across 5 State Exchanges. Therefore, for the standardized disclaimer under § 155.221(b)(2), we estimate each DE entity operating in State Exchanges that operate their own eligibility and enrollment platform would incur a burden of 35 hours at an estimated cost of \$2,697.60 (15 hours × \$73.12 per hour + 20 hours × \$80.04 per hour). We estimate the anticipated 100 DE entities would incur a cumulative burden 3500

hours at an estimated cost of \$269,760 (\$2,697.60 × 100 DE entities).

Costs related to demonstrating operational readiness at new proposed § 155.221(j) would depend on the DE entity's desired enrollment pathway and the options made available by the State Exchange. Although we are allowing States the flexibility to establish operational readiness requirements, including the form and manner for their DE entities to demonstrate operational readiness, we encourage State Exchanges to leverage the existing items in § 155.220(b)(4)(i) and (ii) as the starting point for their operationally readiness reviews. If State Exchanges leverage these items, we anticipate the burden associated with DE entity demonstration of operational readiness can be estimated based on the Federal costs as follows. We estimate it would take up to 360 hours for an Auditor at an hourly rate of \$75.00 to submit business audit documentation across 5 State Exchanges, and we estimate 4 DE entities would participate in a manner that would trigger this information collection, resulting in an estimated cost of \$27,000 per DE entity (360 hours × \$75.00). We estimate it would take up to 610 hours for an Auditor at an hourly rate of \$75.00 to submit a security and privacy audit documentation across 5 State Exchanges, and we estimate 14 DE entities would participate in a manner that would trigger this information collection, resulting in an estimated cost of \$45,750 per DE entity (610 hours × \$75.00). We estimate it would take 45 hours for a Business Operations Specialist to complete and submit a typical Enhanced Direct Enrollment (EDE) documentation package and related information across 5 State Exchanges at an hourly rate of \$73.12, and 77 DE entities would participate in a manner that would trigger this information collection, resulting in an estimated cost of \$3,290.40 per DE entity (45 hours × \$73.12). Therefore, for a DE entity to demonstrate operational readiness and compliance with applicable requirements to State Exchanges, we estimate each DE entity would incur a burden of up to 1,015 hours at an estimated cost of up to \$76,040.40 (360 hours × \$75.00 per hour + 610 hours × \$75.00 per hour + 45 hours × \$73.12), but many DE entities would incur a lower burden and cost due to not participating in a manner that would trigger some of these information collection costs. We estimate a cumulative burden of 13,445 hours at an estimated cost of \$1,001,860.80 for all applicable DE entities operating across the 5 State Exchanges (\$27,000 × 4 DE

entities + \$45,750 × 14 DE entities + \$3,290.40 × 77 entities). We solicit feedback from State Exchanges with regards to how the form and manner of documentation they would require DE entities to submit to demonstrate operational readiness, along with the estimated burden associated with those submissions.

We estimate it would take 100 hours for a Web and Digital Interface Designer at a rate of \$80.04 per hour to modify the DE entity's non-Exchange website to comply with the requirements to display and market QHPs offered through the Exchange, individual health insurance coverage, and any other products on at least three separate websites pages in accordance with §§ 155.221(b)(1) and (3) and (c) across 5 State Exchanges. Therefore, for these website display requirements, we estimate each DE entity operating in State Exchanges would incur an estimated cost of \$8,004 (100 hours × \$80.04 per hour). We estimate 40 DE entities would trigger this information collection with a cumulative burden of 4,000 hours at an estimated cost of \$320,160 across the State Exchanges (\$8,004 × 40 DE entities).

The burden associated with this change also includes costs for DE entities operating in State Exchanges with oversight of direct enrollment entity application assisters, as described in § 155.221(d) (citing § 155.415(b)), for those DE entities that opt to use these application assisters. As described in the preamble, the requirements at 155.415(b)(2) and (b)(3) are already applicable to DE entities operating in all Exchanges and therefore do not represent a new burden for DE entities. The extension of § 155.221(d) to DE entities operating in State Exchanges would require DE entities' application assisters to complete appropriate State-required training and registration in a manner specified by the State Exchange consistent with § 155.415(b)(1). We estimate that up to 1,000 application assisters will operate in each State that opts to implement a DE program and allows DE entity application assisters to assist Exchange consumers. Accordingly, we anticipate that 5,000 application assisters across an estimated 5 States will participate. We estimate the burden for 100 DE entities to comply with this requirement at 3 hours per assister for a total annual burden of 15,000 hours for a Compliance Officer at an hourly wage of \$68.94 for a total cost of \$51,705 per entity. We estimate a cumulative burden of 75,000 hours at an estimated cost of \$5,170,500 for 100 DE entities operating across the 5 State Exchanges (\$51,705 × 100 entities).

Proposed new paragraph § 155.221(j)(3) extends requirements for DE entities operating in State Exchanges to implement and prominently display changes adopted for display on the State Exchanges' websites and with standards defined by State Exchange, unless the State Exchange approves a deviation. The costs associated with DE entities implementing this proposal in State Exchanges is discussed in the ICR section related to new proposed paragraph § 155.221(b)(6).

Regarding new proposed paragraph § 155.221(a) extending requirements under § 156.1230(a) to DE QHP issuers operating in State Exchanges, we do not anticipate additional burden for QHP issuers, beyond the estimated burdens for the website display requirements described above, to provide consumers with correct information, without omission of material fact, regarding the Exchanges, QHPs offered through the Exchanges, and insurance affordability programs, or to refrain from marketing or conduct that is misleading, coercive, or discrimination based on race, color, national origin, disability, age, or sex.

Therefore, we estimate each DE entity operating in State Exchanges would incur a one-time burden in PY 2025 of up to 1,900 hours at a cost of up to \$138,447 for an overall total for all DE entities operating across the State Exchanges of up to 95,945 hours at an estimated cost of \$6,762,280.80 to comply with these proposed requirements. We seek comment on the burden of this proposal on DE entities planning to participate in State Exchanges. For the purposes of better determining burden estimates, we also seek comment on the number of State Exchanges that operate their own eligibility and enrollment platforms and would be interested in implementing a DE program in their State and on the number of DE entities interested in operating in those State Exchanges.

New proposed paragraph § 155.221(j) requires State Exchanges to comply with the Federally-facilitated Exchange standards described above and in the preamble. § 155.221(j)(1) allows State Exchanges the flexibility to add State-specific information to the standardized disclaimer that does not conflict with the HHS-provided language. Proposed paragraph (2) under this new section also requires State Exchanges to establish the form and manner for their DE entities to demonstrate operational readiness and compliance with applicable requirements, in the form and manner specified by the Exchange. Proposed paragraph (3) requires State Exchanges establish requirements for their DE entities to implement and

prominently display changes adopted for display on the State Exchanges' website at the direction of the State Exchange. The burden associated with these proposed changes includes costs for State Exchanges related to drafting new policy, updating standards, and potentially hiring additional staff to perform functions not currently being performed by the State Exchange, such as for drafting DE entity program requirements and guidelines, including establishment of DE entity operational readiness programs, establishment of procedures related to defining and communicating standards for required display changes, establishment of any State-specific disclaimer text, and ongoing monitoring of DE entity compliance with applicable Federal standards and any additional State-specific requirements. DE entities operating in States transitioning off of the Federal Platform to a State Exchange would likely have fewer costs as they should already be meeting the Federal minimum requirements. No State Exchange has implemented DE to date, so we are not able to provide precise costs estimates of the burden associated with these proposed changes for State Exchanges. However, we anticipate that operational costs related to establishing policies and adding staff in order to operate a compliant DE program under § 155.221 may be estimated based on Federal platform costs and would be added to the costs and burdens of transitioning to State Exchange.

We estimate that 5 States will opt to host a DE program for their State Exchanges. We anticipate the total burden associated with the State Exchanges developing the associated policies and procedures to be up to 528 hours per State. This assumes 480 hours for a GS-13, Step 5 employee at an hourly rate of \$121.66 (the hourly wage rate for a GS-13, Step 5 employee in the Washington, DC area,<sup>267</sup> doubled to account for fringe benefits and overhead) and 48 hours for a GS-15, Step 5 employee at an hourly rate of \$169.10 (the hourly wage rate for a GS-15, Step 5 employee in the Washington, DC area,<sup>268</sup> doubled to account for fringe benefits and overhead). In total, for the 5 State Exchanges anticipated to participate, we estimate a burden of 2,640 hours (5 State Exchanges × 528 hours per State Exchange) at a cost of

\$332,568 (2,400 hours × \$121.66 per hour + 240 hours × \$169.10 per hour).

Based on the Federal platform costs, we estimate it would take 60 hours each for the State Exchange equivalent of 2 GS-13, Step 5 employees at an hourly rate of \$121.66 (the hourly wage rate for a GS-13, Step 5 employee in the Washington, DC area,<sup>269</sup> doubled to account for fringe benefits and overhead) to complete initial documentation review related to all DE entity requirements pursuant to this proposal, for a total cost to State governments of \$14,599.20 (2 employees × 60 hours per employee × \$121.66 per hour) per State Exchange. We estimate it would take 12 hours for the equivalent of 1 GS-15, Step 5 employee at an hourly rate of \$169.10 (the hourly wage rate for a GS-15, Step 5 employee in the Washington, DC area,<sup>270</sup> doubled to account for fringe benefits and overhead) to provide managerial review and oversight, for a total cost to State governments of \$2,029.20 (12 hours × \$169.10 per hour) per State Exchange. *Additionally, we estimate the total burden for each State government for State contract and contractors ongoing reviews for oversight would include 1,631 hours for a GS-12, Step 5 employee with an hourly rate of \$102.30 (the hourly wage rate for a GS-12, Step 5 employee in the Washington, DC area,<sup>271</sup> doubled to account for fringe benefits and overhead) and 3,458 hours for a GS-13, Step 5 employee with an hourly rate of \$121.66 (the hourly wage rate for a GS-13, Step 5 employee in the Washington, DC area,<sup>272</sup> doubled to account for fringe benefits and overhead). We estimate a burden to each State government of 5,089 hours at an estimated cost of \$587,551.58 for State contracts and contractors ongoing reviews for oversight. Therefore, each State would incur a burden of 5,749 hours at an estimated cost of \$670,693.58 (\$66,513.60 + \$14,599.20 + \$2,029.20 + \$587,551.58) in total for these proposals, and all 5 States would incur a total burden of 28,745 hours at an estimated cost of \$3,353,468 (5 States × \$670,693.58). We seek comment from State Exchanges on these burden estimates.*

We recognize that some State Exchanges may decide to utilize DE entities already participating in the FFEs and SBE-FPs and encourage State Exchanges to leverage DE operational readiness demonstrated to participate in the FFEs or SBE-FPs when possible, so

<sup>267</sup> OPM. (2023, January). *Salary Table 2023-DCB Incorporating the 4.1 % General Schedule Increase and a Locality Payment of 32.49% For the Locality Pay Area of Washington-Baltimore-Arlington, DC-MD-VA-WV-PA Total Increase: 4.86%*. [https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2023/DCB\\_h.pdf](https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2023/DCB_h.pdf).

<sup>268</sup> *Id.*

<sup>269</sup> *Id.*

<sup>270</sup> *Id.*

<sup>271</sup> *Id.*

<sup>272</sup> *Id.*

as to minimize burden on both the State Exchanges that operate their own eligibility and enrollment platform and their DE entities.

*H. ICRs Regarding Failure To File and Reconcile Process (45 CFR 155.305(f)(4))*

We propose amending § 155.305(f)(4) to provide that State Exchanges must notify a tax filer that has been identified as having FTR status for one-year of the requirement to file and reconcile their APTC, or risk losing their eligibility for APTC if they remain FTR for the subsequent tax-year. This proposed requirement would ensure that State Exchanges provide notifications, similar to how Exchanges on the Federal platform do, and that tax filers on State Exchanges are adequately educated on the requirement to file and reconcile. The proposed rule, if finalized, would impact State Exchange FTR noticing processes for PY 2025 and subsequent years. For State Exchanges, FTR would be conducted in the same manner it had previously been conducted with respect to collection of information, with minimal changes to the language of the Exchange application questions necessary to obtain relevant information; as such, we anticipate that the proposed amendment, if finalized, would not impact the existing information collection requirements (OMB control number: 0938–1191) or burden for consumers.

Under previous FTR policy, State Exchanges were already required to notify tax filers identified as FTR at a minimum of once per year. As such, we do not anticipate this requirement increasing State Exchanges' burden of noticing beyond their existing FTR processes. We seek comment on these assumptions.

*I. ICRs Regarding Verification Process Related to Eligibility for Enrollment in a QHP Through the Exchange (45 CFR 155.315(e))*

The following proposed changes will be submitted to OMB for review under OMB control number 0938–1312 (CMS–10593). We seek comment on these burden estimates.

We propose several revisions to § 155.315(e) that, if finalized, would allow Exchanges to accept consumer attestation of incarceration status without further verification or, alternatively, to propose an alternative data source for incarceration verification for HHS approval. Exchanges that elect to verify incarceration status would continue to be required to use the DMI process if the data source provides a mismatch against the consumer attestation of incarceration status or

other information provided by the applicant or in the records of the Exchange. Should a State Exchange choose to propose using an alternative electronic data source for verifying incarceration status, HHS would review such proposals for consistency with the proposed standard in § 155.315(e)(2).

Of the 18 State Exchanges (operating in 12 States and the District of Columbia) that have incarceration verification processes, 8 conduct incarceration verifications similar to the one used to date by Exchanges on the Federal platform, and 5 have connected to an individual State or local incarceration facility for verifications and have received approval to do so from HHS. Additionally, 3 States are currently in process of transitioning to State Exchanges for PY 2024 or beyond and may choose to connect to an alternative incarceration verification data source with HHS approval. Subtracting the 5 Exchanges with preexisting approvals, we anticipate 11 State Exchanges could connect to an alternative incarceration verification data source, should they assess that an alternative data source exists and want to continue verification of consumer incarceration status using it.

For the purposes of assessing whether an alternative data source should be used, we estimate that a Management Analyst would spend 20 hours, at an hourly rate of \$91.62, to synthesize a cost-benefit analysis regarding whether the Exchange should continue to verify incarceration status using an approved data source instead of accepting a consumer's attestation that they are not incarcerated. If the Exchange finds a viable alternative data source and determines that it should be used, we anticipate that a Business Operations Specialist would take about 2 hours, at an hourly rate of \$73.12, to submit a request for HHS approval. We also anticipate that it would take a Chief Executive equivalent for the Exchange 1 hour, at an hourly rate of \$182.24, to approve the paperwork for submission to request HHS approval of the alternative incarceration data source. In total, the assessment of whether the Exchange should continue to verify incarceration status using an alternative data source instead of accepting consumer attestation would take 20 hours at a cost of \$1,832.40, and the process of approving and submitting a request for HHS approval would take 3 hours at a cost of \$328.48. Therefore, the total one-time burden for each Exchange that elects to verify incarceration status using an HHS-approved data source in 2025 would be 23 hours at a cost of approximately \$2,161, and the total

burden across all 11 State Exchanges would be 253 hours at a cost of approximately \$23,770.

*J. ICRs Regarding Eligibility Redetermination During a Benefit Year (45 CFR 155.330(d))*

The following proposed changes will be submitted to OMB for review under OMB control number 0938–1207 (CMS–10468). We seek comment on these burden estimates.

We propose amending § 155.330(d) to require that Exchanges periodically examine available data sources described in §§ 155.315(b)(1) and 155.320(b) to identify changes related to death of an applicant on whose behalf advance payments of the premium tax credit or cost-sharing reductions are being provided. The Exchanges have developed electronic data exchanges to support obtaining this information to determine the applicant's eligibility at the point of application and could reuse those data exchanges here. Consequently, we estimate costs associated with this requirement to be minimal.

However, State Exchanges not already conducting death PDM with the required frequency or not deemed in compliance with the newly proposed PDM requirements would be required to engage in IT system development activity to communicate with these programs and act on enrollment data either in a new way, or in the same way more frequently. Thus, there may be additional associated administrative cost for these State Exchanges to implement the proposed PDM requirement.

Based on experience with other PDMs, for each State Exchange not already conducting death PDM at least twice a year, we estimate that it would take 40 hours by a Computer Systems Analyst at an hourly rate of \$98.30 to implement this proposed provision, for a cost of \$3,932 per State Exchange. Therefore, for all 11 State Exchanges not currently meeting the proposed requirement, we estimate a total burden of 440 hours at a cost of \$43,252. We assume that this burden would be incurred primarily in 2025.

*K. ICRs Regarding Establishment of Exchange Network Adequacy Standards (45 CFR 155.1050)*

The burden associated with subjecting QHP issuers in State Exchanges and SBE-FPs to time and distance standards as proposed at § 155.1050 is covered by the information collection currently approved under OMB control number 0938–1312 (CMS–10593). We note that we are also revising the information

collection currently approved under OMB control number 0938–1415 (CMS–10803) regarding appointment wait time standards encompassed in previously finalized regulations at 45 CFR 156.230(a)(2)(B). We seek comment on these burden estimates.

Effective for plan years beginning on or after January 1, 2025, we propose to amend § 155.1050 to require that State Exchanges and SBE–FPs establish and impose quantitative time and distance QHP network adequacy standards that are at least as stringent as the FFEs' time and distance standards established for QHPs under § 156.230. We also propose that State Exchanges and SBE–FPs be required to conduct quantitative network adequacy reviews prior to certifying any plan as a QHP, consistent with the reviews conducted by the FFEs under § 156.230. Specifically, when we refer to the review being consistent with the network adequacy reviews conducted by the FFEs under § 156.230, we propose that State Exchanges and SBE–FPs would be required to conduct, prior to QHP certification, quantitative network adequacy reviews to evaluate compliance with requirements under § 156.230(a)(1)(ii) and (iii), and (a)(2)(i)(A), while providing QHP certification applicants the flexibilities described under § 156.230(a)(2)(ii) and (a)(3) and (4). Under this proposal, State Exchanges and SBE–FPs would be prohibited from accepting an issuer's attestation as the only means for plan compliance with network adequacy standards. We further propose to require State Exchanges and SBE–FPs to permit issuers that are unable to meet the specified network adequacy standards to participate in a justification process after submitting their initial network adequacy data, consistent with the processes specified under § 156.230(a)(2)(ii) and (a)(3) and (4), to account for variances and potentially earn QHP certification. In addition, for States Exchanges that employ robust, quantitative network adequacy standards that differ from those used by the FFEs, but still ensure that QHPs provide consumers with reasonable, timely access to practitioners and facilities to manage their health care needs, we propose a framework for granting exceptions to the requirements that State Exchanges and SBE–FPs are required to establish and impose network adequacy time and distance standards for QHPs that are at least as stringent as the standards applicable to QHPs in FFEs and conduct quantitative network adequacy reviews that are consistent with those carried out by the FFEs under § 156.230. Finally, we

propose to mandate that State Exchanges and SBE–FPs require all issuers seeking QHP certification to submit information to the State Exchange or SBE–FP about whether network providers offer telehealth services.

We estimate that the total annual burden associated with State Exchanges and SBE–FPs establishing and imposing the proposed network adequacy standards, conducting the network adequacy reviews as proposed, collecting telehealth information from issuers seeking QHP certification, and submitting any exception to be up to 900 hours. Assuming the compliance officer average hourly rate of \$68.94 per hour, we estimate the cost of the data collection, operations, and maintenance pertaining to these proposed requirements on each State Exchange and SBE–FP to be \$62,046 per year (900 hours × \$68.94 per hour). In total, for the 19 State Exchanges and 3 SBE–FPs anticipated to be operational in 2025, we estimate a burden of 19,800 hours (22 State Exchanges and SBE–FPs × 900 hours per Exchange) at a cost of \$1,365,012 (22 State Exchanges and SBE–FPs × 900 hours per Exchange × \$68.94 per hour).

We estimate that the burden for QHP issuers in State Exchanges and SBE–FPs to gather and submit the time and distance data, including any justification, to the respective State Exchanges or SBE–FPs would be 10 hours in total for each medical QHP issuer (a QHP issuer that is not an SADP issuer) and 2 hours in total for each SADP issuer submitted by a compliance officer at a rate of \$68.94 per hour. The 10-hour estimate includes the burden associated with the requirement that all issuers seeking QHP certification submit information to the State Exchange or SBE–FP about whether network providers offer telehealth services.

Approximately half of the parent companies of issuers on the State Exchanges also offer Medicare Advantage plans. Since Medicare Advantage offers a telehealth credit for network adequacy, we expect those issuers would already have telehealth information available for their providers. We further believe that those QHP issuers that do not currently collect this information may do so using the same means and methods by which they already collect information from their network providers relevant to time and distance standards and provider directory information. For these reasons, we estimate that any additional burden relative to the requirement that all issuers seeking QHP certification submit information to the State Exchange or

SBE–FP about whether network providers offer telehealth services would lead to a minimal increase in burden for many issuers.

The requirement that all issuers seeking QHP certification submit information to the State Exchange or SBE–FP about whether network providers offer telehealth services would account for 3 of the total 10 hours we estimate for gathering and submitting the time and distance data to the respective State Exchange or SBE–FP for medical QHP issuers and 30 minutes of the total 2 hours we estimate for SADP issuers. We believe the cost estimates of 3 hours for medical QHP issuers and 30 minutes for SADP issuers to be a maximum and that the burden could be less to issuers that are already collecting telehealth data for other purposes.

We estimate that the total annual burden associated with QHP issuers in State Exchanges and SBE–FPs to gather and submit the time and distance and telehealth data to the respective State Exchanges or SBE–FPs for up to 149 medical QHP issuers in State Exchanges and SBE–FPs would be up to 1,490 hours (10 hours × 149 medical QHP issuers). Assuming the compliance officer average hourly rate of \$68.94 per hour, we estimate that the cost of gathering and submitting this network adequacy data for an individual medical QHP issuer could be up to \$689.40 (10 hours × \$68.94 per hour), and for all 149 medical QHP issuers in State Exchanges and SBE–FPs, up to \$102,720.60 (149 medical QHP issuers × 10 hours per issuer × \$68.94 per hour). We estimate that the total annual burden associated with this requirement for 89 SADP issuers in State Exchanges and SBE–FPs would be up to 178 hours (2 hours × 89 SADP issuers). Assuming the compliance officer average hourly rate of \$68.94 per hour, we estimate that the cost of gathering and submitting the network adequacy data for an individual SADP could be up to \$137.88 (2 hours × \$68.94 per hour), and for all 89 SADP issuers in State Exchanges and SBE–FPs, up to \$12,271.32 (89 SADP issuers × 2 hours per issuer × \$68.94 per hour). We estimate the total annual burden associated with this proposed requirement across both medical QHP and SADP issuers in State Exchanges and SBE–FPs beginning in 2025 would be approximately \$114,992.

*L. ICRs Regarding the State Selection of EHB-Benchmark Plans for Plan Years Beginning on or After January 1, 2027 (45 CFR 156.111)*

The existing OMB approval (0938–1174) PRA package, for which we are

seeking a renewal for use beginning in March 2024, would remain in effect until the proposed changes to § 156.111 would come into effect, if finalized, for the State selection of EHB-benchmark plans in 2025, impacting plans that are effective beginning on January 1, 2027. We seek comment on these burden estimates.

We propose several revisions to § 156.111 that, if finalized as proposed, would reduce the burden associated with State selection of EHB-benchmark plans. For plan years beginning on or after January 1, 2027, we propose to revise the standards for State selection of EHB-benchmark plans at § 156.111 to consolidate the options for States to change EHB-benchmark plans at § 156.111(a); revise the scope of benefit requirements at § 156.111(b)(2); and revise § 156.111(e)(3) to require States to submit a formulary drug list as part of their application to change EHB-benchmark plans only if the State is seeking to change their prescription drug EHB. We also propose revisions to the actuarial certification requirements at § 156.111 to reflect the proposed scope of benefit changes. If the proposed changes to § 156.111 are finalized as proposed, they would not be effective until 2025, and the anticipated reduction in burden to States would not be realized until that time.

If the proposed changes to § 156.111 are finalized as proposed, we anticipate an overall reduction in burden on States to change their EHB-benchmark plans in accordance with the revisions to § 156.111. If finalized as proposed in this rule, the revisions to § 156.111 would remove the requirement that States report which option under § 156.111(a) they are using as a basis to change their EHB-benchmark plans, their methodology for confirming compliance with the generosity standard at current § 156.111(b)(2)(ii), and the submission of a formulary drug list under § 156.111(e)(3) unless the State is seeking to make changes to their prescription drug EHB. We would also change the information States submit to HHS to confirm compliance with the scope of benefit requirements at § 156.111(b)(2), for which we estimate an overall reduction in burden.

These proposals would not change the number of documents States would be required to submit to change their EHB-benchmark plans under § 156.111(e)(3), unless the State is not seeking to make changes to its prescription drug EHB, in which case, the State would not be required to submit a formulary drug list as specified in § 156.111(e)(3). In addition, a response would not be required from all States under current

§ 156.111 and its proposed revisions, if finalized as proposed in this rule. Only States choosing to modify the State's EHB-benchmark plan would need to submit this information to HHS.

Since finalizing the addition of § 156.111 in the 2019 Payment Notice, between one and three States have changed their EHB-benchmark plan each year between 2019 and 2023. While we anticipate that the proposed revisions to § 156.111 would reduce overall burden on States and incentivize more frequent changes to EHB-benchmark plans, we anticipate that at most 5 States would choose to make a change to their EHB-benchmark plans in any given year (15 States over 3 years within the authorization of this ICR).

To change an EHB-benchmark plan, a State currently provides confirmation that the State's EHB-benchmark plan selection complies with certain requirements, including those under § 156.111(a), (b), and (c). This information collection would be revised under the proposals in this rule, if finalized. To comply with the proposed requirement, we estimate that a financial examiner would require 4 hours (at a rate of \$79.04 per hour) to fill out, review, and transmit a complete and accurate document. We estimate that it would cost each State approximately \$316.16 to meet the proposed reporting requirement, with a total annual burden for all 5 States of 20 hours and an associated total cost of \$1,580.80.

Section 156.111(e)(2) currently requires States to submit an actuarial certification and associated actuarial report of the methods and assumptions when selecting options under § 156.111(a). Presently, before compiling this report, States must consider which of the options provided at current § 156.111(a) best facilitate their intended EHB-benchmark changes. This deliberation often involves both research and discussion within the State and between the State and HHS. The proposed consolidation of the options currently available at § 156.111(a) into one overarching approach for EHB-benchmark plan updates would eliminate the need for, and time spent by, States contemplating the merits of one option or another. This actuarial certification and associated actuarial report must also demonstrate compliance with section § 156.111(b)(2)(i), which requires a State's EHB-benchmark plan to provide a scope of benefits that is equal in scope to the scope of benefits under one of the typical employer plans at § 156.111(b)(2)(i)(A) and (B). While the proposed revisions to § 156.111(b)(2)(i)

would still require a State's EHB-benchmark plan to provide benefits that are equal in scope to the scope of benefits under a typical employer plan, they would also allow a State to select any scope of benefits that is as or more generous than the scope of benefits in the least generous plan (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)), and as or less generous than the scope of benefits in the most generous plan in the State (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)), among the plans currently defined at § 156.111(b)(2)(i)(A) and (B). We anticipate that these proposed revisions would substantially reduce the burden on States to perform the required actuarial analyses. Under this proposed revision, we anticipate that a State would typically only need to perform three actuarial analyses to determine the scope of benefits in the least and most generous plans among the plans currently defined at § 156.111(b)(2)(i)(A) and (B), and the scope of benefits in the State's new EHB-benchmark plan. Under current regulation, a State may need to perform an indeterminate number of actuarial analyses of the plans defined at § 156.111(b)(2)(i)(A) and (B) until the State identifies a plan with a scope of benefits equal to the State's EHB-benchmark plan. This proposed revision would significantly reduce the likelihood that a State would need to perform as many actuarial analyses. Accordingly, we would anticipate a reduction in the estimated burden on States to perform the actuarial analysis to confirm compliance with § 156.111(b)(2)(i).

This actuarial certification and associated actuarial report must also demonstrate compliance with § 156.111(b)(2)(ii), which currently requires a State's EHB-benchmark plan to not exceed the generosity of the most generous among a set of comparison plans. For benefit years beginning on or after January 1, 2027, we are proposing to remove this requirement and would revise this estimate to reflect a reduced burden on States that would no longer need perform the actuarial analyses required to confirm compliance with § 156.111(b)(2)(ii).

The actuarial certification that would be collected under this ICR would be required to include an actuarial report that complies with generally accepted actuarial principles and methodologies. This estimate includes complying with all applicable actuarial standards of practice (ASOPs) (including ASOP 41 on actuarial communications). For

example, ASOP 41 on actuarial communications includes disclosure requirements, including those that apply to the disclosure of information on the methods and assumptions being used for the actuarial certification and report. The actuarial certification for this requirement currently includes an attestation that the standard actuarial practices have been followed or that exceptions have been noted. The signing actuary is required to be a Member of the American Academy of Actuaries. These requirements would continue to apply if this policy is finalized as proposed.

We estimate that an actuary, who is a member of the American Academy of Actuaries, would be required to complete 12 hours of work (at a rate of \$109.60 per hour) on average for § 156.111(e)(2). This would include the certification and associated actuarial report from an actuary to affirm, in accordance with generally accepted actuarial principles and methodologies that the State's EHB-benchmark plan must provide a scope of benefits that is equal to the scope of benefits provided under a typical employer plan. For these calculations, the actuary would need to conduct the appropriate calculations to create and review an actuarial certification and associated actuarial report, including minimal time required for recordkeeping. The precise level of effort for the actuarial certification and associated actuarial report under § 156.111(e)(2) would likely vary depending on the State's approach to its EHB-benchmark plan and this certification requirement, but we are estimating 12 hours of work for the actuary to complete the actuarial certification and associated report in this proposed rule in recognition that the definition of typical employer plan may require the actuary to determine whether the typical employer plan meets minimum value requirements. We estimate that it would cost each State approximately \$1,315.20 to meet this reporting requirement, with a total annual burden for all 5 States of 60 hours and an associated total cost of \$6,576.

We estimate that a financial examiner would require 1 hour (at a rate of \$79.04 per hour) to review, combine, and electronically transmit these documents to HHS, as part of a State's EHB-benchmark plan submission. We estimate that each State would incur a burden of 1 hour with an associated cost of \$79.04 with a total annual burden for 5 States of 5 hours at associated total cost of \$395.20.

We require at § 156.111(e)(3) that each State submit its new EHB-benchmark

plan documents. The level of effort associated with this requirement could depend on the State's selection of the EHB-benchmark plan options under the regulation at § 156.111(a). However, for the purposes of this estimate, we estimate that it would require a financial examiner (at a rate of \$79.04 per hour) 12 hours on average to create, review, and electronically transmit the State's EHB-benchmark plan document that accurately reflects the benefits and limitations, resulting in a burden of 12 hours and an associated cost of \$948.48, with a total annual burden for all 5 States of 60 hours and an associated cost of \$4,742.40. This estimate of 12 hours would also include the burden necessary for a State to submit a formulary drug list for the State's EHB-benchmark plan in a format and manner specified by HHS, in accordance with § 156.111(e)(3). However, we propose to revise § 156.111(e)(3) in this proposed rule to require a State to submit this formulary drug list only if the State is changing the prescription drug EHB. We do not anticipate that all States would change prescription drug EHB, so we anticipate this burden would be lower for some States. To collect the formulary drug list, the State would be required to use the template provided by HHS and must submit the formulary drug list as a list of RxNorm Concept Unique Identifiers (RxCUIs).

Section 156.111(e)(4) requires a State to submit the documentation necessary to operationalize the State's EHB-benchmark plan. This reporting requirement includes the EHB summary file that is currently posted on CCIO's website and is used as part of the QHP certification process and is integrated into HHS' IT Build systems that feeds into the data that is displayed on *HealthCare.gov*.<sup>273</sup> We estimate that it requires a financial examiner 12 hours, on average, (at a rate of \$79.04 per hour) to create, review, and electronically submit a complete and accurate document to HHS resulting in a burden of 12 hours and an associated cost of \$948.48, with a total annual burden for all 5 States of 60 hours and an associated cost of \$4,742.40.

We estimate that the total number of respondent States would be 5 per year, for a total yearly burden of 205 hours<sup>274</sup> and an associated cost of approximately

\$18,036<sup>275</sup> to meet these reporting requirements.

#### *M. ICRs Regarding Non-Standardized Plan Option Limits (45 CFR 156.202)*

The following proposed changes will be submitted to OMB for review under OMB control number 0938–New (CMS–#####). We seek comment on these burden estimates.

As was previously discussed in the preamble to this proposed rule, we propose to permit issuers to offer non-standardized plan options in excess of the limit of two per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area for PY 2025 and subsequent years, if issuers demonstrate that these additional non-standardized plans beyond the limit at § 156.202(b) have specific design features that would substantially benefit consumers with chronic and high-cost conditions.

Specifically, issuers would be permitted to offer more than two non-standardized plan options if these additional plans' cost sharing for benefits pertaining to the treatment of chronic and high-cost conditions (including benefits in the form of prescription drugs, if pertaining to the treatment of the condition(s)) is at least 25 percent lower, as applied without restriction in scope throughout the plan year, than the cost sharing for the same corresponding benefits in an issuer's other non-standardized plan option offerings in the same product network type, metal level, and service area. The reduction could not be limited to a part of the year, or an otherwise limited scope of benefits. Instead, issuers would be required to apply the reduced cost sharing for these benefits any time the covered item or service is furnished. For example, an issuer could not reduce cost sharing for the first three office visits or drug fills and then increase it for remaining visits or drug fills. Furthermore, issuers would be prohibited from conditioning reduced cost sharing for these benefits on a particular diagnosis. That is, although the benefit design would have reduced cost sharing to address one or more articulated conditions, the reduced cost sharing must be available to all enrolled in the plan who receive the service(s) covered by the benefit.

Under this proposal, no other plan design features (such as the inclusion of additional benefit coverage, different provider networks, different formularies, or reduced cost sharing for

<sup>273</sup> Information on Essential Health Benefits (EHB) Benchmark Plans. Accessed at <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>.

<sup>274</sup> This is calculated as follows: (29 hours for the financial examiner + 12 hours for the actuary) × 5 States = 205 hours.

<sup>275</sup> This is calculated as follows: (\$11,460.80 for the financial examiner + \$6,576.00 for the actuary) × 5 States = \$18,036.80.



benefits provided through the telehealth modality) would be evaluated under this exceptions process, meaning no other differences in plan design features would allow issuers to be excepted from the limit to the number of non-standardized plan options offered per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area.

Additionally, as part of this exceptions process, issuers would be required to submit a written justification in a form and manner and at a time prescribed by HHS that provides additional details and explains how the particular plan design the issuer desires to offer above the non-standardized plan option limit of two satisfies the proposed standards for receiving an exception to this limit—namely, how the particular plan would substantially benefit consumers with chronic and high-cost conditions. We would provide issuers with a justification template upon publication of the final rule and when the QHP templates for the applicable plan year are released. We anticipate requesting that issuers submit QHP applications for non-standardized plan options that exceed the two-plan limit by the QHP certification Early Bird deadline.

This justification form would ask the issuer to: (1) identify the specific condition(s) for which cost sharing is reduced, (2) explain which benefits would have reduced annual enrollee cost sharing (as opposed to reduced cost

sharing for a limited number of visits) for the treatment of the specified condition(s) by 25 percent or more relative to the cost sharing for the same corresponding benefits in an issuer's other non-standardized plan offerings in the same product network type, metal level, and service area, and (3) explain how the reduced cost sharing for these services pertains to clinically indicated guidelines for treatment of the specified chronic and high-cost condition(s).

In order for an issuer to complete the necessary documentation to submit a request to be excepted from the non-standardized plan option limit at § 156.202(b) in accordance with the proposed requirements at § 156.202(d), we estimate that it would take an actuary (OES occupational code 15–2011) 5 hours annually at a median hourly cost of \$109.60 per hour (amounting to \$548 annually) to create a new plan design with sufficiently differentiated cost sharing and to set the premium rate for this plan; a general internal medicine physician (OES occupational code 29–1216) 2 hours annually at a median hourly cost of \$206.22 (amounting to \$412.44 annually) to complete the justification form for this exceptions process; and a general and operations manager (OES occupational code 11–1021) 10 hours annually at a median hourly cost of \$94.32 per hour (amounting to \$943.20 annually) to review and submit the justification form, including all required

data, as part of an issuer's portfolio of plan offerings that it seeks certification of during QHP certification.

Altogether, we estimate a total burden of 17 hours at a cost of \$1,903.64 per issuer annually to submit a request for each additional non-standardized plan option to be excepted from the non-standardized plan option limit. Although issuers would not be limited in the number of potential exceptions they may be granted under this proposal, we do not anticipate that issuers would seek to have more than one additional non-standardized plan options excepted from the limit. We further estimate that approximately 50 FFE and SBE–FP issuers (of the 228 issuers based on current PY 2024 plan offering data, amounting to approximately 22 percent) would request to be excepted from the non-standardized plan option limit in order to offer these additional plans annually, at a total burden of 850 hours and associated cost of \$95,182 for all issuers annually. We estimate that only 50 issuers would submit a request to be excepted from the non-standardized plan option limit since we anticipate that most issuers would believe that the burden of creating and certifying additional plans intended to benefit a comparatively small population of consumers would outweigh the benefit of doing so.

#### *N. Summary of Annual Burden Estimates for Proposed Requirements*



**TABLE 15: Proposed Annual Recordkeeping and Reporting Requirements**

Regulation Section(s)	OMB Control Number	Number of Respondents	Number of Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting (\$)	Total Cost (\$)
45 CFR 155.1050	0938-XXXX	22	22	900	19,800	1,365,012	1,365,012
45 CFR 155.220	0938-XXXX	20	20	565	11,300	1,071,474	1,071,474
45 CFR 155.220	0938-XXXX	5	5	4,008	20,040	2,346,128	2,346,128
45 CFR 155.221	0938-XXXX	100	100	1,900	95,945	6,762,280	6,762,280
45 CFR 155.221	0938-XXXX	5	5	5,749	28,745	3,353,468	3,353,468
45 CFR 155.221(b)(6)	0938-XXXX	100	100	33	3,300	1,226,453	1,226,453
45 CFR 155.315	0938-XXXX	11	11	23	253	23,770	23,770
45 CFR 155.330(d)	0938-XXXX	11	11	40	440	43,252	43,252
45 CFR 156.111	0938-1174	5	5	41	205	18,036	18,036
45 CFR 156.202	0938-XXXX	50	50	17	850	95,182	95,182
<b>TOTAL</b>		329	329		180,878	15,078,602	15,078,602

#### *O. 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 our website at [www.cms.hhs.gov/PaperworkReductionActof1995](http://www.cms.hhs.gov/PaperworkReductionActof1995), or call the Reports Clearance Office at 410-786-1326.

We invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule and identify the rule (CMS-9895-P), the ICR's CFR citation, CMS ID number, and OMB control number.

ICR-related comments are due January 16, 2024.

#### **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 rule proposes to make several HHS risk adjustment updates, such as to use the 2019, 2020, and 2021 data for recalibration of the HHS risk adjustment models for benefit year 2025; to update and retain the AI/AN CSR adjustment factors for benefit year 2025 and beyond, unless changed through notice-and-comment rulemaking; to establish the risk adjustment user fee for benefit year 2025; and to give HHS the authority to require corrective action plans for certain observations identified as a result of high-cost risk pool audits. The rule further proposes State Exchange and agent, broker, web-broker, and DE entity standards; requiring State Exchanges and State Medicaid and CHIP agencies to pay to access and use optional CSI data from the Hub for income verification; eligibility and auto re-enrollment standards; open enrollment period and special enrollment period standards; and permitting enrollees to retroactively terminate their enrollment in a QHP through the Exchange when the enrollee enrolls in Parts A or B Medicare retroactively effective to the date

Medicare coverage begins. Additionally, the rule proposes the FFE and SBE-PP user fee rates for the 2025 benefit year, as well as EHB-benchmark plan selection updates, other EHB updates, minor updates to the standardized plan options for PY 2025, an exceptions process for issuers to offer additional non-standardized plan options in excess of the limit of two for PY 2025, Consumer Operated and Oriented Plan (CO-OP) loan term revisions, and modifications to section 1332 waiver implementing regulations governing public hearing procedures.

##### *B. Overall Impact*

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), Executive Order 14094 entitled "Modernizing Regulatory Review" (April 6, 2023), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), and Executive Order 13132 on Federalism (August 4, 1999).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory

alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). The April 6, 2023 Executive Order on Modernizing Regulatory Review<sup>276</sup> amends Section 3(f) of Executive Order 12866 to define a “significant regulatory action” as an action that is likely to result in a rule that may: (1) have an annual effect on the economy of \$200 million or more (adjusted every 3 years by the Administrator of OMB’s Office of Information and Regulatory Affairs (OIRA) for changes in gross domestic product), or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or tribal governments or communities; (2) create a serious inconsistency or otherwise

interfere with an action taken or planned by another agency; (3) materially alter the budgetary impacts of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise legal or policy issues for which centralized review would meaningfully further the President’s priorities or the principles set forth in the Executive Order, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

A regulatory impact analysis (RIA) must be prepared for significant rules. OMB’s OIRA has determined that this rulemaking is ‘significant’ as measured by the \$200 million threshold under section 3(f)(1). We have prepared an RIA that to the best of our ability presents the costs and benefits of the rulemaking. OMB has reviewed these proposed regulations, and the Departments have provided the following assessment of their impact.

*C. Impact Estimates of the Payment Notice Provisions and Accounting Table*

As required by OMB Circular A–4 (available at [https://](https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf)

[www.whitehouse.gov/wp-content/uploads/legacy\\_drupal\\_files/omb/circulars/A4/a-4.pdf](https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf)), we have prepared an accounting statement in Table 16 showing the classification of the impact associated with the provisions of this proposed rule.

This proposed rule implements standards for programs that will have numerous effects, including providing consumers with access to affordable health insurance coverage, reducing the impact of adverse selection, and stabilizing premiums in the individual and small group (including merged) health insurance markets and in Exchanges. We are unable to quantify all the benefits and costs of this proposed rule. The effects in Table 16 reflect qualitative assessment of impacts and estimated direct monetary costs and transfers resulting from the provisions of this proposed rule for health insurance issuers and consumers. The annual monetized transfers described in Table 16 include changes to costs associated with the risk adjustment user fee paid to HHS by issuers.

<sup>276</sup> Executive Order 14094. <https://www.whitehouse.gov/briefing-room/presidential-actions/2023/04/06/executive-order-on-modernizing-regulatory-review/>.

**TABLE 16: Accounting Table**

Benefits:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	\$25.79 million	2023	7 percent	2024-2028
	\$26.32 million	2023	3 percent	2024-2028
<p>Quantitative:</p> <ul style="list-style-type: none"> <li>• Annual cost savings to State Exchanges of approximately \$20,317,000 beginning in 2025 associated with the proposal to permit Exchanges to accept consumer incarceration attestations without further verification.</li> <li>• Annual cost savings to the Federal Government of approximately \$570,000 beginning in 2025 due to the proposal to stop generating incarceration DMIs and thereby stop paying the PUPS annual maintenance and transaction fees for the purposes of verification incarceration status for QHP eligibility.</li> <li>• Annual cost savings to the Federal Government of approximately \$12.5 million associated with the proposal to conduct an additional death PDM check annually beginning in 2025.</li> </ul>				
<p>Qualitative:</p> <ul style="list-style-type: none"> <li>• Increased State flexibility with respect to determining the effective date of eligibility for enrollment in a standard health plan for purposes of a BHP.</li> <li>• Improved transparency as a result of the proposal to require States seeking to transition to a State Exchange to provide the public with a notice and copy of its State Exchange Blueprint application at the time of submission to HHS for approval, and conduct periodic public engagements whereby interested parties can learn about the State's intent to transition, as well as a State's progress toward transitioning. Although, historically, States that have transitioned to State Exchanges conducted some level of public engagements that would meet what is being proposed, they have done so voluntarily, so this proposal would set a clear expectation moving forward for all States that intend to establish and operate a State Exchange.</li> <li>• Improved consumer experience associated with the proposal to require that Exchange call centers must provide consumers with access to a live call center representative during the Exchanges' published hours of operations who must be able to assist consumers with submitting their application for QHP coverage.</li> <li>• Improved consumer experience and access to accurate insurance information associated with the proposal to require all Exchanges to have a centralized eligibility and enrollment platform on its website. Although all current Exchanges meet this requirement, there may be States transitioning to State Exchanges in the future that would not consider operating a centralized eligibility and enrollment platform in the absence of this proposed amendment. This proposal would set a clear expectation moving forward for all States that intend to establish and operate a State Exchange.</li> <li>• Increased transparency for agents, brokers, and web-brokers by specifying who will be reviewing their reconsideration request.</li> <li>• Improved consumer experience on non-Exchange websites by requiring DE entities to implement <i>HealthCare.gov</i> and State Exchange website display changes that enhance the consumer experience, simplify the plan selection process, and increase consumer understanding of plan benefits, cost-sharing responsibilities and eligibility for financial assistance.</li> <li>• Reduced burdens and barriers to care for applicants as a result of the proposal to permit Exchanges to accept incarceration attestations without further verification.</li> <li>• Improved continuity of coverage for enrollees due to the proposal to require Exchanges to automatically re-enroll enrollees in catastrophic coverage into QHP coverage for the coming plan year.</li> <li>• Reduced consumer confusion and increased consumer access to assisters as a result of the proposal to require State Exchanges to adopt an open enrollment period that begins on November 1 of the calendar year preceding the benefit year and ends no earlier than January 15 of the applicable benefit year, with the option to extend the open enrollment period beyond January 15.</li> <li>• Reduced consumer confusion and coverage gaps due to the proposal to align the effective dates of coverage after selecting a plan during certain special enrollment periods across all Exchanges.</li> <li>• Reduced overlaps in coverage and premium payments for Exchange enrollees who retroactively enroll in Medicare Part A or B as a result of the proposal to permit Exchange enrollees to retroactively terminate Exchange coverage back to the date in which they retroactively enroll in Medicare Part A or B.</li> <li>• Reduced costs for States to perform actuarial analyses to confirm compliance of EHB-benchmark plans with scope of benefit requirements at § 156.111(b)(2).</li> </ul>				

- Reduced coverage barriers to expanding access to adult dental benefits, improved State flexibility to add benefits to improve adult oral health, and promotion of health equity associated with the proposal to remove the prohibition on including routine non-pediatric dental services as an EHB.
- Increased issuer flexibility in plan design as a result of the proposed exceptions process to allow issuers to offer additional non-standardized plan options in excess of the limit of two per product network type, metal level, including of dental and/or vision benefit coverage, and service area, if particular requirements are met.
- Streamlined payments and collections processes and limited administrative burden for operating HHS programs due to the proposal to align netting regulations at § 156.1215 with the policies proposed in the Federal Independent Dispute Resolution (IDR) Process Administrative Fee and Certified IDR Entity Fee Ranges proposed rule.

Costs:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	\$11.41 million	2023	7 percent	2024-2028
	\$11.37 million	2023	3 percent	2024-2028

Quantitative:

- Cost to issuers being audited for high-cost risk pool payments of approximately \$25,078 to complete, submit to HHS, and implement corrective action plans for certain high-cost risk pool audit observations for each benefit year being audited, if required by HHS.
- One-time cost in PY 2025 to web-brokers operating in State Exchanges of approximately \$1,071,474 due to the proposal to ensure agents, brokers, and web-brokers operating in these State Exchanges are meeting certain requirements applicable in the FFE and SBE-FPs.
- Costs to States of \$2,346,128 associated with the policy that agents, brokers, and web-brokers operating in State Exchanges meet certain requirements applicable in the FFEs and SBE-FPs.
- Costs to DE entities operating in FFE and SBE-FP States of approximately \$240,120 annually beginning in 2025 as a result of the proposal to require that changes adopted by *HealthCare.gov* be reflected on DE entity websites within a notice period set by HHS, unless HHS approves a deviation in advance.
- Costs to DE entities participating in State Exchanges of approximately \$1,226,452.50 annually beginning in 2025 associated with implementing display changes and submitting requests to deviate from the standards defined by the State Exchange.
- Costs to DE entities operating in FFE and SBE-FP States of approximately \$5,171 to submit a request to deviate from the display approach adopted by *HealthCare.gov* standards defined by HHS annually beginning in 2025.
- Costs to States of \$3,353,468 associated with the policy that DE entities operating in State Exchanges meet certain requirements applicable in the FFEs and SBE-FPs, including the costs for States associated with policy surrounding DE entities operating in State Exchanges regarding implementing display changes and reviewing associated deviation requests.
- One-time cost in PY 2025 to DE entities in State Exchanges of approximately \$6,762,281 to comply with the proposal to add language to ensure DE entities operating in these State Exchanges are meeting certain requirements applicable in the FFE and SBE-FPs.
- One-time cost in PY 2025 to State Exchanges of \$23,770 to conduct an analysis of whether to accept consumer attestation of incarceration status or identify an alternative data source to verify incarceration status and to make changes to their eligibility systems and processes to either accept consumer attestation or use an alternative data source to verify incarceration status.
- One-time cost to HHS of \$2.3 million in 2024 to build the structure and set up operations for the purposes of distinguishing costs of accessing CSI data through the VCI Hub service between the State Exchange and State Medicaid agency and annual costs of \$1 million starting in 2024 to administer this process.
- One-time cost to 1 to 3 States with State Exchanges, who currently have one Hub connection shared between the State Exchange and Medicaid, of approximately \$3 to 6 million in 2024 (averaged to approximately \$4.5 million for purposes of this proposed rule) if they elect to build a second, separate Hub connection for the purposes of distinguishing costs of accessing CSI data through the VCI Hub service between the State Exchange and State Medicaid agency. Should any of these States elect to build a second Hub connection, the State would determine if the State Exchange or Medicaid agency would finance the implementation and operational costs associated with the second Hub connection.
- One-time cost in 2025 of approximately \$43,252 to 11 State Exchanges that are not currently meeting the proposed requirement to conduct death PDM at least twice a year.
- Costs to 5 States per year of approximately \$18,036 to comply with the proposal regarding the State selection of EHB-benchmark plans.
- Costs to 50 issuers of approximately \$95,182 annually to complete the proposed exceptions process in order to offer one additional non-standardized plan option in excess of the non-standardized option plan limit of two for PY 2025 and

subsequent years.

- Costs to QHP issuers in State Exchanges and SBE-FPs of approximately \$114,992 annually beginning in 2025 associated with the network adequacy proposals in this proposed rule.
- Costs to State Exchanges and SBE-FPs of approximately \$1,365,012 annually beginning in 2025 associated with the network adequacy proposals in this proposed rule.
- Costs to interested parties of approximately \$136,937 in 2024 to review and interpret this rule.
- Costs to HHS per year of approximately \$58,923 to conduct an additional check for deceased enrollees associated with the proposal to require Exchanges to conduct periodic checks for deceased enrollees twice yearly and subsequently end deceased enrollees' QHP coverage beginning with the 2025 calendar year.
- One-time cost in 2025 of \$1,540,000 to HHS to modify the Federal platform's current incarceration verification processes for the purposes of verifying eligibility for QHP, and to update the Federal platform's system logic for HHS to stop sending incarceration verification requests to PUPS.

Qualitative:

- Increased premium amounts and PTC, to the extent that the proposals to address State-mandated benefits and the process to change EHB-benchmark plans incentivize States to update and modernize the EHB with additional benefits, including routine non-pediatric dental services.
- Increased administrative burden to States and issuers to develop criteria used to select a consumer representative for the P&T committee, to create or revise standard operating procedures for the committee, as well as for any additional training.

Transfers:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	\$1.86 billion	2023	7 percent	2024-2028
	\$1.92 billion	2023	3 percent	2024-2028

Quantitative:

- Estimated average transfers of costs from the Federal government to Medicaid beneficiaries of approximately \$0 million to \$538 million per year beginning in 2025 (averaged to \$269 million for the purposes of this proposed rule) for additional health care benefits paid by the Medicaid program to new beneficiaries covered under States using the proposed eligibility flexibilities.
- Estimated average transfers of costs from States to beneficiaries of approximately \$0 million to \$392 million per year beginning in 2025 (averaged to \$196 million for the purposes of this proposed rule) for additional health care benefits paid by the Medicaid program to new beneficiaries covered under States using the proposed eligibility flexibilities.
- Estimated transfers of costs from the Federal government to States of approximately \$78 million to \$122 million per year beginning in 2024 (averaged to \$100 million for purposes of this proposed rule) by requiring State Exchanges and State Medicaid agencies to pay for their use of the optional CSI income data accessed through the VCI Hub service.
- Reduction in risk adjustment user fee transfers from issuers to the Federal government of approximately \$3.5 million for benefit year 2025 compared to the prior benefit year.
- Estimated increased PTC outlays from the Federal government to issuers of \$2 billion to \$3 billion (averaged to \$2.5 billion for purposes of this proposed rule) annually beginning in 2026 associated with the proposal to remove the limitation that the 150 percent FPL SEP be available only when the applicable taxpayer's applicable tax percentage is set to zero.

Qualitative:

- Provide States additional flexibilities to cover more Medicaid beneficiaries and improve health care for those individuals as a result of the Medicaid proposal in this proposed rule.
- Increase in the overall absolute value of risk adjustment State transfers calculated under the State payment transfer formula of approximately 8 percent in Oklahoma, 2.5 percent in Alaska, 2 percent in Montana, and less than 0.5 percent in South Dakota and North Dakota as a result of the proposal to recalibrate the CSR adjustment factors for AI/AN plan variant enrollees.

**TABLE 17: Estimated Federal Government Outlays and Receipts for the HHS Risk Adjustment and Reinsurance Programs from Fiscal Year 2025-2029, in billions of dollars<sup>277</sup>**

Year	2025	2026	2027	2028	2029	2025-2029
HHS Risk Adjustment and Reinsurance Program Payments	8	9	10	10	10	47
HHS Risk Adjustment and Reinsurance Program Collections	9	10	10	10	10	49

Note: HHS risk adjustment program payments and receipts lag by one quarter. Receipt will fully offset payments over time. Source: Congressional Budget Office. Federal Subsidies for Health Insurance Coverage for People Under Age 65: CBO and JCT's May 2023 Baseline Projections. Table 2. May 2023. <https://www.cbo.gov/system/files/2023-05/1298-2023-05-healthinsurance.pdf>.

1. Proposed Amendments to Normal Public Notice Requirements (31 CFR 33.112, 31 CFR 33.120, 45 CFR 155.1312, and 45 CFR 155.1320)

In this proposed rule, the Departments propose modifications to the section 1332 waiver implementing regulations to set forth flexibilities in the public notice requirements and post-award public participation requirements for section 1332 waivers. However, this proposed rule does not propose to alter any of the requirements related to section 1332 waiver applications, compliance and monitoring, or evaluation in a way that would create any additional costs or burdens for States submitting proposed waiver applications or those States with approved waiver plans that have not already been captured in prior burden estimates. The Departments are of the view that both States with approved section 1332 waivers and States that apply for section 1332 waivers would be minimally impacted or would benefit from reduced burden by these proposed changes in policy, if finalized. The Departments anticipate that implementing these provisions would not significantly change the associated burden currently approved under OMB control number: 0938-1389, Expiration date: February 29, 2024. The Departments are of the view that section 1332 waivers help increase State innovation, which in turn could lead to more affordable health coverage for individuals and families in States that consider implementing a section 1332 waiver program.

The Departments seek comment on these impacts and assumptions.

2. Increase State Flexibility in the Use of Income and Resource Disregards for Non-MAGI Populations (42 CFR 435.601)

Current 42 CFR 435.601(d) authorizes States to apply less restrictive methodologies than those that would otherwise be required to be considered in the individual's eligibility determination. Paragraph (d)(4) requires that the application of less restrictive methodologies by State Medicaid agencies be comparable for all persons within each Medicaid eligibility group. For example, if a State wants to apply an income disregard to an eligibility group serving individuals who are 65 years old or older, it must either agree to apply the income disregard to all members of the eligibility group who are 65 years old or older or forego application of the disregard.

In this proposed rule, we propose to remove the requirement that less restrictive methodologies be comparable for all members of an eligibility group. This would allow States that want to expand their Medicaid eligibility rules through the use of less restrictive methodologies to have more flexibility in managing the extent to which their programs are expanded.

This proposed rule, however, would not create an entirely new State option, but, instead, would permit States to exercise an existing option in a more limited manner. Additionally, the proposed rule, if finalized, would not require new State plan material or impose any new administrative tasks for States in their development and submission of State plan amendments. We therefore do not anticipate that implementing this provision would create any new information collection burden for States.

Estimating the impact on Medicaid enrollment and expenditures is difficult. Notably, it is not known how many States would use this new authority, and the extent to which they would use

this. Some States may be interested in using this flexibility to make a significant expansion to coverage, and in turn, spending on Medicaid services. Other States may not use these options at all or may use them to a limited degree. Moreover, how States use this authority—which populations would be affected, the number of people in these groups, and the underlying healthcare needs of these individuals—is also unknown. Therefore, we have estimated a range of potential impacts as part of the regulatory impact analysis.

At the low end of the range, we have assumed that the impact on enrollment and Medicaid expenditures would be 0 (or negligible). In this scenario, we assume that States do not make any substantial changes under this new authority, and as a result there is no measurable increase in enrollment or spending. Historically, States have had many options in expanding coverage, including but not limited to other authorities to use income and resource disregards and section 1115 waivers. Recent State plan amendments to expand the use of income disregards (either broadly or targeted to certain groups) have been modest, ranging from estimated impacts of \$0 million to \$49 million per year. Thus, it may be possible that the use of these flexibilities is limited and the impacts relatively small.

On the other hand, it is possible that States may be more active in using these proposed options. To estimate the high end of the range, we made the following assumptions. First, we assumed that 10 States would take up these options. Second, we assumed that States would apply these options to non-MAGI populations (mainly enrollees age 65 and over, and enrollees qualifying on the basis of a disability) and have an average increase of 1 percent in enrollment among these groups. We assumed the average total, Federal, and State Medicaid costs for these enrollees

<sup>277</sup> Reinsurance collections ended in FY 2018 and outlays in subsequent years reflect remaining payments, refunds, and allowable activities.

would be equal to the national average for these groups.

Under these assumptions, we project that enrollment would increase by 36,000 to 38,000 across 10 States (or

3,600 to 3,800 per State) and Medicaid expenditures would increase by about \$4,660 million over the first 5 years (\$2,700 million Federal, \$1,960 million

State share). (The estimates rely on projections of enrollment and spending from the Mid-Session Review of the President's FY 2024 Budget.)

**TABLE 18: Projected Impacts on Medicaid Enrollment and Expenditures**

<b>Low scenario</b>	<b>2025</b>	<b>2026</b>	<b>2027</b>	<b>2028</b>	<b>2029</b>	<b>2025-2029</b>
Enrollment	0	0	0	0	0	
<b>Expenditures (millions)</b>						
Total	\$0	\$0	\$0	\$0	\$0	\$0
Federal	\$0	\$0	\$0	\$0	\$0	\$0
State	\$0	\$0	\$0	\$0	\$0	\$0
<b>High scenario</b>	<b>2025</b>	<b>2026</b>	<b>2027</b>	<b>2028</b>	<b>2029</b>	<b>2025-2029</b>
Enrollment	36,000	36,000	37,000	38,000	38,000	
<b>Expenditures (millions)</b>						
Total	\$890	\$910	\$930	\$950	\$980	\$4,660
Federal	\$510	\$530	\$540	\$550	\$570	\$2,700
State	\$380	\$380	\$390	\$400	\$410	\$1,960

It is important to note that there is a wide range of outcomes due to the flexibility afforded in the proposed rule. We expect actual costs and enrollment impacts to fall within the range shown here, but the effects are highly dependent on which States would take up these options and how extensively such options are used.

We seek comment on these impacts and assumptions.

### 3. Changes to the Basic Health Program Regulations (42 CFR 600.320)

Section 1331 of the ACA (42 U.S.C. 18051) requires the Secretary to establish a BHP, and section 1331(c)(4) specifically provides that a State shall coordinate the administration of, and provision of benefits under the BHP with other State programs. These proposed regulations build from previous BHP regulations to provide for options for BHP implementation and operations beginning with program year 2024.

In this proposed rule, we propose to add an option for a State establishing a uniform method of determining the

effective date of eligibility for enrollment in a standard health plan. We believe this proposal would provide additional flexibility for States when implementing their BHP. If the State chooses to follow this new effective date of eligibility option, we believe this proposal would also benefit enrollees by providing coverage sooner than if the State were to follow the Exchange effective date of eligibility option. We do not anticipate any costs to States because of this proposal, as we are only proposing to provide another option by which a State could determine the effective date of eligibility for purposes of its BHP. We seek comment on these impacts and assumptions.

### 4. HHS Risk Adjustment (45 CFR 153.320)

We propose to recalibrate the HHS risk adjustment models for the 2025 benefit year using the 2019, 2020, and 2021 enrollee-level EDGE data. We believe that continuing to maintain the approach of blending (or averaging) 3 years of separately solved coefficients provides stability within the HHS-

operated risk adjustment program and minimizes volatility in changes to risk scores from the 2024 benefit year to the 2025 benefit year. We also propose to continue applying a market pricing adjustment to the plan liability associated with Hepatitis C drugs in the HHS risk adjustment models, consistent with the approach adopted beginning with the 2020 benefit year HHS risk adjustment models.

We propose to recalibrate the CSR adjustment factors for AI/AN zero-cost sharing and limited cost sharing CSR plan variant enrollees for the 2025 benefit year, and to retain the proposed AI/AN CSR adjustment factors, if finalized, for all future benefit years unless changed through notice-and-comment rulemaking. We also propose to maintain the current CSR adjustment factors for silver plan variant enrollees (70 percent, 73 percent, 87 percent, and 94 percent AV plan variants)<sup>278</sup> for the

<sup>278</sup> See 83 FR 16930 at 16953; 84 FR 17478 through 17479; 85 FR 29190; 86 FR 24181; 87 FR 27235 through 27236; and 88 FR 25772 through 25774.

2025 benefit year and beyond, unless changed through notice-and-comment rulemaking. In addition, we affirm that for plan liability risk score calculations under the State payment transfer formula, we use the CSR adjustment factors that align with the AV of the plan. Thus, for unique State-specific plans that have higher plan liability than the standard silver plan variants (for example, CSR wrap-around and Medicaid-expansion plans), we would continue to apply the applicable CSR adjustment factor that corresponds to the plan's AV, as determined by HHS in consultation with the applicable State Departments of Insurance and other relevant State institutions.

We anticipate that this proposal would result in an increase in overall individual market risk pool HHS risk adjustment transfers under the State payment transfer formula in States with a sizable share of AI/AN enrollees. All things being equal, we anticipate that recalibrating the AI/AN CSR adjustment factors as proposed would increase transfer payments (or decrease transfer charges) to the issuers with the larger shares of the AI/AN subpopulation and increase transfer charges (or decrease transfer payments) under the State payment transfer formula for the issuers with smaller shares of the AI/AN subpopulation. Therefore, we anticipate that issuers with larger shares of AI/AN enrollees would have the ability to lower premium rates slightly, as the additional plan liability associated with AI/AN CSR recipients would be offset by the increase in HHS risk adjustment transfer payments (or decrease in transfer charges) to these issuers.

Based on internal analyses, the States with the highest proportion of AI/AN enrollees as a percentage of member months in the 2021 benefit year were Oklahoma (15 percent), Alaska (4 percent), Montana (2 percent), South Dakota (2 percent), and North Dakota (1 percent). Based on internal analyses of 2021 enrollee-level EDGE data, we anticipate that recalibrating the AI/AN CSR adjustment factors as proposed would increase total transfers under the State payment transfer formula by 8 percent in Oklahoma, 2.5 percent in Alaska, 2 percent in Montana, and less than 0.5 percent in South Dakota and North Dakota. We further anticipate that these transfer impacts would result in modest decreases in premiums among issuers that enroll a high proportion of AI/AN consumers, as issuers with larger AI/AN enrollment would benefit from increased transfer payments (or decreased transfer charges) under the State payment transfer formula. We do not anticipate that States with a low

proportion of AI/AN enrollees would experience a transfer or premium impact due to the very low number of enrollees (less than 1 percent) who would be impacted by the proposed recalibrated CSR adjustment factors for this population in those States.

We seek comment on these impacts and assumptions.

#### 5. HHS Risk Adjustment User Fee for 2025 Benefit Year (45 CFR 153.610(f))

For the 2025 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 ACA on behalf of States is funded through a risk adjustment user fee. For the 2025 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 2024 Payment Notice. As discussed previously in this proposed rule, risk adjustment user fee costs for the 2025 benefit year are expected to increase from the prior 2024 benefit year estimates. However, we project higher enrollment than our prior estimates in the individual and small group (including merged) markets in the 2024 and 2025 benefit years due to the enhanced PTC subsidies provided for in section 9661 of the ARP<sup>279</sup> and extended through the 2025 benefit year pursuant to section 12001 of the IRA.

We estimate that the total cost for HHS to operate the risk adjustment program on behalf of all States and the District of Columbia will increase from \$60 million in 2024 to approximately \$65 million in 2025. However, we believe that the increased enrollment projections will more than offset the increased risk adjustment user fee costs, and therefore, the proposed risk adjustment user fee would be reduced from the \$0.21 PMPM for the 2024 benefit year to \$0.20 PMPM for the 2025 benefit year. We expect the proposed risk adjustment user fee for the 2025 benefit year to reduce the amount transferred from issuers of risk adjustment covered plans to the Federal government by approximately \$3.5 million.

We seek comment on these impact estimates and assumptions.

#### 6. Audits and Compliance Reviews of Risk Adjustment Covered Plans (45 CFR 153.620(c))

We propose amending § 153.620(c)(4) to require issuers of risk adjustment

covered plans to complete, implement, and provide to HHS written documentation of any corrective action plans when required by HHS if a high-cost risk pool audit results in the inclusion of a finding or certain observations in the final audit report. Based on data from the 2018 benefit year high-cost risk pool audits, we estimate that each issuer audited may receive approximately 2 observations on average in future benefit years of high-cost risk pool audits where there is evidence of non-compliance with applicable Federal requirements, thereby triggering the proposed requirement for the issuer to take corrective action. We also estimate that it would take approximately 4 hours by a business operations specialist (at \$73.12 per hour), 2 hours by a compliance officer (at \$68.94 per hour), and 2 hours by a computer systems analyst (at \$98.30 per hour) to complete, implement, and provide documentation to HHS of a corrective action plan for 2 observations. This results in a total cost per issuer of \$626.96 (4 hours × \$73.12 per hour + 2 hours × \$68.94 per hour + 2 hours × \$98.30 per hour). We estimate that we may conduct high-cost risk pool audits for approximately 40 issuers for each benefit year. Therefore, the total estimated cost to issuers of risk adjustment covered plans for each benefit year being audited would be approximately \$25,078.40 (40 issuers × \$626.96 per issuer).

We seek comment on these burden estimates and assumptions.

#### 7. Approval of a State Exchange (45 CFR 155.105)

We propose to add a requirement that a State seeking to transition to a State Exchange must first operate an SBE-FP, meeting all requirements under § 155.200(f), for at least one plan year, including its first open enrollment period.

We do not anticipate this proposal would create an additional burden to the States that are currently transitioning to a State Exchange, since those States have already operated an SBE-FP for at least 1 year or will first be operating an SBE-FP. Since PY 2020, all States that have transitioned to a State Exchange have first transitioned to an SBE-FP for one or more plan years. Furthermore, based on our experience, the costs for a State to transition from the FFE to operating an SBE-FP is relatively low in comparison to the costs a State would incur to transition from an FFE, or an SBE-FP, to establishing a State Exchange. This is due to the significant investment of costs incurred in implementing and operating a State

<sup>279</sup> Public Law 117–2.



Exchange consumer-facing website, eligibility and enrollment technology platform, and associated eligibility and enrollment support infrastructure, such as the State Exchange's consumer call center technology and resources, that FFEs and SBE-FPs rely on HHS to provide. We would also expect the impact and costs to States that are considering, or may consider, establishing a State Exchange in the future to be minimal because we believe there would be sufficient time to plan for operating as an SBE-FP before operating as a State Exchange.

We believe that one of the primary benefits of States operating an SBE-FP prior to implementing and operating a State Exchange lies in the investment of time and resources that a State transitioning to, and operating, an SBE-FP makes in the establishment of direct relationships with their consumers, assisters, issuers, and other interested parties that will ultimately help in the successful implementation and operation of its State Exchange. Furthermore, we believe that the benefit of these activities to a State and its consumers and partners far outweigh the relatively low cost for the State to first transition to, and operate, an SBE-FP for at least one year before implementing and operating a State Exchange. We are also of the view that this proposal would mitigate the significant risk and disruption, for consumers, assisters, issuers, and other interested parties, associated with a scenario where a State wishes to transition from an FFE to establishing and operating a State Exchange in a timeframe of less than a year or otherwise not in alignment with the timelines associated with the approval of a State Exchange specified in § 155.106.

We seek comment on these assumptions of the financial impact of this proposal, if finalized, on States that transition to an SBE-FP for at least one plan year before operating a State Exchange pursuant to this proposal, if finalized.

#### 8. Election To Operate an Exchange After 2014 (45 CFR 155.106)

As discussed in the preamble, we propose to add that we may require that a State submitting a Blueprint Application to implement a State Exchange provide supplemental documentation demonstrating progress toward meeting State Exchange Blueprint requirements, or documentation that details a State's implementation of its State Exchange Blueprint requirements. This could include a State submitting detailed

plans regarding its State Exchange consumer assistance, such as information on its direct outreach plans.

We do not anticipate additional burden associated with this proposal, as HHS already has the authority to request any evidence it determines necessary for the State to show progress towards implementing the required Exchange functionality in the State Exchange Blueprint, or documentation that details the implementation of the required Exchange functionality. In this proposal, we are merely seeking to codify in our regulations a clear expectation for a State establishing a State Exchange that, as part of the State's submission of a State Exchange Blueprint Application. The information collection burden associated with this proposal is already accounted for under approved OMB control number: 0938-1172, Expiration date: August 31, 2025.

Further, as discussed in the preamble, we propose to require that when a State submits its State Exchange Blueprint application to HHS for approval, the State must provide the public with notice and a copy of its State Exchange Blueprint application. We also propose to require that at some point following a State's submission of its State Exchange Blueprint application to HHS, a State must conduct at least one public engagement (such as a townhall meeting or public hearing), in a timeline and manner considered effective by the State, with concurrence from HHS, at which interested parties can learn about the State's intent to transition to a State Exchange and the State's progress toward effectuating that transition. We also propose to require that while a State is making this transition and until HHS has approved or conditionally approved the State Exchange Blueprint application, a State conducts periodic public engagements at which interested parties can continue to learn about the State's progress toward finalizing its transition to a State Exchange, in a timeline and manner, either in-person or virtually, considered effective by the State.

We do not anticipate significant additional burden associated with these proposals, as States are currently required to submit a State Exchange Blueprint application to HHS for approval, and so the impact of sharing a copy of the submitted Exchange Blueprint application with the public using their website would be de minimis. Further, we believe that since States seeking to establish, or are in the process of establishing, a State Exchange for PY 2025 or in subsequent years would be given broad flexibility to design the public engagements in a

manner that best suits their respective State, for meeting the interested party consultation requirement under § 155.130, that States will design their public engagements in a manner such that the additional burden incurred by the State would be minimal. The goal of the proposed changes at § 155.106(a)(2)(ii) is to clearly state, for States who are seeking to establish State Exchanges, HHS' expectations of the State engaging with the public regarding its transition to a State Exchange, thus strengthening the transparency requirements of the State Exchange Blueprint review and approval process. We believe this proposal would help States that establish a State Exchange meet the consultation requirements of interested parties at § 155.130 during the period when the State is establishing a State Exchange, by formalizing a process whereby States and interested parties communicate about the State's establishment of a State Exchange throughout the transition process. As such, we believe the impact of this proposal would be de minimis.

We seek comment on this burden estimate and assumptions.

#### 9. Additional Required Benefits (45 CFR 155.170)

We propose to amend § 155.170(a)(2) to provide that benefits covered in a State's EHB-benchmark plan would not be considered in addition to EHB and thus would not be subject to defrayal by the State beginning with PY 2025. We believe that this revision would have a mixed effect on the cost to the Federal government. In States that update EHB-benchmark plans to include benefits, the costs of which are currently being defrayed, the percentage of premium attributable to coverage of EHB for purpose of calculating APTC may increase just as if the State updated its EHB-benchmark plan through the process set forth in § 156.111 and any increase remains subject to the typicality requirement in that section. In a State that enacts a mandate for a benefit that is currently covered in its EHB-benchmark plan, there will be no effect on Federal government expense as the benefit was already included in the percentage of premium attributable to coverage of EHB for purpose of calculating APTC since it was EHB. States may choose to evaluate the overlap between mandates and EHB benchmark-plans for benefits they are currently defraying the costs of but are not required to. 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. We do not anticipate an additional burden on States or issuers associated with this proposal.

We seek comment on these impacts and assumptions.

#### 10. Consumer Assistance Tools and Programs of an Exchange (45 CFR 155.205)

As discussed in the preamble, we propose additional minimum standards for Exchange call center operations, such that Exchanges, other than SBE-FPs and SHOP Exchanges that do not provide for enrollment in SHOP coverage through an online SHOP enrollment platform, meet the following additional requirements: their call center must provide consumers with access to a live call center representative during the Exchanges' published hours of operation and their live call center representatives must be able to assist consumers with submitting their application for QHP coverage.

We believe this proposal would support the intent of sections 1311(d)(4)(B) and 1413(b)(1)(A)(ii) of the ACA by codifying the requirement that a consumer must be able to obtain live call center support with submitting an application for QHP coverage during reliable, published hours of operation. It is our presumption that speaking to a live representative would better aid in troubleshooting consumer QHP application issues, provide a real time opportunity for a live representative to explain QHP application terminology to a consumer, provide for a live representative to ensure the consumer provides the most correct information to the QHP application (thereby alleviating unnecessary follow-up), and provide greater overall consumer satisfaction.

As stated in the preamble, we believe that all State Exchanges already meet these proposed minimum standards, and we know that the Exchanges on the Federal platform do. As such, we do not anticipate an additional burden associated with this proposal.

We seek comment on these impacts and assumptions.

#### 11. Requirement for Centralized Exchange Eligibility and Enrollment Platform on the Exchange's Website (45 CFR 155.205(b) and 155.302(a)(1))

We propose to amend § 155.205(b)(4) to require that an Exchange operate a centralized eligibility and enrollment platform on the Exchange's website (or, for an SBE-FP, through the Federal eligibility and enrollment platform) such that the Exchange allows for the submission of the single, streamlined

application for enrollment in a QHP and insurance affordability programs by consumers, in accordance with § 155.405, through the Exchange's website and performs eligibility determinations for all consumers based on submissions of the single, streamlined application. Further, we propose to amend § 155.302(a)(1) to clarify that the Exchange, through the centralized eligibility and enrollment platform operated on the Exchange's website (or, for an SBE-FP, the Federal eligibility and enrollment platform) is the entity responsible for making all determinations regarding the eligibility for QHP coverage and insurance affordability programs regardless of whether an individual files an application for enrollment in a QHP on the Exchange's website, or on a website operated by an entity described under § 155.220, such as a web-broker defined at § 155.20, or a direct enrollment entity or QHP issuer described under § 155.221. This amendment to § 155.302(a)(1) would also clarify that only entities that an Exchange elects to contract with to operate its centralized eligibility and enrollment platform can perform this function on behalf of an Exchange and would prohibit Exchanges from solely relying on non-Exchange entities, including a web-broker (defined at § 155.20) or other entities under § 155.220 or § 155.221, from making such eligibility determinations on behalf of an Exchange.

We also propose to amend § 155.205(b)(5) to require that an Exchange operate a centralized eligibility and enrollment platform through the Exchange's website (or, for an SBE-FP, by relying on the Federal eligibility and enrollment platform) so that the Exchange (or, for an SBE-FP, the Federal eligibility and enrollment platform) meets the requirement under § 155.400(c) to maintain records of all effectuated enrollments in QHPs, including changes in effectuated QHP enrollments.

Since all Exchanges, including State Exchanges, SBE-FPs, and FFEs, currently provide access to a centralized eligibility and enrollment platform and process for consumers that they serve, and all Exchanges also currently perform all eligibility determinations through the operation of a centralized eligibility and enrollment platform on their websites, we believe the burden of this proposal on Exchanges and interested parties would be minimal.

We seek comment on the assumptions and estimated impacts of this proposal.

#### 12. Adding and Amending Language To Ensure Web-Brokers Operating in State Exchanges Meet Certain Standards Applicable in the FFEs and SBE-FPs (45 CFR 155.220)

We propose to amend § 155.220 to apply to web-brokers operating in State Exchanges, and consequently in State Exchanges, for both the State Exchange's Individual Exchange and SHOP, certain existing Federal standards governing use of web-brokers' non-Exchange websites to assist consumers with enrolling in QHPs and applying for APTC/CSRs in a manner that constitutes enrollment through an Exchange. As discussed in the preamble of this proposed rule, the proposed regulatory amendments would require these State Exchanges to draft policy, update standards, and potentially hire more staff to perform functions not currently being performed by the State Exchange as a result of applying the identified § 155.220 standards to web-brokers participating in State Exchanges. These proposed changes would also require web-brokers hosting non-Exchange websites in these State Exchanges to perform web-development and oversight to ensure compliance with the Federal minimum standards this rulemaking proposes to extend to these web-brokers. These proposed changes would also require web-brokers in State Exchanges who want to assist consumers with enrolling in QHPs and applying for APTC and CSRs to display standardized disclaimers, display QHP comparative information, display information pertaining to a consumer's eligibility for APTC or CSRs, to participate in operational readiness reviews and potentially maintain relevant documentation, and to extend downstream agent and broker requirements to web-brokers operating in State Exchanges. Although these proposals allow States certain flexibility for State Exchanges with regards to establishing procedures and requirements for website displays (including flexibility to add State-specific information to required disclaimers and for the State Exchange to determine how consumer educational information is displayed), downstream agent and broker access to and use of web-broker non-Exchange websites, and demonstration of operational readiness, we expect the impact and costs to be reasonably based on the impacts seen on the FFEs and SBE-FPs.

Although there would be some additional burden for web-brokers operating in State Exchanges, amounting to approximately \$48,586.60 per web-broker as discussed in the

information collection requirements section of this proposed rule, we anticipate that some of these State Exchanges may utilize web-broker entities already participating in the FFEs and SBE-FPs, which would help provide administrative savings related to the approval process if the State Exchange does not impose additional State-specific requirements beyond the HHS minimum standards. We encourage State Exchanges to leverage web-broker operational readiness demonstrated for the FFEs and SBE-FPs when possible. Additionally, we expect those web-brokers already participating in the FFEs and SBE-FPs to be able to leverage their existing web-development work with additional burden and costs only required for tailoring the website display, operational readiness, and downstream agent and broker access to any State-specific requirements adopted by the applicable State Exchange. Additionally, as described in the accompanying ICR discussion, we anticipate an impact on State governments totaling \$2,346,128 for 5 States to opt to host a web-broker program for their State Exchange.

We estimate a total cumulative burden of \$1,071,474.40 associated with this proposal for an estimated 20 web-brokers operating across the 5 State Exchanges. We anticipate these proposed changes to extend certain HHS minimum standards governing web-broker participation in FFEs and SBE-FPs to also apply to State Exchanges and their web-brokers would be beneficial to consumers by establishing uniform, baseline requirements for agent, broker, and web-broker participation across all Exchange types. These proposed changes would allow State Exchanges to leverage the framework that has already been established and currently applies to FFEs and SBE-FPs, thereby decreasing the burden to these State Exchanges to establish such a program, while providing some flexibility for these State Exchanges to tailor the new requirements to include State-specific content (such as the updating disclaimer language to refer to the State Exchange website rather than the *HealthCare.gov* website). Additionally, these proposed changes would establish administrative and operational consistency throughout the Exchanges, which is beneficial to agents, brokers, and web-brokers by allowing them to expand their business into States with State Exchanges in a more streamlined fashion, as well as to Exchanges and their consumers.

We seek comment on these estimated impacts and assumptions.

### 13. Ability of States To Permit Agents and Brokers and Web-Brokers To Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (45 CFR 155.220(h))

As discussed in the preamble to this proposed rule, we propose to revise and add language to § 155.220(h) to specify that the CMS Administrator, a principal officer, would review agent, broker, and web-broker requests for reconsideration of decisions to terminate their Exchange agreement(s) under § 155.220(h)(3). We propose that the CMS Administrator's determination would be final and binding. We believe this proposal would positively impact agents, brokers, and web-brokers by ensuring entities who utilize the FFE and SBE-FPs know, through increased transparency, who would be responsible for handling these reconsideration decisions under § 155.220(h)(3).

### 14. Establishing Requirements for DE Entities Mandating *HealthCare.gov* Changes Be Reflected on DE Entity Non-Exchange Websites Within a Notice Period Set by HHS (45 CFR 155.221(b))

We propose to amend § 155.221 to require that DE Entity non-Exchange websites implement and prominently display website changes in manner consistent with that adopted by HHS for *HealthCare.gov* by implementing standards defined by HHS within a notice period set by HHS, unless HHS approves a deviation. We also propose to require State Exchanges implement a similar process to require display changes on State Exchange websites be reflected on the websites of their DE entities, with the procedures for defining standards defined by the State Exchange.

As discussed in the preamble of this proposed rule, this proposal would require web-brokers and QHP issuers participating in DE to update their non-Exchange websites to incorporate website display changes that mirror those adopted by HHS for *HealthCare.gov* by conforming with standards defined by HHS. This proposal would provide DE entities flexibility in their user interface graphic design, provided that their design complies with the standards defined by HHS. This proposal would also allow DE entities to submit a deviation request for review and approval by HHS if they would like to implement a display that does not meet those standards. We anticipate an average of three or fewer required display changes annually, with the majority of changes being simpler website display changes that are relatively easy to implement.

Furthermore, HHS would provide examples and associated disclaimer text with the release of any required website display changes pursuant to this proposal, and therefore we expect the overall impact of these simple website display changes to be minimal. As described in the information collection requirements section of this proposed rule, we estimate a total cumulative annual burden of \$240,120 associated with the requirement for DE entity non-Exchange websites to incorporate website display changes that mirror those adopted by HHS for *HealthCare.gov* and a burden of \$5,171 associated with completing and submitting a request to deviate from the *HealthCare.gov* display.

As discussed in the preamble for this rule, we continue to support DE entities' use of innovative decision-support tools and user interface designs, and this proposal is not intended to prohibit the implementation of display features beyond the baseline provided by *HealthCare.gov*. As such, there may be occasions where some web-brokers and QHP issuers participating in direct enrollment may have implemented the standards of the desired display before the change was made on *HealthCare.gov*. In these instances where the DE entity non-Exchange website is already meeting the minimum standards associated with the website display changes communicated by HHS pursuant to this proposal, the entity would not have to make any further website updates. We also anticipate approximately one more complex display change per plan year, potentially involving updates to backend UI algorithms and display methodologies. Although more complex display changes may represent additional burden for DE entities, we would ease the burden by providing them with examples of *HealthCare.gov*'s display, technical implementation guidance (including Marketplace API (MAPI) or Public Use Files (PUF) data integration guidance), and technical assistance as needed. We anticipate that giving examples of a user interface design that meets HHS' standards will ease the burden of implementation as compared to solely providing HHS' standards and relying on DE entities to determine how to configure their websites to meet those standards.

The proposed new § 155.221(j) would extend this new proposed DE entity non-Exchange website display requirement to require State Exchanges to require their DE entities to implement and prominently display changes adopted for display on the State Exchanges' websites on their non-

Exchange websites for purposes of assisting consumers with DE in QHPs offered through the Exchange in a manner that constitutes enrollment through the Exchange. This would require State Exchanges to establish requirements for DE entities operating in State Exchanges to reflect changes to the State Exchange website on their DE entity non-Exchange websites. This change would also require State Exchanges to establish processes for communicating and defining standards and for setting advance notice periods. We also encourage State Exchanges to consider the same factors (that is, complexity of the change and the urgency with which the change must be reflected on the DE entity's non-Exchange website) when setting advance notice periods. Similarly, we encourage State Exchanges to provide DE entities operating in their States examples of the State Exchange display, and technical assistance, including technical implementation guidance, to ease the burden of required display changes.

We anticipate this proposal would benefit consumers by codifying and expanding our existing EDE HHS-initiated change request process to apply to all DE entities and ensuring that all Exchange consumers receive consistent, clear, and accurate information in a timely fashion as they navigate the QHP selection and enrollment process. We are further of the view that this proposal would mitigate the risk that consumers receive different, and possibly confusing or misleading, information based on the platform they choose to utilize when enrolling in or applying for coverage. This proposal would help ensure consumers using the DE pathways benefit from policies we introduce to improve the *HealthCare.gov* website display, and in State Exchanges the State Exchange website, by enhancing the consumer experience, increasing consumer understanding, and simplifying the plan selection process.

As discussed in the ICR for this proposal, the cumulative cost estimate as a result of this proposal would be approximately \$1,226,453 for 100 entities operating in the Exchanges (including State Exchanges under new proposed paragraph § 155.221(j)(3)) in the 2025 benefit year. Entities that submit a request to deviate from the display approach adopted by *HealthCare.gov*, or in State Exchanges, the State Exchange website, would incur a cumulative cost of approximately \$31,023 annually.

We seek comment on the estimated impacts associated with this proposal.

#### 15. Adding and Amending Language To Ensure DE Entities Operating in State Exchanges Meet Certain Standards Applicable in the FFEs and SBE-FPs (45 CFR 155.221)

We propose to amend § 155.221 to apply to DE entities operating in State Exchanges, and consequently State Exchanges that utilize DE entities, certain existing Federal standards regarding DE entities assisting consumers with enrolling in QHPs and applying for APTC/CSRs, both for the State Exchange's Individual Exchange and SHOP.

As discussed earlier in this proposed rule, the proposed regulatory amendments would require these State Exchanges to draft policy, update standards, and potentially hire additional staff to perform functions not currently being performed by the State Exchange because of applying certain § 155.221 standards to State. The proposal would also require DE entities participating in DE programs in State Exchanges to perform web-development to ensure compliance with the Federal minimum standards this rulemaking proposes to extend to these DE entities, along with any State-specific requirements that may be adopted under the proposed flexibility provided to State Exchanges in this rulemaking.

Although there will be additional burden for DE entities operating in State Exchanges, amounting to approximately \$138,447 per DE entity, as discussed in the information collection requirements section of this proposed rule, we anticipate that some of these State Exchanges may utilize DE entities already participating in the FFEs and SBE-FPs, which would help provide administrative savings related to the approval process under § 155.221(b)(4) if the State does not impose additional State-specific requirements beyond the Federal standards. We encourage State Exchanges to leverage DE operational readiness demonstrated for the FFEs and SBE-FPs when possible.

Additionally, we expect those DE entities already participating in the FFEs and SBE-FPs to be able to leverage their existing web-development work with additional burden only required for tailoring the website display to any State-specific requirements adopted by the State Exchange (for example, updating website disclaimers to reference the State Exchange website rather than the *HealthCare.gov* website). Although these proposals allow States certain flexibility for State Exchanges with regards to establishing procedures and requirements for website displays and demonstration of operational

readiness, we expect the impact and costs to be reasonably based on the impacts seen on the FFEs and SBE-FPs. As described in the information collection requirements section, we anticipate a total cumulative burden of \$6,762,281 for DE entities in State Exchanges to comply with this proposal to ensure DE entities operating in these State Exchanges are meeting certain requirements applicable in the FFEs and SBE-FPs. Additionally, we anticipate this proposal would have an impact on State governments totaling \$3,353,467.90 for 5 States to opt to host a DE program for their State Exchange.

We anticipate that these proposed changes to extend certain minimum Federal standards governing DE entity participation in FFEs and SBE-FPs to also apply to State Exchanges would benefit consumers by establishing uniform, baseline requirements for DE entity participation across all Exchange types. These proposed changes would allow State Exchanges to leverage the framework that has already been established and currently applies to FFEs and SBE-FPs, thereby decreasing the burden to these State Exchanges to establish such a program, while providing some flexibility for these State Exchanges to tailor the applicable standards to include State-specific content. Additionally, this proposal would establish administrative and operational consistency throughout the Exchanges, which benefits DE entities by allowing them to expand their business into States with State Exchanges with minimal costs and burdens. Consumers would also benefit by the expansion of entities and enrollment pathways available to assist with enrolling in health insurance coverage.

We seek comment on these estimated impacts and assumptions.

#### 16. Failure To Reconcile (FTR) Process (45 CFR 155.305(f)(4))

We are proposing in connection with the FTR process described in § 155.305(f)(4) that Exchanges would be required to send notices to tax filers for the first year in which they failed to reconcile APTC as an initial warning to inform and educate tax filers that they need to file and reconcile, or risk being determined ineligible for APTC if they fail to file and reconcile for a second consecutive year.

Under this policy, Exchanges on the Federal platform would continue to send notices to tax filers for the year in which they have failed to reconcile APTC as an initial warning to inform and educate tax filers that they need to file and reconcile, or risk being

determined ineligible for APTC if they fail to file and reconcile for a second consecutive tax year. Our proposal to codify this practice and require it of all Exchanges, including State Exchanges, would ensure that tax filers who have been determined to have FTR status for 1 year are adequately educated on the file and reconcile requirement, and have ample opportunity to address the issue and file and reconcile their APTC before they are determined to have FTR status for 2 consecutive years. We request comment on how best to conduct outreach to tax filers who need more intensive assistance in understanding FTR status, including directing them to resources such as Navigator or Assistors that could help explain what they need to do to reconcile their APTC.

This proposal would support compliance with the filing and reconciling requirement under 36B(f) of the Code and its implementing regulations at 26 CFR 1.36B–4(a)(1)(i) and (a)(1)(ii)(A), minimize the potential for APTC recipients to incur large tax liabilities over time, and support eligible enrollees' continuous enrollment in Exchange coverage with APTC by avoiding situations where enrollees become uninsured when their APTC is terminated. Additionally, this proposal would better align State Exchanges' failure to reconcile processes with that of the Exchanges on the Federal platform.

We are aware of seven States that will operate their own State Exchange for PY 2025 and have not yet fully implemented the infrastructure to run FTR operations for plan years through 2024 due to the flexibility the Exchanges were given to temporarily pause FTR operations due to the COVID–19 PHE. We are seeking comment on the estimated one-time costs for these States to fully implement the functionality and infrastructure to conduct FTR operations, and the estimated annual costs to maintain FTR operations.

#### 17. Verification Process Related to Eligibility for Enrollment in a QHP Through the Exchange (45 CFR 155.315(e))

We believe that the proposal to revise § 155.315(e) so that Exchanges can accept incarceration attestations without further verification and verify incarceration status using an HHS-approved data source only if they choose to, would minimize administrative costs and burdens for Exchanges. Flexibility in verifying incarceration status for Exchanges would result in significant cost savings through not creating and processing

incarceration DMIs. The current incarceration verification process resulted in a high number of DMIs, almost all of which are resolved in favor of the applicant and has been burdensome and costly for the Exchanges to implement. By revising the current incarceration verification process, this proposal would also eliminate undue burdens and barriers to care for applicants, particularly formerly incarcerated people, a population comprised of a significant number of people with disabilities.<sup>280</sup> Many documents that can prove incarceration status cannot be obtained without an unexpired proof of identity document, and most cannot be obtained without submitting non-refundable payments. Incarceration may inhibit one's financial savings, and formerly incarcerated individuals are less likely to secure employment.<sup>281</sup> As discussed further in the information collection requirements section for this proposal, we anticipate a one-time cost to 11 State Exchanges of approximately \$23,770 to conduct analyses to determine whether to accept consumer attestation of incarceration status or use an alternative data source to verify incarceration status and to submit such request to HHS, and make associated changes to their eligibility systems and processes to implement the option they choose.

From PY 2018 to 2019, there were 110,802 incarceration DMIs generated. In PY 2019, nearly 38,000 out of 78,000 applicants submitted documents to attempt to resolve the incarceration DMI. Conducting an intensive incarceration verification check through the DMI process for each DMI caused HHS to incur additional costs totaling about \$0.57 million per year for verification of incarceration along with the PUPS annual maintenance and transaction fees. The additional costs associated with generating incarceration DMIs include the costs to inform applicants of their DMI through their eligibility determination notice, and to process the DMI and any documentation mailed by the applicants. State Exchanges have likely incurred similar costs. Of the 13 State Exchanges (operating in 12 States and the District of Columbia) with incarceration verification processes, eight conduct incarceration verifications similar to those conducted by the Exchanges on the Federal platform. We estimate that incarceration DMI processing costs

approximately \$9,561,000 annually across all eight of these State Exchanges. Of the 13 State Exchanges with incarceration verification processes, five State Exchanges connected to an individual State or local incarceration facility for verifications and fully process incarceration DMIs. These State Exchanges currently incur DMI processing costs, including costs associated with noticing the applicant of their DMIs and costs associated with DMI and appeals casework. Based on costs incurred by the Exchanges on the Federal platform to process DMIs, we estimate that incarceration DMI processing costs State Exchanges approximately \$7,171,000 annually across all 5 of these State Exchanges. Finally, 3 States are transitioning to State Exchanges. We anticipate their incarceration verification operations would cost approximately \$3,585,000 annually. In total, the costs to an anticipated 16 State Exchanges would be approximately \$20,317,000 annually if current policy continued.

By providing flexibility to Exchanges to verify incarceration status and allowing Exchanges to accept applicant attestations without verification, this proposal would enable HHS and Exchanges to avoid incurring the aforementioned costs associated with DMI creation and processing. Exchanges would not have to invest resources into building data transfer connections with an alternative incarceration verification data source and would not have to invest in providing DMI notices and support to applicants. Therefore, the cost savings to State Exchanges associated with this proposal would be approximately \$20,317,000.

As previously mentioned, conducting an intensive incarceration verification check through the DMI process for each DMI caused HHS to incur additional costs totaling approximately \$570,000 per year for verification of incarceration along with the PUPS annual maintenance and transaction fees. While overall, this proposal would reduce the burden and costs associated with incarceration verification operations and data sourcing, there would be a modest up-front cost of \$1,200,000 to HHS to modify the Federal platform's current incarceration verification processes for the purposes of verifying eligibility for QHP, and it would cost \$340,000 to update the Federal platform's system logic for HHS to stop sending incarceration verification requests to PUPS. Once these operations and noticing have stopped, no further costs should be incurred by HHS, or by Exchanges that opt to act on the flexibilities provided by this proposal.

<sup>280</sup> Robert Apel, Gary Sweeten, *The Impact of Incarceration on Employment during the Transition to Adulthood*, Social Problems, Volume 57, Issue 3, 1 August 2010, Pages 448–479, <https://doi.org/10.1525/sp.2010.57.3.448>.

<sup>281</sup> *Id.*

In total, we anticipate a cost of \$1,540,000 to HHS because of this proposal. We reiterate that this cost would be overshadowed by the expected savings of approximately \$20,317,000 as a result of this proposal, if finalized.

We seek comment on these estimates.

#### 18. Verification Process Related to Eligibility for Insurance Affordability Programs (45 CFR 155.320)

We are proposing to amend § 155.320(c) by adding a new requirement at paragraph (c)(1)(iii) to now require that State Exchanges pay in advance for their utilization of the CSI data provided by the VCI Hub service to verify a tax household's attested annual income and, or the current income of the Medicaid household for an application member due to our reinterpretation of State Exchange and State Medicaid and CHIP agency use of the Hub to access and use the income data provided by the optional VCI Hub service as a State Exchange or a State Medicaid and CHIP agency function. We propose that beginning on July 1, 2024, State Exchanges will be required to pay in advance for 100 percent of the costs of their utilization of the CSI data. We anticipate working with States to develop an estimate of their annual usage of the CSI data service. States that notify HHS that they want to continue to use the CSI data through the VCI Hub service must pay in advance to HHS for the total each respective State Exchange's anticipated annual utilization, specifically the anticipated number of successful transactions to the VCI Hub service that return usable CSI data, as defined by the criteria discussed above in preamble, multiplied by the fixed price. We are also planning that beginning on July 1, 2024, State Medicaid agencies and HHS will share in the costs with State Medicaid agencies being responsible for 25 percent of the cost of the utilization of the VCI Hub service and HHS responsible for the remaining 75 percent of the costs.

Because the price per transaction for CSI data is proprietary information, we are unable to provide those numbers, or the precise utilization rates for State Exchanges and State Medicaid agencies as this would be a direct conflict of the contract that HHS holds with the CSI contractor. However, based on HHS' own analysis, in fiscal year (FY) 2022, State Exchange utilization of the VCI Hub service led to costs of approximately \$26 million dollars. Similarly, in FY 2022, State Medicaid agency utilization of the VCI Hub service resulted in costs of

approximately \$77 million dollars. We also estimate that by having State Medicaid agencies pay for 25 percent of their transaction costs, the Federal government can save between \$32 to \$55 million per year. By having State Exchanges pay for 100 percent of their transaction costs, we estimate savings to the Federal government could be between \$39 and \$67 million per year; this cost estimate includes an assumption of one to two States transitioning to State Exchanges in future years. Assuming one to two new States transition to a State Exchange in the next 4 years, we applied a 5 percent increase to estimate the additional pings from these additional States. We estimate that taken together, this proposed policy would result in a transfer of between \$72 to \$122 million per year of costs from the Federal government to States beginning in 2024.

We are aware that six State Exchanges currently only have one connection for both their State Exchange and State Medicaid agency, which may pose a challenge when determining which VCI Hub transactions are attributable to the State Exchange, and which are attributed to the State Medicaid agency. We anticipate that one to three State Exchanges may elect to build a separate connection in order to accurately account for which VCI Hub transactions originate from their State Exchange and their State Medicaid agency and we estimate about \$1 to 3 million in one-time costs in 2024 to build the IT infrastructure for a second Hub connection, totaling about \$3 to 6 million in one-time costs for the one to three States that choose to make any changes with how they currently access the VCI Hub service. States that do not elect to build a separate connection would instead need to develop a cost allocation methodology to track VCI Hub transaction volume from their State Exchange and State Medicaid agency and communicate this to HHS so that HHS can invoice accurately and appropriately.

As noted in preamble, under this proposal, States would pay annually in advance for their anticipated utilization of the optional VCI Hub service. States would be required to reconcile with HHS on an annual basis the anticipated utilization of CSI data provided by the VCI Hub service with the actual utilization. In the alternative, HHS would invoice States on a monthly basis for their actual utilization of CSI data provided by the VCI Hub service after that utilization occurs. Because we are still exploring how HHS will invoice States and State Medicaid agencies for their respective utilization of the VCI

Hub Service depending on which invoicing methodology HHS ultimately finalizes, we believe that there may be some increased costs to the Federal Government, including contractor resources and administrative costs associated with collecting these funds from States. We estimate the ongoing administrative annual costs beginning in 2024 to be approximately \$1 million and cover operational expenses for maintaining systems and collections. We estimate an additional \$2.3 million as a one-time cost in 2024 to build the invoicing process/structure and setup operations. We note, however, that these estimates may be higher or lower, as they are dependent on whether HHS finalizes advanced billing as proposed or an alternative invoicing structure, such as monthly billing.

We seek comment on these estimates.

#### 19. Eligibility Redetermination During a Benefit Year (45 CFR 155.330(d))

We propose to revise § 155.330(d) to require Exchanges to conduct periodic checks for deceased enrollees twice yearly and subsequently end deceased enrollees' QHP coverage beginning with the 2025 calendar year. Additionally, we propose to amend § 155.330(d)(3) to grant the Secretary the authority to temporarily suspend the PDM requirement during certain situations or circumstances that lead to the unavailability of data needed to conduct PDM.

Currently, § 155.330(d)(3) defines "periodically" only for PDM activities that identify enrollment in Medicare, Medicaid, CHIP, and BHP, meaning that Exchanges must conduct Medicare PDM, Medicaid or CHIP PDM, and BHP PDM twice a year. The current regulation does not specify the frequency by which PDM activities to identify deceased enrollees must occur. The 2019 Program Integrity Rule did not require Exchanges to perform PDM for death at least twice in a calendar year so that Exchanges could prioritize the implementation of the new requirement to conduct PDM for Medicare, Medicaid, CHIP and, if applicable, BHP eligibility or enrollment at least twice yearly. Periodic checks for deceased enrollees are a critical aspect to ensuring Exchange program integrity.

We propose to revise § 155.330(d) to require Exchanges to conduct periodic checks for deceased enrollees twice yearly and subsequently end deceased enrollees' QHP coverage beginning with the 2025 calendar year. This proposal would not only align with current policy and operations on the Exchanges on the Federal platform but would also prevent overpayment of QHP premiums

and accurately capture household QHP eligibility based on household size.

Based on internal data, we anticipate that it will cost the Federal Government approximately \$58,923 to conduct an additional check for deceased enrollees per year. In 2023, we conducted two rounds of Death PDM where the average number of expired households was 7,151; the average APTC amount per household was \$549 per month; and, at the time of the expiration activities, there was an average of 6.5 months left in the plan year. We calculate the APTC savings to be approximately \$25 million. Prior to implementing Death PDM in 2019, we looked at the number of consumers that were removed from coverage by the surviving family without the aid of Death PDM and close to 50 percent of the deceased consumers were removed from coverage. Thus, we estimate the net amount of APTC saved is estimated would be approximately \$12.5 million per year beginning in 2025.

State Exchanges that are not already conducting Death PDM with the proposed required frequency, or deemed in compliance with PDM requirements, would be required to engage in IT system development activity to communicate with these programs and act on enrollment data either in a new way, or in the same way more frequently if this proposal is finalized. Thus, there may be additional associated administrative cost for these State Exchanges to implement the proposed PDM requirement, if finalized. As discussed in the information collection requirements section of this proposed rule, for a State Exchange not already conducting death PDM at least twice a year, we estimate that it would cost approximately \$3,932 per State Exchange (a total of \$43,252 for all 11 State Exchanges currently not meeting the proposed requirement) to implement this proposed provision through their system. We assume that this cost would be incurred primarily in 2025 by State Exchanges. These costs would be incurred by the State Exchanges as they are required to be financially self-sustaining and do not receive Federal funding for their establishment or operations.

We seek comments in response to the burden estimates for this policy.

#### 20. Incorporation of Catastrophic Coverage Into the Auto Re-Enrollment Hierarchy (45 CFR 155.335(j))

We propose to amend the regulations at § 155.335(j)(1) and (2) to require Exchanges to re-enroll enrollees in catastrophic coverage as defined in section 1302(e) of the ACA into QHP

coverage for the coming plan year. We believe that some Exchanges already re-enroll these enrollees, and we generally do so in Exchanges on the Federal platform when issuers include a plan crosswalk information for catastrophic plans when they submit the information part of the annual QHP Certification process. However, explicitly incorporating catastrophic plan enrollees into the rules at § 155.335(j) would help ensure continuity of coverage in cases where the issuer does not offer the catastrophic plan for the subsequent plan year and these enrollees do not actively select a different QHP. We also propose to add new § 155.335(j)(5) to establish that an Exchange may not newly auto re-enroll an enrollee into catastrophic coverage who is currently enrolled in coverage of a metal level as defined in section 1302(d) of the ACA. We believe that Exchanges likely also adhere to this practice, but that all interested parties would benefit from clear regulation on this aspect of the re-enrollment process.

If this proposal is finalized, we would also update the FFE Enrollment Manual to incorporate catastrophic coverage into the re-enrollment hierarchy for alternate enrollments, which we use to implement the regulation to crosswalk enrollees whose current issuer will no longer offer plans available to them through the Exchange under § 155.335(j)(3).

The inclusion of additional criteria in the auto re-enrollment process may result in a small increase in costs and burden for issuers and Exchanges. However, burden in Exchanges on the Federal platform would be mitigated because we already encourage issuers to submit crosswalk options for catastrophic enrollees, including those who will lose eligibility for catastrophic coverage. We solicit comment on whether these proposals reflect current practices of State Exchanges that are not on the Federal platform. Finally, we believe this change would make it more likely that catastrophic coverage enrollees will be auto re-enrolled. This support may disproportionately benefit enrollees who are less likely to have the time or background knowledge to compare their coverage options for the coming plan year, such as those with limited health insurance literacy.

We seek comment on these impacts and assumptions.

#### 21. Premium Payment Deadline Extensions (45 CFR 155.400(e)(2))

We anticipate that the proposal to amend § 155.400(e)(2) to codify that flexibility for issuers experiencing billing or enrollment problems due to

high volume or technical errors is not limited to extensions of the binder payment will benefit issuers. Because HHS has already provided enforcement discretion in the past to account for such situations, we do not anticipate that there would be any additional costs for HHS associated with this proposal, nor do we anticipate any costs to interested parties.

We seek comment on these impacts and assumptions.

#### 22. Initial and Annual Open Enrollment Periods (45 CFR 155.410)

We propose amending § 155.410(e)(4)(ii) to revise parameters around the adoption of an alternative open enrollment period by a State Exchange not utilizing the Federal platform. We propose that for benefit years beginning on or after January 1, 2025, State Exchanges may extend the open enrollment period so that the open enrollment period begins on November 1 of the calendar year preceding the benefit year and ends no earlier than January 15 of the applicable benefit year.

We have previously observed that when open enrollment ends in December, certain consumers may be subjected to unexpected plan cost increases that they may not be notified about until January. This proposal would benefit consumers by reducing the number of consumers who may be subjected to such unexpected plan cost increases. This proposal would also ensure ample time for Navigators, certified application counselors, agents, and brokers to fully assist all interested consumers during open enrollment while also improving access to health coverage by giving consumers ample time to react to updated plan cost information and seek enrollment assistance, including consumers in underserved communities who face additional barriers to accessing health coverage. Finally, by reducing consumer confusion, increasing consumer access to assisters, and giving consumers more time to consider up-to-date plan cost information, this proposal could increase QHP enrollment, benefiting all interested parties, including consumers, Exchanges, issuers, and assisters.

All 18 State Exchanges except one already meet these proposed parameters, beginning their annual open enrollment periods on November 1 and concluding on or after January 15 of the benefit year, pursuant to current § 155.410(e)(4)(ii). Moreover, many continue open enrollment beyond January 15 of the benefit year. Since most State Exchanges already are aligned with the parameters described



in the new proposal, we anticipate that this proposal would have a de minimis impact and not impose significant additional burden overall.

We seek comment on this burden estimate and assumptions. We are particularly interested in comments regarding whether this proposal would impose a significant burden on outlying State Exchanges and interested parties (for instance, Navigators, assisters, issuers).

**23. Special Enrollment Periods—Effective Dates of Coverage (45 CFR 155.420(b))**

We propose amending § 155.420(b)(1) and (b)(3)(i) to align the effective dates of coverage after selecting a plan during certain special enrollment periods across all Exchanges, including State Exchanges, so that during a special enrollment period that follows the regular effective dates of coverage listed at § 155.420(b)(1), qualifying individuals or enrollees who select and enroll in a QHP receive coverage beginning the first day of the month after the consumer selects a QHP.

In the 2021 Payment Notice final rule (85 FR 29251) where this policy was finalized for Exchanges on the Federal platform, we noted that ensuring that consumers who select a plan during a special enrollment period provided using the regular effective dates at § 155.420(b)(1) receive coverage on the first day of the following month, rather than on the first day of the second month following plan selection, would result in several benefits, such as reducing consumer confusion and minimizing coverage gaps while also enhancing operational efficiency. In addition, we noted that the standardization of effective coverage dates for special enrollment periods provided using the regular effective dates at § 155.420(b)(1) would result in standardization for issuers due to more plans beginning in the same month, Exchanges, and consumers; the reduction of system errors and related casework, including reduced confusion among relevant consumer support staff; and simplified Exchange billing practices due to the expedited effective dates. We believe that State Exchanges, and the issuers and consumers in those States will also experience these benefits under the proposal to align the effective coverage dates across all Exchanges for special enrollment periods that use the regular effective dates of coverage at § 155.420(b)(1) (unless an earlier coverage effective date were selected pursuant to § 155.420(b)(3), which would reduce

potential burdens associated with this proposal.

Additionally, we maintain our expectation that issuers will not incur substantial new costs as a result of applying this policy across Exchanges since they routinely effectuate coverage on the first of the month following plan selection or earlier when permitted or required under applicable regulation. We expect that consumers in States which do not currently apply this policy will also benefit from a faster effectuation of coverage, as this will result in fewer coverage gaps for consumers transitioning between or newly enrolling in a health insurance plan.

We seek comment on these assumptions.

**24. Special Enrollment Periods—Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals With a Household Income At or Below 150 Percent of the Federal Poverty Level (45 CFR 155.420(d)(16))**

We are proposing to amend § 155.420(d)(16) to revise the parameters around the availability of a special enrollment period (SEP) for APTC-eligible qualified individuals with a projected household income at or below 150 percent of the Federal Poverty Level (FPL), hereinafter referred to as the “150 percent FPL SEP.” Specifically, we are proposing to remove the limitation that this SEP be available only when the applicable taxpayer’s applicable tax percentage is set to zero, a circumstance provided for under section 9661 of the American Rescue Plan (ARP) and later under the Inflation Reduction Act (IRA).

The impact of this policy would be zero if enhanced subsidies under the IRA were continued beyond 2025. It is difficult to estimate, with confidence, the impacts of this policy on premiums, PTC payments, and enrollment if the enhanced subsidies are not continued, and we note that those impacts are likely to be quite different by State. However, under various scenarios, we estimate that if this proposed policy were to be finalized, national premiums in the individual market could increase by an average of 3 to 4 percent for plan year 2026 when the enhanced PTC provisions of the IRA are due to expire. We would expect that any average national impact would have a high variance between States that have expanded Medicaid coverage compared to States that have not, because States that have not expanded Medicaid coverage are likely to have more consumers with projected annual household income below 150 percent FPL applying for coverage through the

Exchange. Unknown factors making these parameters difficult to estimate include the utilization of this SEP by healthy and unhealthy enrollees, the impact to the average duration of coverage for enrollees, and additional policy changes between now and 2025. At an aggregate level, PTC outlays could increase nationally up to \$2 billion to \$3 billion beginning in 2026. The direction and magnitude of enrollment changes in the individual market is also highly uncertain.

We seek comment on these estimates, including on the premium impacts at the State level.

**25. Termination of Exchange Enrollment or Coverage (45 CFR 155.430)**

We anticipate that the proposal to permit enrollees in Exchanges on the Federal platform to retroactively terminate coverage back to the date in which they retroactively enroll in Medicare Part A or B would benefit enrollees by allowing them to avoid an overlap in coverage and paying premiums for coverage they do not need. We anticipate that there would be some minor costs for HHS associated with processing the additional requests for retroactive terminations of coverage allowed by this proposal. However, we do not have adequate data to estimate the number of requests for retroactive termination HHS is likely to receive, and so we cannot provide an estimate for these costs, nor for the amount of APTC that is likely to be returned to the government as a result of this proposal. In addition, we anticipate that there would be a minor financial impact to issuers associated with processing the additional retroactive termination requests allowed by this proposal, including reversing claims and refunding premium paid by the enrollee, but we likewise do not have adequate data to estimate these costs.

Finally, we also anticipate that there may be a financial impact to State Exchanges associated with implementing this proposal if the rule is finalized such that implementation is optional for State Exchanges or required for all Exchanges. However, we do not have access to the data necessary to estimate the costs to State Exchanges associated with implementing this proposal, nor do we have access to the data necessary to determine how long it would take State Exchanges to implement it.

We seek comment on these impacts and assumptions, as well as any additional data sources we could use to estimate the costs associated with this proposal.



## 26. Establishment of Exchange Network Adequacy Standards (45 CFR 155.1050)

Effective for plan years beginning on or after January 1, 2025, we propose to require that State Exchanges and SBE-FPs establish and impose quantitative time and distance QHP network adequacy standards that are at least as stringent as the FFEs' time and distance standards established for QHPs under § 156.230. We also propose that State Exchanges and SBE-FPs be required to conduct quantitative network adequacy reviews prior to certifying any plan as a QHP, consistent with the reviews conducted by the FFEs under § 156.230. We further propose to require State Exchanges and SBE-FPs to permit issuers that are unable to meet the specified network adequacy standards to participate in a justification process after submitting their initial network adequacy data to account for variances and potentially earn QHP certification. Finally, we propose to mandate that State Exchanges and SBE-FPs require all issuers seeking QHP certification to submit information to the State Exchange or SBE-FP about whether network providers offer telehealth services.

For purposes of the proposal to require 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, "as stringent as" means time and distance standards that use a specialty list that includes at least the same specialties as our provider specialty lists and time and distance parameters that are at least as short as our parameters. States would be permitted to implement network adequacy standards that are more stringent than those performed by the FFEs under § 156.230. In other words, States could use a specialty list that is broader than our specialty lists, but it must include all the provider specialties included in our lists. Similarly, the time and distance parameters could also be narrower than our parameters, meaning they could require shorter time and/or distances, but they cannot be less demanding than our time and distance parameters. Consistent with the standards for the FFEs, the State Exchanges and SBE-FPs' time and distance standards would be calculated at the county level and vary by county designation. State Exchanges and SBE-FPs would be required to use a county type designation method that is based upon the population size and density parameters of individual counties.

Under this proposal, the time and distance standards State Exchanges and SBE-FPs would establish and impose would apply to our provider specialty lists. To count towards meeting the time and distance standards, individual and facility providers in these lists would have to be appropriately licensed, accredited, or certified to provide services in their State, as applicable, and would need to have in-person services available.

We propose that State Exchanges and SBE-FPs be required to conduct quantitative network adequacy reviews prior to QHP certification, and that they conduct them consistent with network adequacy reviews conducted by the FFEs under § 156.230. When we refer to the review being consistent with the network adequacy reviews conducted by the FFEs under § 156.230, we propose that State Exchanges and SBE-FPs would be required to conduct, prior to QHP certification, quantitative network adequacy reviews to evaluate compliance with requirements under § 156.230(a)(1)(ii) and (iii), and (a)(2)(i)(A), while providing QHP certification applicants the flexibilities described under § 156.230(a)(2)(ii) and (a)(3) and (4). Under this proposal, State Exchanges and SBE-FPs would be prohibited from accepting an issuer's attestation as the only means for plan compliance with network adequacy standards. We further propose that State Exchanges and SBE-FPs would make available to SADP applicants the limited exception available to SADPs under § 156.230(a)(4), pursuant to which SADPs may not be required to meet FFE network adequacy standards under § 156.230(a)(4). This exception is not available to medical QHP issuers.

We acknowledge that State-specific challenges may necessitate exceptions, and so we propose to require State Exchanges and SBE-FPs to permit issuers that are unable to meet the specified standards to participate in a justification process after submitting their initial data to account for variances, consistent with the processes specified under § 156.230(a)(2)(ii) and (a)(3) and (4). The issuer would include this justification as part of its QHP application and describe 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 would be required to provide information as requested by the State Exchange or SBE-FP to support this justification. State Exchanges and SBE-FPs would be required to review

the issuer's justification to determine whether making such health plan available through the Exchange is in the interests of qualified individuals in the State or States in which such Exchange operates as specified under § 156.230(a)(3). In making this determination, the factors State Exchanges and SBE-FPs could consider include whether the exception is reasonable based on circumstances such as the local availability of providers and variables reflected in local patterns of care. If the State Exchange or SBE-FP determines that making such health plan available through its Exchange is in the interests of qualified individuals in the State or States in which such Exchange operates, it could then certify the plan as a QHP.

We are aware that some States Exchanges employ robust, quantitative network adequacy standards that differ from those used by the FFEs, but still ensure that QHPs provide consumers with reasonable, timely access to practitioners and facilities to manage their health care needs, consistent with the ultimate aim of these proposals. In light of this, we propose a framework for granting exceptions to the requirements that State Exchanges and SBE-FPs are required to establish and impose network adequacy time and distance standards for QHPs that are at least as stringent as the standards applicable to QHPs in FFEs and conduct quantitative network adequacy reviews that are consistent with those carried out by the FFEs under § 156.230. HHS could grant State Exchanges and SBE-FPs an exception if it determines that the Exchange applies and enforces quantitative network adequacy standards that are different from the FFEs' but ensure reasonable access as defined under § 156.230. The exception would be available only to State Exchanges and SBE-FPs that conduct quantitative reviews of network adequacy prior to certifying plans as QHPs. Exchanges seeking to employ alternative quantitative network adequacy standards would be required to submit an exception request, in a form and manner specified by HHS, and to support their exception request with evidence-based data demonstrating that such standards ensure reasonable access as defined under § 156.230.

We further propose to require State Exchanges and SBE-FPs to require that all issuers seeking certification of plans to be offered as QHPs submit information to the respective State Exchanges or SBE-FPs about whether network providers offer telehealth services. This data would be for informational purposes; it would be

intended to help inform the future development of telehealth standards and would not be displayed to consumers. We note that this proposal is not intended to suggest that telehealth services would be counted in place of in-person service access for the purpose of meeting network adequacy standards for PY 2025. While we acknowledge the growing importance of telehealth, we want to ensure that telehealth services do not reduce the availability of in-person care. For this purpose, telehealth encompasses professional consultations, office visits, and office psychiatry services delivered through technology-based methods, including virtual check-ins, remote evaluation of pre-recorded patient data, and inter-professional internet consultations. Currently, for issuers in FFEs to comply with telehealth reporting standards, issuers must indicate whether each provider offers telehealth with the options 'Yes,' 'No,' or 'Requested information from the provider, awaiting their response.' We are proposing that State Exchanges and SBE-FPs also impose this same standard.

As discussed in the information collection requirements section of this proposed rule, we estimate that the total annual burden associated with State Exchanges and SBE-FPs establishing and imposing the proposed network adequacy standards, conducting the network adequacy reviews as proposed, collecting telehealth information from issuers seeking QHP certification, and submitting any exception to be up to 19,800 hours and to have a total cost of \$1,365,012 per year. This estimate includes State Exchanges and SBE-FPs developing the proposed standards, reviewing any issuer justification, and submitting any exception requests to HHS. We further estimate that the total annual burden associated with both medical QHP and SADP issuers in State Exchanges and SBE-FPs gathering and submitting the time and distance and telehealth data, including any justification, to the respective State Exchanges or SBE-FPs beginning in 2025 would be approximately \$114,992.

As discussed in the information collection requirements section of this proposed rule, the proposed requirement that State Exchanges and SBE-FPs collect telehealth data may increase related administrative costs for State Exchange and SBE-FP issuers that do not already possess these data, though many issuers already collect and submit this information for network adequacy submissions in other markets. While we anticipate that increased burden related to telehealth data collection would be minimal for many

State Exchange and SBE-FP issuers, the increased burden could ultimately lead to an increase in premiums for consumers. As noted previously, we believe that obtaining telehealth information and using it to inform future network adequacy standards is in the best interests of both QHP enrollees and QHP issuers. As such, we anticipate that the additional burden would be outweighed by the expected benefits.

We seek comment on the potential costs and benefits associated with this proposal.

#### 27. FFE and SBE-FP User Fee Rates for the 2025 Benefit Year (45 CFR 156.50)

We propose an FFE user fee rate of 2.2 percent of monthly premiums for the 2025 benefit year, which is the same FFE user fee rate finalized in the 2024 Payment Notice (88 FR 25845 through 25847). We also propose an SBE-FP user fee rate of 1.8 percent for the 2025 benefit year, which is the same SBE-FP user fee rate finalized in the 2024 Payment Notice. Therefore, because this proposal would impose the same user fee rates as the 2024 Payment Notice, we do not anticipate that these proposed user fee rates would have any impact on premiums compared to the 2024 benefit year. We believe that maintaining the same user fee rates as in the 2024 Payment Notice (that is, the previous benefit year) will provide stability and certainty to issuers and enrollees.

We seek comment on these impact estimates and assumptions.

#### 28. State Selection of EHB-Benchmark Plans for Plan Years Beginning on or After January 1, 2027 (45 CFR 156.111)

For plan years beginning on or after January 1, 2027, we propose to revise the standards for State selection of EHB-benchmark plans at § 156.111 to consolidate the options for States to change EHB-benchmark plans at § 156.111(a); revise the regulatory standard for States to comply with scope of benefit requirements at § 156.111(b)(2); and revise § 156.111(e)(3) to require States to submit a formulary drug list as part of their application to change EHB-benchmark plans only if the State is seeking to change their prescription drug EHB.

We understand that certain aspects of the current process to change EHB-benchmark plans under § 156.111 may impose unanticipated difficulty for and burden on States, and we have received feedback that this difficulty can have a chilling effect on States' ability to make more frequent or more substantial changes to their EHB-benchmark plans. We believe that, to the extent States take

advantage of the proposed changes to the EHB-benchmark plan standards, if finalized, States would experience an overall decrease in burden to develop new EHB-benchmark plans compared to if they were to do so under the existing requirements at § 156.111. We anticipate that these proposals would reduce the burden on States to perform additional actuarial analyses to comply with the typicality and generosity standards at § 156.111(b)(2)(i) and (ii), respectively. Instead of performing an indeterminate number of actuarial analyses to find a typical employer plan with an actuarial equivalent scope of benefits, a State may only need to perform two such actuarial analyses to identify the State's least generous typical employer plan and the State's most generous typical employer plan. Further, States would no longer need to perform an actuarial analysis to demonstrate compliance with the generosity standard at § 156.111, which we are proposing to remove as a requirement in this proposed rule. As a result, we estimate an overall decrease in burden to States utilizing this proposed provision to change their EHB-benchmark plan.

We also estimate a potential increase in burden to States and issuers to develop new policies and implement new plan designs, to the extent these proposed changes would result in more frequent or more substantial changes to EHB-benchmark plans by States. It is our aim that these proposals would allow States and issuers to offer more comprehensive and innovative benefit structures that benefit the consumer, including by addressing health equity concerns. However, we realize that this proposed policy would have varied impact on consumers depending on how a State chooses to implement these proposals. To the extent these proposed changes result in more frequent or more substantial changes to EHB-benchmark plans by States, consumers enrolled in individual and small group market plans would be impacted by changes to EHB in that their benefits may change, and in some cases, premiums could increase or decrease depending upon State implementation of the proposed policies. Additionally, a new EHB-benchmark plan selection may impact the amount of PTC and CSRs for enrollees in a State. For these consumers, subsidies would increase or decrease when compared to their State's current EHB-benchmark plan. PTC is available only for that portion of a plan's premium attributed to EHB, so to the extent that a State's EHB-benchmark plan leads to lower premiums for the second lowest cost silver plan, PTC

would be reduced, but not the percent of income a consumer with PTC is expected to contribute to their premium. This effect would represent a transfer from consumers who receive PTC to the Federal government. Individual and small group market enrollees who do not receive PTC would experience lower premiums for less comprehensive coverage that could result in more affordable coverage options but possibly higher out-of-pocket costs for the consumer. To the extent that a State's EHB-benchmark plan leads to higher premiums for the second lowest cost silver plan, we expect the opposite outcome to occur.

Consumers who have specific health needs may also be impacted by the proposed changes. In the individual and small group markets, depending on the selection made by the State in which the consumer lives, consumers with more comprehensive plans may gain coverage for certain services. In other States, again depending on State choices, consumers may no longer have coverage for some services, though we note that no State has sought to remove benefits from their EHB-benchmark plan to date under § 156.111.

Although we are uncertain as to how States might take advantage of these proposals, if finalized, and as States are not required to make any changes under this policy, we also believe the reduced burden might produce premium savings in the long-term, as States would have greater incentive to update their EHB-benchmark plans more frequently and more substantively. We believe that States with more regular and more substantive EHB-benchmark plan changes would better respond to public health priorities and would contribute to greater overall population health, which would improve the health of the State's risk pool over time and reduce plan premiums, increasing affordability of health insurance for consumers in the individual and small group markets in the State.

We stress that States would not be required to make any changes under this proposal; as already implemented at § 156.115(d)(1), if a State does not make an EHB-benchmark plan selection by the first Wednesday in May of the year that is 2 years before the effective date of the new EHB-benchmark plan, or its benchmark plan selection does not meet the requirements of this section and section 1302 of the ACA, the State's EHB-benchmark plan for the applicable plan year will be that State's EHB-benchmark plan applicable for the prior year.

As discussed in the ICR for this policy, we anticipate a total annual cost

estimate associated with this policy of approximately \$18,036.

We solicit comments on the impact of these proposals on the EHB-benchmark plan selection process and whether other impacts should be considered.

#### 29. Provision of EHB (45 CFR 156.115)

We propose to remove the regulatory prohibition at § 156.115(d) on issuers from including routine non-pediatric dental services as an EHB.

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 adult dental benefits. This would allow States greater flexibility to add benefits to improve adult oral health and overall health outcomes, which are disproportionately low among marginalized communities such as people of color and people with low incomes. Therefore, this policy would promote health equity by addressing adult oral health disparities and improving the health outcomes of vulnerable populations.

Pursuant to section 2707(b) of the ACA, a group health plan must ensure that any annual cost sharing imposed under the plan does not exceed the limitations provided for under section 1302(c)(1) of the ACA. To the extent that a group health plan selects an EHB-benchmark plan that includes non-routine pediatric dental coverage as an EHB, such plan would need to ensure that any cost sharing for those services is limited in accordance with section 1302(c)(1) of the ACA.

We do not anticipate any immediate costs to the Federal government, States, issuers, or enrollees because of this proposed policy. This proposal would simply remove the prohibition on issuers from including routine non-pediatric dental services as an EHB; it would not automatically make any routine non-pediatric dental services an EHB. This policy would only have a premium impact to the extent that States choose to include routine non-pediatric dental services in their EHB-benchmark plans. It may also increase costs for issuers to expand their networks to cover these new required services, although issuers could contract with a dental vendor to administer the routine non-pediatric dental EHB if such a benefit is adopted by a State as an EHB. It should also be noted that the size of adult dental networks varies by State. Therefore, some States would be affected by the need to build a new network of dental providers (or contract with dental vendors) more than others. It is up to each State to consider the potential costs and network burden and

determine whether to add routine non-pediatric dental services as an EHB.

We solicit comment on the impact of this proposal to remove the regulatory prohibition on issuers from including routine non-pediatric dental services as an EHB and whether other impacts should be considered.

#### 30. Prescription Drug Benefits (45 CFR 156.122)

At § 156.122(a)(3)(i), we propose to update P&T membership standards by adding a new proposed § 156.122(a)(3)(i)(E), which would require the P&T committee to include a consumer representative as part of its membership for plan years beginning on or after January 1, 2025. While there is no Federal requirement to provide compensation to P&T committee members, those plans or issuers that choose to compensate their P&T committee members for their service to the committee may incur a nominal fee when adding an additional member to the committee. Further, we estimate a potential increase in burden to States and issuers to develop criteria used to select a consumer representative for the P&T committee, to create or revise standard operating procedures for the committee, as well as for any additional training that may be required of the selectee because of the new membership standard. We believe that the impact of this burden would be most notable during the initial plan year that this policy, if finalized, goes into effect and should be minimal in future years. We solicit comments on the impact of this proposal to the P&T committee membership standards and whether other impacts should be considered.

We also propose to amend § 156.122 to codify the requirement for coverage of prescription drug benefits. Specifically, we propose to amend § 155.122 by adding a new § 156.122(f) to further clarify that, to the extent that a health plan covers drugs in excess of the benchmark, these drugs would be considered an EHB and are subject to requirements, including that cost sharing incurred for drugs must count towards the annual limitation on cost sharing and the restriction on annual and lifetime dollar limits, consistent with § 156.130. This policy would apply unless the coverage of the drug is mandated by State action and is in addition to EHB pursuant to § 155.170, in which case the drug would not be considered EHB. Given that this revision merely codifies our existing policy regarding the coverage of prescription drugs as EHB, we do not anticipate any additional burden on States or issuers.

We seek comment on these impact estimates and assumptions.

### 31. Standardized Plan Options (45 CFR 156.201)

We propose to update the standardized plan options for PY 2025 with minor changes to ensure these plans continue to have AVs within the permissible *de minimis* range for each metal level. We believe that maintaining a high degree of continuity in the approach to standardized plan options year over year minimizes the risk of disruption for interested parties, including issuers, agents, brokers, States, and enrollees. We believe that making major departures from the approach to standardized plan options set forth in the 2023 and 2024 Payment Notices could result in changes that may cause undue burden for interested parties. For example, if the standardized plan options we create vary significantly from year to year, those enrolled in these plans could experience unexpected financial harm if the cost sharing for services they rely upon differs substantially from the previous year. Ultimately, we believe consistency in standardized plan options is important to allow both issuers and enrollees to become accustomed to these plan designs.

Thus, like the approach taken in the 2023 and 2024 Payment Notices, we propose standardized plan options that would continue to resemble the most popular QHP offerings that millions of consumers are already enrolled in. As such, these proposed standardized plan options are based on updated PY 2023 cost sharing and enrollment data to ensure that these plans continue to reflect the most popular offerings in the Exchanges.

By proposing to maintain an approach to standardized plan options like that taken in the 2023 and 2024 Payment Notices, issuers would continue to be able to utilize many existing benefit packages, networks, and formularies, including those paired with standardized plan options for PY 2024. Also, issuers would continue to not be required to extend plan offerings beyond their existing service areas.

Furthermore, as discussed earlier in the preamble, we would continue to differentially display standardized plan options on *HealthCare.gov* per § 155.205(b)(1). Since we would continue to assume responsibility for differentially displaying standardized plan options on *HealthCare.gov*, FFE and SBE-FP issuers would continue to not be subject to this burden.

In addition, as noted in the preamble, we would continue enforcement of the

standardized plan option display requirements for approved web-brokers and QHP issuers using a direct enrollment pathway to facilitate enrollment through an FFE or SBE-FP—the Classic DE and EDE Pathways—at §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv), respectively. We believe that continuing the enforcement of these differential display requirements would not impose a significant burden on these entities or require major modification of their non-Exchange websites, especially since the bulk of this burden was previously imposed in the 2018 Payment Notice,<sup>282</sup> which finalized the standardized plan option differential display requirements, or during the PY 2023 open enrollment period, when enforcement of these requirements resumed.

Finally, since we would continue to allow approved web-brokers and QHP issuers to submit requests to deviate from the manner in which standardized plan options are differentially displayed on *HealthCare.gov*, the burden on these entities would continue to be minimal. We intend to continue providing access to information on standardized plan options to web-brokers through the Health Insurance Marketplace Public Use Files (PUFs) and QHP Landscape file to further minimize burden by ensuring that affected entities have timely access to accurate and helpful information on standardized plan option requirements, including those related to the differential display of these plans.

We seek comment on these impact estimates and assumptions.

### 32. Non-Standardized Plan Option Limits (45 CFR 156.202)

In this proposed rule, we propose an exceptions process at § 156.202 that would allow issuers to offer additional non-standardized plan options more than the limit of two per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area if particular requirements are met. We previously finalized this limit in the 2024 Payment Notice (88 FR 25855 through 25865).

Specifically, issuers would be permitted to offer more than two non-standardized plan options if these additional plans' cost sharing for benefits pertaining to the treatment of chronic and high-cost conditions (including benefits in the form of prescription drugs, if pertaining to the treatment of the condition(s)) is at least

25 percent lower, as applied without restriction in scope throughout the plan year, than the cost sharing for the same corresponding benefits in an issuer's other non-standardized plan option offerings in the same product network type, metal level, and service area. The reduction could not be limited to a part of the year, or an otherwise limited scope of benefits. Instead, issuers would be required to apply the reduced cost sharing for these benefits any time the covered item or service is furnished. For example, an issuer could not reduce cost sharing for the first three office visits or drug fills and then increase it for remaining visits or drug fills. Furthermore, issuers would be prohibited from conditioning reduced cost sharing for these benefits on a particular diagnosis. That is, although the benefit design would have reduced cost sharing to address one or more articulated conditions, the reduced cost sharing must be available to all enrolled in the plan who receive the service(s) covered by the benefit.

Under this proposal, no other plan design features (such as the inclusion of additional benefit coverage, different provider networks, different formularies, or reduced cost sharing for benefits provided through the telehealth modality) would be evaluated under this exceptions process, meaning no other differences in plan design features would allow issuers to be excepted from the limit to the number of non-standardized plan options offered per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area.

We do not anticipate that the exceptions process proposed in this rule would substantially impact the average weighted number of non-standardized plan options available to each consumer, the average weighted number of standardized plan options available to each consumer, the average weighted number of total plan options available to each consumer, the number of plan-county discontinuations, or the number of affected enrollees since we do not anticipate a substantial number of issuers would utilize this exceptions process to offer the aforementioned additional non-standardized plan options that would substantially benefit consumers with chronic and high-cost conditions. This is because we expect that most issuers would believe that the burden of creating and certifying additional plans intended to benefit a comparatively small population of consumers would outweigh the benefit of doing so. We also previously solicited comment on innovative plan designs, such as in the 2024 Payment Notice

<sup>282</sup> These differential display requirements were first effective and enforced beginning with PY 2018. See 81 FR 94117 through 94118, 94148.

proposed rule, but received only two examples of such plan designs.

Although we do not anticipate that a substantial number of issuers would utilize this exceptions process, we acknowledge that issuers that choose to do so would be impacted. Specifically, if issuers choose to utilize this exceptions process, they would be required to design additional non-standardized plan options and proceed through QHP certification for these plans, which would necessarily entail additional burden.

Furthermore, issuers would be required to submit a written justification in a form and manner and at a time prescribed by HHS that would: (1) identify the specific condition(s) for which cost sharing is reduced, (2) explain which benefits would have reduced annual enrollee cost sharing (as opposed to reduced cost sharing for a limited number of visits) for the treatment of the specified condition(s) by 25 percent or more relative to the cost sharing for the same corresponding benefits in an issuer's other non-standardized plan offerings in the same product network type, metal level, and service area, and (3) explain how the reduced cost sharing for these services pertain to clinically indicated guidelines for treatment of the specified chronic and high-cost condition(s). We estimate the burden of this would be approximately \$95,182 for an estimated 50 issuers annually, and we discuss this burden in further detail in the ICRs Regarding Non-Standardized Plan Option Limits (§ 156.202) section of the Collection of Information Requirements section of this proposed rule.

We also acknowledge that this exceptions process could impact consumers in a range of ways. Specifically, if we were to finalize this proposed exceptions process, and if issuers choose to utilize this exceptions process to offer additional non-standardized plan options, consumers with qualifying chronic and high-cost conditions would benefit from reduced cost sharing for benefits that pertain to the treatment of these conditions. We reiterate that, for purposes of this standard, chronic conditions are those that have an average duration of one year or more and require ongoing medical attention or limit activities of daily living, or both. We also reiterate that, for purposes of this standard, high-cost conditions are those that account for a disproportionately high portion of total Federal health expenditures. Reduced cost sharing for these benefits would reduce barriers to access to benefits important to consumers with these chronic and high-cost conditions,

which could play an important role in combatting health disparities and advancing health equity since disadvantaged populations<sup>283</sup> are disproportionately affected by many of these conditions.<sup>284</sup> In addition to enhancing health outcomes, this exceptions process could also reduce the risk of financial harm to individuals with chronic and high-cost conditions by reducing their cost sharing obligations for treatment for those conditions.

We do not have sufficient data to further estimate the costs associated with these proposed changes. As such, we seek comment from interested parties regarding cost estimates associated with this proposal and data sources that may be used to determine those estimates.

### 33. CO-OP Loan Terms (45 CFR 156.520)

In this rule, we propose to revise § 156.520(f) to provide a clear mechanism by which an existing CO-OP may request termination of its loan agreement with CMS to enable it to pursue new, innovative business plans that are otherwise not compatible with CO-OP requirements, but which CMS believes would be in the best interest of affected consumers. Of the 23 CO-OP loan agreements CMS successfully executed with qualified borrowers in 2012, only 3 remain in operation as active insurance companies offering QHPs. The others have been placed in receivership by State regulators, or otherwise gone out of business due to the borrower's inability to establish a viable CO-OP that is financially stable and on course to ultimately repay the loans. As discussed in section III.E.8 of this preamble, CO-OPs operate under governance and product limitations that can present significant obstacles to new business opportunities. To provide a means to overcome these limitations, under the proposed revisions to § 156.520(f), we would be able to consider proposals initiated by a CO-OP to terminate its loan agreement with us if we believe the proposal would benefit consumers by enhancing consumer access to quality, affordable, member-focused, non-profit health care options in affected markets. Examples of such proposals that may be deemed

<sup>283</sup> Disadvantaged populations are groups of persons that experience a higher risk of poverty, social exclusion, discrimination, and violence than the general population, including, but not limited to, ethnic minorities, migrants, people with disabilities, isolated elderly people, and children.

<sup>284</sup> Waters, H., & Graf, M. (2018). The Cost of Chronic Disease in the U.S. Milken Institute. [https://milkeninstitute.org/sites/default/files/reports-pdf/ChronicDiseases-HighRes-FINAL\\_2.pdf](https://milkeninstitute.org/sites/default/files/reports-pdf/ChronicDiseases-HighRes-FINAL_2.pdf).

innovative and in the interests of consumers would be plans that appear well-calculated to lead directly to marketing non-profit, member-focused health plans in new regions of a State, to offer health plans on a Statewide basis for the first time, to expand operations into new States, or enhance consumer access to new non-profit products that are not qualified health plans, in particular when such plans are likely to favorably impact traditionally underserved communities. These examples are illustrative, however, not exclusive.

This regulatory proposal also contemplates plans that involve non-profit enterprises, and that reflect a strong consumer focus. A strong consumer focus would generally consist of an enterprise that focuses informational or financial resources, or plans to focus informational or financial resources, on member-oriented programs such as health education, consumer education, or forms of direct or indirect health-related financial assistance. We recognize that significant coordination with State regulators would be essential to implementing any plans to act on the proposed regulatory changes, if finalized.

Given that only three CO-OPs remain in business operating with small portfolios across five States, we do not believe there would be a significant economic impact because of this proposal for at least several years, if ever. We seek comment on these impact estimates and assumptions.

### 34. Conforming Amendment to Netting Regulation To Include Federal IDR Administrative Fees (45 CFR 156.1215)

We propose to amend § 156.1215(b) and (c) to align with the policies and regulations proposed in the Federal Independent Dispute Resolution Operations proposed rule (88 FR 75744). If finalized, these amendments would provide that administrative fees for utilizing the No Surprises Act Federal IDR process for health insurance issuers that participate in financial programs under the ACA would be subject to netting as part of HHS' integrated monthly payment and collections cycle.

To implement this policy, we propose to amend § 156.1215(b) to allow HHS to net payments owed to issuers and their affiliates operating under the same TIN against amounts due to the Federal government from the issuers and their affiliates operating under the same TIN for APTC, advance payments of and reconciliation of CSRs, payment of FFE user fees, payment of SBE-FP user fees, HHS risk adjustment, reinsurance, and risk corridors payments and charges,

and administrative fees from these issuers and their affiliates for utilizing the Federal IDR process in accordance with § 149.510(d)(2). 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 administrative fees due to the Federal government from these issuers and their affiliates for utilizing the Federal IDR process after netting under proposed § 156.1215(b) would be the basis for calculating a debt owed to the Federal government.

We do not believe that the proposed amendments would impose substantial additional costs to HHS beyond the costs previously estimated in the Federal Independent Dispute Resolution Process proposed rule.<sup>285</sup> Furthermore, this proposal would only apply to those issuers and their affiliates operating under the same TIN that participate in the financial programs under the ACA. Since the provisions of the Federal IDR process apply more broadly to include issuers and their affiliates that do not participate in the financial programs under the ACA currently specified in the list of programs for which netting is permitted,<sup>286</sup> we believe that only a small proportion of issuers that utilize the Federal IDR process would be subject to netting under this proposal.

Therefore, we anticipate that this proposal would streamline our payments and collections processes and limit the administrative burden for operating our programs.

We seek comment on these impact estimates and assumptions.

### 35. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on last year's proposed rule (286) will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed last year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons, we believe that the number of past

commenters would be a fair estimate of the number of reviewers of this rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore, for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. We seek comments on this assumption.

Using the wage information from the BLS for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this rule is \$100.80 per hour, including overhead and fringe benefits.<sup>287</sup> Assuming an average reading speed of 250 words per minute, we estimate that it would take approximately 4.75 hours for the staff to review half of this proposed rule. For each entity that reviews the rule, the estimated cost is \$478.80 (4.75 hours × \$100.80 per hour). Therefore, we estimate that the total cost of reviewing this regulation is approximately \$136,937 (\$478.80 per reviewer × 286 reviewers).

### D. Regulatory Alternatives Considered

For the HHS-operated risk adjustment program (§ 153.320), we propose to recalibrate the CSR adjustment factors for AI/AN zero cost sharing and limited cost sharing CSR plan variant enrollees for the 2025 benefit year, and we propose to retain the proposed AI/AN CSR adjustment factors for future benefit years unless changed through notice-and-comment rulemaking. We also propose to maintain the current CSR adjustment factors for silver plan variant enrollees (70 percent, 73 percent, 87 percent, and 94 percent AV plan variants)<sup>288</sup> for the 2025 benefit year and beyond, unless changed through notice-and-comment rulemaking. As an alternative, we considered not proposing any changes to the CSR adjustment factors used in the State payment transfer formula. However, after continuing to conduct analyses on more recently available enrollee-level EDGE data, we found the underprediction of plan liability in the State payment transfer formula for AI/AN zero cost sharing and limited cost sharing CSR plan variant enrollees continued. We also considered recalibrating all the silver CSR adjustment factors. However, we are not

proposing any changes to those factors at this time, because we continue to find that the current silver CSR adjustment factors (70 percent, 73 percent, 87 percent, and 94 percent plan variants) are reasonably accurately predicted given the offsets, described above, that continue to occur for these enrollees.

As an alternative to our proposed amendments to § 155.315(e), we considered using an electronic data source other than PUPS to verify applicant incarceration status. However, we estimate that sourcing an alternative national incarceration verification data source would be a significant expense to HHS, costing the agency approximately \$35 million annually. Additionally, these other data sources are currently not sufficiently comprehensive to meet the needs of the Exchanges using the Federal eligibility and enrollment platform and therefore may not provide Exchanges with accurate results on a consistent basis. Thus, the alternative data source must be current, accurate, and minimize burden and costs to administration.

About the proposed changes to § 155.320(c), we considered taking no action to add new language in paragraph (c)(1)(iii) that State Exchanges and State Medicaid agencies must pay in advance for their use of the VCI Hub service to verify income. However, we determined that this proposed reinterpretation and proposed policy change is appropriate given our better understanding of how the VCI Hub service is used by State Exchanges and State Medicaid agencies to verify eligibility for QHP coverage or other insurance affordability programs. We also considered requiring State Medicaid agencies and State Exchanges to obtain their own contracts to administer their CSI data usage; however, we had concerns that these services cannot be procured reasonably and expeditiously, which would undermine the system we have implemented under section 1413 of the ACA. We also believe that there may be benefits to the State Medicaid agencies and State Exchanges that prefer to use the CSI data accessible through the VCI Hub service in their States. Therefore, we propose to retain optional access to the VCI Hub service on behalf of State Medicaid agencies and State Exchanges that prefer to continue to use this service and are willing to pay for their CSI data usage in advance. Under this proposal, State Medicaid agencies and State Exchanges can choose to discontinue their use of the CSI data accessible through the VCI Hub service. As described in the preamble of this rulemaking, we are also seeking comment on an alternative approach

<sup>285</sup> 88 FR 75814 through 75815.

<sup>286</sup> See 86 FR at 55982 (explaining that the No Surprises Act applies to group health plans and health insurance issuers offering group or individual health insurance coverage in the Code, ERISA, and the PHS Act).

<sup>287</sup> [https://www.bls.gov/oes/current/oes\\_nat.htm](https://www.bls.gov/oes/current/oes_nat.htm).

<sup>288</sup> See 83 FR 16930 at 16953; 84 FR 17478 through 17479; 85 FR 29190; 86 FR 24181; 87 FR 27235 through 27236; and 88 FR 25772 through 25774.

that we could finalize that would have HHS invoice States on a monthly basis for their actual utilization of CSI data provided by the VCI Hub service after that utilization occurs.

About amending 155.330(d)(2), we have considered maintaining the status quo for continuing the PDM requirements under § 155.330(d)(1)(i) and (d)(ii) but note that it may be difficult or infeasible to operationalize existing processes and operations during certain emergency situations. Allowing consumers to go uninsured during a national emergency, such as a public health emergency like the COVID-19 public health emergency, will not improve the national health and well-being of all consumers. We found it to be least burdensome for Exchanges to implement as a successful pause of PDM operations occurred during the 2020 pandemic.

We considered only updating sub-regulatory guidance to incorporate catastrophic coverage into the auto re-enrollment hierarchy, for example, through the annual draft and final Letters to Issuers. However, we believe that instead incorporating catastrophic coverage into the auto re-enrollment hierarchy in regulation at § 155.335(j) creates stronger authority for Exchanges to auto re-enroll catastrophic enrollees and provides better transparency for our auto re-enrollment operations in the Exchanges on the Federal platform.

We considered taking no action regarding the proposal to amend § 155.400(e)(2) to codify that the flexibility for issuers experiencing billing or enrollment problems due to high volume or technical errors is not limited to extensions of the binder payment. However, we believe it is important to clarify for interested parties that HHS may provide enforcement discretion for other premium payment requirements.

We considered taking no action related to amending § 155.420(d)(16), to revise the parameters around the availability of a SEP that grants APTC-eligible qualified individuals with a projected household income at or below 150 percent of the FPL. However, HHS believes that many consumers will benefit from having additional opportunities to enroll in low-cost Exchange coverage, and that those who will be eligible for this special enrollment period and who do not enroll during the annual open enrollment period are likely to have been unaware of their option to enroll in a plan with no monthly premium through the Exchange, after application of APTC.

We considered taking no action regarding our proposal to modify § 155.430(b)(1)(iv) to permit enrollees in Exchanges on the Federal Platform to retroactively terminate coverage back to the date in which they retroactively enroll in Medicare Part A. However, we believe it is important to allow enrollees to retroactively terminate coverage when they were unable to do so prospectively due to retroactive enrollment in Medicare coverage. We considered whether to also permit Exchange enrollees to retroactively terminate coverage back to the date in which they enrolled in Medicaid, CHIP, or BHP coverage retroactively, but we determined that this would not be appropriate due to the increased risk that claims reversed by QHP issuers would not be covered by providers under these programs.

For standardized plan options (§ 156.201), we considered a range of proposals, such as modifying the methodology used to create the standardized plan options for PY 2025. Specifically, we considered lowering the deductibles in these plan designs and offsetting this increase in plan generosity by increasing cost sharing amounts for several benefit categories. We also considered simultaneously maintaining the current cost-sharing structures and decreasing the deductibles for these plan designs, which would increase the AVs of these plans to the ceiling of each *AV de minimis* range. Ultimately, we decided to propose to maintain the AVs of these plans near the floor of each *de minimis* range by largely maintaining the cost sharing structures and deductible values from the standardized plan options from PY 2024, as well as by increasing the MOOP values and, to a lesser degree, the deductible values for these plan designs. We believe this proposed approach strikes the greatest balance in providing enhanced pre-deductible coverage while ensuring competitive premiums for these standardized plan options.

For non-standardized plan option limits (§ 156.202), we considered a range of proposals. Specifically, for PY 2025 and subsequent years, we considered maintaining the PY 2024 limit of four non-standardized plan options per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area. We also considered not proposing an exceptions process that would allow issuers to offer non-standardized plan options more than the limit of two that we previously finalized for PY 2025 and subsequent years. We also considered basing this exceptions process on a

range of other factors, including the degree of plan proliferation in a given service area (as determined by the number of plan offerings per consumer or issuer), whether a plan has a sufficiently differentiated network, and whether a plan has a sufficiently differentiated formulary. We also considered permitting issuers to request to offer only one additional non-standardized plan option per product network type, metal level, and service area, as opposed to an indefinite number (as in the current proposal). We also considered permitting exceptions only for an exclusive list of chronic and high-cost conditions, as opposed to any condition that is chronic and high-cost in nature (as described in the current proposal).

However, we ultimately decided to propose an exceptions process that would allow issuers to offer more than two non-standardized plan options if these additional plans' cost sharing for benefits pertaining to the treatment of chronic and high-cost conditions (including benefits in the form of prescription drugs, if pertaining to the treatment of the condition(s)) is at least 25 percent lower, as applied without restriction in scope throughout the plan year, than the cost sharing for the same corresponding benefits in an issuer's other non-standardized plan option offerings in the same product network type, metal level, and service area, which is discussed in greater detail in section III.E.7 of the preamble to this rule.

We proposed this approach primarily because we believe that allowing exceptions to the non-standardized plan option limit of two could play an important role in enhancing the quality of life for those affected by these conditions, combatting health disparities, advancing health equity, and reducing health care expenditures. We further believe that introducing this exceptions process would balance the dual aims of reducing the risk of plan choice overload while simultaneously ensuring that issuers can continue to offer truly innovative plan designs that may benefit consumers with chronic and high-cost conditions.

#### *E. Regulatory Flexibility Act (RFA)*

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that small businesses, nonprofit organizations, and small governmental jurisdictions are small entities as that term is used in the RFA. The great majority of hospitals and most



other healthcare providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than \$8.0 million to \$41.5 million in any 1 year). We do not anticipate that providers would be directly impacted by the provisions in this proposed rule. Individuals and States are not included in the definition of a small entity. The provisions in this proposed rule would affect issuers, agents, brokers, web-brokers, and DE entities.

For purposes of the RFA, we believe that health insurance issuers and DE entities<sup>289</sup> will be classified under the North American Industry Classification System (NAICS) code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of \$47 million or less will be considered small entities for these NAICS codes. Issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard will be \$44.5 million or less.<sup>290</sup> We believe that few, if any, insurance companies underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) fall below these size thresholds. Based on data from MLR annual report submissions for the 2021 MLR reporting year, approximately 87 out of 483 issuers of health insurance coverage nationwide had total premium revenue of \$47 million or less.<sup>291</sup> This estimate may overstate the actual number of small health insurance issuers that may be affected, since over 77 percent of these small issuers belong to larger holding groups, and many, if not all, of these small companies are likely to have non-health lines of business that will result in their revenues exceeding \$47 million. Therefore, although it is likely that fewer than 87 issuers are considered small entities, for the purposes of this analysis, we assume 87 small issuers/DE entities would be impacted by this proposed rule.

We further believe that agents, brokers, and web-brokers will be classified under NAICS code 524210 (Insurance Agencies and Brokerages). According to SBA size standards, entities with average annual receipts of \$15 million or less will be considered small entities for these NAICS codes. Therefore, based on SBA data and for

purposes of this analysis, we assume 122,547 agents, brokers, and web-brokers are small entities. However, the policies impacting agents, brokers, and web-brokers proposed in this rule would only impact such entities in States with State Exchanges that host web-broker programs. Currently, no States with State Exchanges host web-broker programs, but we estimate 5 States could opt to host a web-broker program for their State Exchange in the future. We further estimate that 20 web-brokers could operate in those States in the future and seek comment on this estimate.

The proposed policies that would result in an increased burden to small entities are described below.

We propose to require issuers of risk adjustment covered plans to complete, implement, and provide to HHS written documentation of any corrective action plans when required by HHS if a high-cost risk pool audit results in the inclusion of a finding or certain observations in the final audit report. The annual burden per issuer associated with this proposal is \$627. For more details, please refer to the Regulatory Impact Analysis section associated with this policy in this proposed rule.

We propose to apply to agents, brokers, and web-brokers operating in State Exchanges that operate their own eligibility and enrollment platform, and consequently in State Exchanges, for both the State Exchange's Individual Exchange and SHOP, certain existing Federal standards regarding web-brokers assisting consumers with enrolling in QHPs and applying for APTC/CSRs. The one-time burden per agent, broker, or web-broker associated with this proposal is \$48,587. For more details, please refer to the information collection requirements section associated with this policy in this proposed rule.

We propose to require that display changes adopted by *HealthCare.gov* be reflected on DE entity websites within a time period specified by HHS, unless HHS approves a deviation. The annual burden associated with this proposal is \$2,608 (\$2,401 to comply with the requirements and \$207 to make a request to deviate from the requirements). For more details, please refer to the information collection requirements section associated with this policy in this proposed rule.

We propose to apply to DE entities operating in State Exchanges that operate their own eligibility and enrollment platform, and consequently State Exchanges that utilize DE entities, certain existing Federal standards regarding DE entities assisting consumers with enrolling in QHPs and applying for APTC/CSRs, both for the State Exchanges Individual Exchange and SHOP program. The one-time burden per DE entity associated with this proposal is \$138,447. For more details, please refer to the information collection requirements section associated with this policy in this proposed rule.

We also propose to require State Exchange and SBE-FP issuers to gather and submit network adequacy data, including time and distance data and telehealth data. The annual burden per issuer associated with this proposal is \$689. For more details, please refer to the information collection requirements section associated with this policy in this proposed rule.

Finally, we propose to permit issuers to offer non-standardized plan options in excess of the limit of two per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area for PY 2025 and subsequent years, if issuers demonstrate that these additional non-standardized plans beyond the limit at § 156.202(b) have specific design features that would substantially benefit consumers with chronic and high-cost conditions. The annual burden per issuer associated with this proposal is \$1,904. For more details, please refer to the information collection requirements section associated with this policy in this proposed rule.

Thus, the per-entity estimated annual cost for small issuers and DE entities is \$5,828, and the total estimated annual cost for small issuers and DE entities is \$507,036. The per-entity estimated one-time cost for small issuers and DE entities is \$138,447, and the total estimated one-time cost for small issuers and DE entities is \$12,044,889. The per-entity estimated one-time cost for small agents, brokers, and web-brokers is \$48,587, and the total estimated one-time cost for small agents, brokers, and web-brokers is \$971,740. There is no estimated annual cost for small agents, brokers, and web-brokers. See Tables 19, 20, 21, and 22.

<sup>289</sup> DE entities are QHP issuers approved by CMS to enroll consumers in Exchange coverage directly from their websites.

<sup>290</sup> <https://www.sba.gov/document/support-table-size-standards>.

<sup>291</sup> <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

**TABLE 19: Detailed Annual Costs for Small Entities**

Description of Cost	Annual Cost per Small Issuer/DE Entity
High-cost risk pool audit	\$627
Applying <i>HealthCare.gov</i> display changes	\$2,608
Network adequacy	\$689
Non-standardized plan options	\$1,904
Total	\$5,828

**TABLE 20: Aggregate Annual Costs for Small Entities**

Affected Entity	Affected Small Entities	Annual Cost per Entity	Aggregate Annual Cost for Small Entities
Issuers/DE entities	87	\$5,828	\$507,036

**TABLE 21: One-Time Costs for Small Entities**

Description of Cost	One-Time Cost per Small Issuer/DE Entity	One-Time Cost per Small Agent, Broker, or Web-broker
Applying Federal standards to State Exchange entities	\$138,447	\$48,587
Total	\$138,447	\$48,587

**TABLE 22: Aggregate One-Time Costs for Small Entities**

Affected Entity	Affected Small Entities	One-Time Cost per Entity	Aggregate One-Time Cost for Small Entities
Issuers/DE entities	87	\$138,447	\$12,044,889
Agents, brokers, and web-brokers	20	\$48,587	\$971,740

The annual cost per small issuer/DE entity of \$5,828 is approximately 0.32 percent of the average annual receipts per small issuer. We anticipate that small issuers could pass on these increased costs to consumers in the form of higher premiums, resulting in an increase in receipts commensurate with the increase in costs. However, because the proportion of cost to receipts is so small, we anticipate this would have a *de minimis* impact on premiums, if any impact at all. We seek comment on this assumption.

We seek comment on this analysis and seek information on the number of small issuers/DE entities, agents, brokers, or web-brokers that may be affected by the provisions in these proposed rules.

As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent. We do not believe that this threshold will be reached by the

requirements in this proposed rule, given that the annual per-entity cost of \$5,828 per small issuer represents approximately 0.32 percent of the average annual receipts for a small issuer,<sup>292</sup> and there is no annual per-entity cost per small agent, broker, or web-broker. Therefore, the Secretary has certified that this proposed rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For the purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is

located outside of a metropolitan statistical area and has fewer than 100 beds. While this rule is not subject to section 1102 of the Act, we have determined that this rule will not affect small rural hospitals. Therefore, the Secretary has certified that this proposed rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

#### *F. Unfunded Mandates Reform Act (UMRA)*

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2023, that threshold is approximately \$177 million. Although we have not been able to quantify all costs, we expect that the combined impact on State, local, or Tribal governments and the private

<sup>292</sup> United States Census Bureau (March 2020). *2017 SUSB Annual Data Tables by Establishment Industry, Data by Enterprise Receipt Size*. <https://www.census.gov/data/tables/2020/econ/susb/2020-susb-annual.html>.

sector does not meet the UMRA definition of unfunded mandate.

### *G. Federalism*

Executive Order 13132 establishes certain requirements that an agency must meet when it 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 rule, we attempted to balance the States' interests in regulating health insurance issuers with the need to ensure market stability. By doing so, we complied with the requirements of E.O. 13132.

Because States have flexibility in designing their Exchange and Exchange-related programs, State decisions will ultimately influence both administrative expenses and overall premiums. States are not required to establish an Exchange or risk adjustment program. For States that elected previously to operate an Exchange, those States had the opportunity to use funds under Exchange Planning and Establishment Grants to fund the development of data. Accordingly, some of the initial cost of creating programs was funded by Exchange Planning and Establishment Grants. After establishment, Exchanges must be financially self-sustaining, with revenue sources at the discretion of the State. Current State Exchanges charge user fees to issuers.

In our view, while this proposed rule will not impose substantial direct requirement costs on State and local governments, this regulation has Federalism implications due to potential direct effects on the distribution of power and responsibilities among the State and Federal Governments relating to determining standards relating to health insurance that is offered in the individual and small group markets. For example, we propose to add requirements by which a State seeking to transition to a State Exchange provide the public with a notice and copy of its State Exchange Blueprint application. We further propose to require that a State, within 3 months of submitting its

State Exchange Blueprint to HHS for approval, conduct at least one public hearing whereby interested parties can learn about the State's intent to transition, as well as a State's progress toward transitioning, and conduct regular hearings every 3 months until the transition is complete. However, we believe the Federalism implications of this proposal are mitigated because States have the option to establish their own Exchange, and we do not anticipate any additional burden on States because of this proposal.

We believe that the proposal to revise § 155.220(h) does not have Federalism implications as the CMS Administrator review of agent, broker, and web-broker requests for reconsideration of decisions to terminate their Exchange agreement(s) is not based on State law, nor does it prevent a State from taking other legal actions under State law against an entity whose Exchange agreement(s) are terminated for cause by HHS.

We believe that the proposals to revise §§ 155.220 and 155.221 to apply certain web-broker and DE entity standards to State Exchanges that operate their own eligibility and enrollment platform may have Federalism implications, but they are substantially mitigated by allowing State Exchanges to leverage the oversight framework established by HHS for Exchanges that utilize the Federal Platform to evaluate web-broker and DE entity operational readiness to participate in an Exchange. We expect State Exchanges would be able to leverage audits conducted for the FFEs and SBE-FPs, as well as disclaimer language developed by HHS, while State operational costs would include any State-specific requirements or language to be added at the States' discretion. We believe that providing State Exchanges the opportunity to leverage the FFEs' oversight framework would likely reduce costs to State Exchanges as compared to the costs associated with State Exchanges establishing an independent framework for oversight and web-broker or DE entity approval independent of the FFEs.

We believe that the proposal to revise § 155.315(e) has Federalism implications due to our proposal to use existing requirements and flexibilities under § 155.315(e) permitting all Exchanges to accept consumer attestation of incarceration status without further electronic verification. However, Exchanges that wish to continue electronically verifying an individual's incarceration status would be permitted to do so, if HHS determines their data source is current, accurate,

and minimizes administrative costs and burdens.

In addition, we believe this proposed rule does have Federalism implications due to the proposed revisions pertaining to State selection of EHB-benchmark plans. The existing requirements pertaining to State selection of EHB-benchmark plans at § 156.111 already imposed Federalism implications on States that choose to change or revise their EHB-benchmark plans. As discussed elsewhere in this proposed rule, we understand that certain aspects of the current process to change or revise EHB-benchmark plans may impose unanticipated difficulty on and create confusion for States. Accordingly, the proposals to revise § 156.111 are intended to reduce State burden and confusion to change or revise EHB-benchmark plans. As a result, we believe the proposals to revise § 156.111 would reduce the existing Federalism implications.

We believe that our proposal to amend § 155.320 by adding new paragraph (c)(1)(iii) does have Federalism implications for States given that State Exchanges and State Medicaid agencies use the VCI Hub service. However, we believe that the Federalism implications are mitigated as State Exchanges and State Medicaid agencies continue to have flexibility as the use of the VCI Hub service is optional and that States continue to have flexibility under § 155.315(h) and § 155.320(c)(3)(iv) to use other data sources, like State wage data, when income is not verified using IRS tax data or SSA Title II data.

We believe that our proposal to amend § 155.420(d)(16) has Federalism implications; however, we believe that by maintaining the 150 percent FPL SEP to be available at the option of the Exchange, these implications are mitigated because we allow State Exchanges to decide whether to implement it based on their specific market dynamics, needs, and priorities.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on XX XX, 2023.

### **List of Subjects**

#### *31 CFR Part 33*

Health care, Health insurance, and Reporting and recordkeeping requirements.

#### *42 CFR Part 435*

Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa.

**42 CFR Part 600**

Administrative practice and procedure, Health care, health insurance, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements.

**45 CFR Part 153**

Administrative practice and procedure, Health care, Health insurance, Health records, Intergovernmental relations, Organization and functions (Government agencies), Reporting and recordkeeping requirements.

**45 CFR Part 155**

Administrative practice and procedure, Advertising, Brokers, Conflict of interests, Consumer protection, Grants administration, Grant programs-health, Health care, Health insurance, Health maintenance organizations (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Intergovernmental relations, Loan programs-health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, Technical assistance, Women and youth.

**45 CFR Part 156**

Administrative practice and procedure, Advertising, Advisory committees, Brokers, Conflict of interests, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs-health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, and Youth.

**Department Of The Treasury**

For the reasons set forth in the preamble, the Department of the Treasury proposes to amend 31 CFR subtitle A, part 33 as set forth below:

**PART 33—WAIVERS FOR STATE INNOVATION**

■ 1. The authority citation for part 33 continues to read as follows:

**Authority:** Sec. 1332, Pub. L. 111–148, 124 Stat. 119.

■ 2. Section 33.112 is amended by adding paragraph (c)(3) to read as follows:

**§ 33.112 State public notice requirements.**

\* \* \* \* \*

(c) \* \* \*

(3) Such public hearings shall be conducted in an in-person, virtual (that is, one that uses telephonic, digital, and/or web-based platforms), or hybrid (that is, one that provides for both in-person and virtual attendance) format.

\* \* \* \* \*

■ 3. Section 33.120 is amended by revising paragraph (c) introductory text to read as follows:

**§ 33.120 Monitoring and compliance.**

\* \* \* \* \*

(c) *Post award.* Within at least 6 months after the implementation date of a section 1332 waiver and annually thereafter, a State must hold a public forum to solicit comments on the progress of a section 1332 waiver. The State must hold the public forum at which members of the public have an opportunity to provide comments and must provide a summary of the forum to the Secretary as part of the quarterly report specified in § 33.124(a) that is associated with the quarter in which the forum was held, as well as in the annual report specified in § 33.124(b) that is associated with the year in which the forum was held. The public forum shall be conducted in an in-person, virtual (that is, one that uses telephonic, digital, and/or web-based platforms), or hybrid (that is, one that provides for both in-person and virtual attendance) format.

\* \* \* \* \*

**Department Of Health And Human Services**

For the reasons set forth in the preamble, under the authority at 5 U.S.C. 301, the Department of Health and Human Services proposes to amend 42 CFR chapter IV, subchapters C and I, and 45 CFR subtitle A, subchapter B, as set forth below.

**Title 42 Public Health****PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA.**

■ 1. The authority citation for part 435 continues to read as follows:

**Authority:** 42 U.S.C 1302.

**§ 435.601 [Amended]**

■ 2. Section 435.601 is amended by removing paragraph (d)(4), redesignating paragraph (d)(5) as paragraph (d)(4).

**PART 600—ADMINISTRATION, ELIGIBILITY, ESSENTIAL HEALTH BENEFITS, PERFORMANCE STANDARDS, SERVICE DELIVERY REQUIREMENTS, PREMIUM AND COST SHARING, ALLOTMENTS, AND RECONCILIATION**

■ 3. 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).

■ 4. Section 600.320 is amended by revising paragraph (c) to read as follows:

**§ 600.320 Determination of eligibility for and enrollment in a standard health plan.**

\* \* \* \* \*

(c) *Effective date of eligibility.* The State must establish a uniform method of determining the effective date of eligibility for enrollment in a standard health plan which –

(1) Follows the Exchange effective date standards at 45 CFR 155.420(b)(1);

(2) Follows the Medicaid effective date standards at 42 CFR 435.915 exclusive of § 435.915(a); or

(3) Follows an effective date of eligibility of the first day of the month following the month in which BHP eligibility is determined.

\* \* \* \* \*

**Title 45 Public Welfare****PART 153—STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND HHS RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT**

■ 5. The heading for Part 153 is revised to read as set forth above:

■ 6. The authority citation for part 153 continues to read as follows:

**Authority:** 42 U.S.C. 18031, 18041, and 18061 through 18063.

■ 7. Section 153.620 is amended by revising the section heading and paragraph (c)(4) introductory text to read as follows:

**§ 153.620 Compliance with HHS risk adjustment standards.**

\* \* \* \* \*

(c) \* \* \*

(4) *Final audit findings.* If an audit results in the inclusion of a finding or observation in the final audit report, the issuer must comply with the actions set forth in the final audit report in the manner and timeframe established by HHS, and the issuer must complete all of the following, if required by HHS:

\* \* \* \* \*

**PART 155—EXCHANGE  
ESTABLISHMENT STANDARDS AND  
OTHER RELATED STANDARDS  
UNDER THE AFFORDABLE CARE ACT**

■ 8. 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.

■ 9. Section 155.105 is amended—

■ a. In paragraph (b)(2) by removing “and” after the semicolon;

■ b. In paragraph (b)(3) by removing “.,” and adding in its place “; and”; and

■ c. Adding paragraph (b)(4).

The revision reads as follows:

**§ 155.105 Approval of a State Exchange.**

\* \* \* \* \*

(b) \* \* \*

(4) The Exchange first operates successfully a State Exchange on the Federal platform under § 155.106(c), meeting all requirements established under § 155.200(f), for at least one plan year, including its first open enrollment period, as part of the establishment of a State Exchange.

\* \* \* \* \*

■ 10. 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. HHS requires that a State submitting a Blueprint Application to operate a State Exchange provide, upon request, supplemental documentation to HHS detailing the State’s implementation of its State Exchange functionality.

(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.

\* \* \* \* \*

■ 11. Section 155.170 is amended by revising paragraph (a)(2) to read as follows:

**§ 155.170 Additional required benefits.**

(a) \* \* \*

(2) A benefit required by State action taking place on or before December 31, 2011, a benefit required by State action for purposes of compliance with Federal requirements, or a benefit covered in the State’s EHB-benchmark plan is considered an EHB. A benefit required by State action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements that is not a benefit covered in the State’s EHB-benchmark plan, is considered in addition to the essential health benefits.

\* \* \* \* \*

■ 12. Section 155.205 is amended by revising paragraphs (a) introductory text and (b)(4) and (5) to read as follows:

**§ 155.205 Consumer assistance tools and programs of an Exchange.**

(a) *Call center.* If the Exchange is not an Exchange described in paragraphs (a)(1) or (2) of this section, the Exchange must provide for operation of a toll-free call center that addresses the needs of consumers requesting assistance and meets the requirements outlined in paragraphs (c)(1), (c)(2)(i), and (c)(3) of this section. At a minimum, the Exchange call center must provide consumers with access to a live call center representative during an Exchange’s published hours of operation and a live call center representative who must be able to assist consumers with their QHP application, including providing

consumers with information on their eligibility for advance premium tax credits and cost-sharing reductions, helping consumers understand their QHP options, helping consumers select a QHP, and helping consumers submit QHP enrollment applications to the Exchange. If the Exchange is an Exchange described in paragraphs (a)(1) or (2) of this section, the Exchange must provide at a minimum a toll-free telephone hotline that includes the capability to provide information to consumers about eligibility and enrollment processes, and to appropriately direct consumers to the applicable Exchange website and other applicable resources.

\* \* \* \* \*

(b) \* \* \*

(4) Allows for an individual to submit a single streamlined eligibility application to the Exchange in accordance with § 155.405 and 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, through the operation of a centralized eligibility and enrollment platform on the Exchange’s website; or, if the Exchange is a State-based Exchange on the Federal platform, through the Federal eligibility and enrollment platform.

(5) Allows a qualified individual to select a QHP and allows the Exchange to maintain records of all QHP enrollments, in accordance with subpart E of this part, through the operation of a centralized eligibility and enrollment platform on the Exchange’s website; or, if the Exchange is a State-based Exchange on the Federal platform, through the Federal eligibility and enrollment platform.

\* \* \* \* \*

■ 13. Section 155.220 is amended by—

■ a. Adding paragraph (c)(4)(iii);

■ b. Revising paragraphs (h)(2) and (3); and

■ c. Adding paragraph (n).

The additions and revisions read as follows:

**§ 155.220 Ability of States to permit agents and brokers and web-brokers to assist qualified individuals, qualified employers, or qualified employees enrolling QHPs.**

\* \* \* \* \*

(c) \* \* \*

(4) \* \* \*

(iii) Web-brokers operating in State Exchanges that do not use the Federal platform that permit other agents and brokers, through a contract or other arrangement, to use their internet website to help an applicant or enrollee complete a QHP selection or complete

the Exchange eligibility application must comply with the standards in paragraphs (c)(4)(i)(A), (B), (D) and (F), except that all references to “Federally-facilitated Exchange” or “HHS” in paragraphs (c)(4)(i)(A), (B), (D), and (F) of this section will be understood to mean “the applicable State Exchange.”

\* \* \* \* \*

(h) \* \* \*

(2) *Timeframe for request.* The agent, broker, or web-broker must submit a request for reconsideration to the CMS Administrator within 30 calendar days of the written notice from HHS.

(3) *Notice of reconsideration decision.* The CMS Administrator will provide the agent, broker, or web-broker with a written notice of the reconsideration decision within 60 calendar days of the date the CMS Administrator receives the request for reconsideration. This decision will constitute HHS’ final determination.

\* \* \* \* \*

(n) *Application to State Exchanges that do not use the Federal platform.* A web-broker that assists or enrolls qualified individuals, qualified employers or qualified employees in coverage in a manner that constitutes enrollment through the State Exchange, or assists individual market consumers with submission of applications for advance payments of the premium tax credit and cost-sharing reductions through the State Exchange, must comply with the Federally-facilitated Exchange standards in paragraphs (c)(3)(i)(A), (G), (I), and (j)(2)(i) of this section, including any additional State-specific standards under paragraph (n)(1) of this section, and the State Exchange’s operational readiness standards under paragraph (n)(2) of this section. For the purposes of paragraph (j)(2)(i) of this section, references to “HHS” and “the Federally-facilitated Exchanges” will be understood to mean “the applicable State Exchange, applied for web-brokers”, and the reference to “HealthCare.gov” will be understood to mean “the State Exchange website, applied for web-brokers.”

(1) State Exchanges may add State-specific information to the standardized disclaimers and information under paragraphs (c)(3)(i)(A), (G), and (I) of this section that does not conflict with the HHS-provided language.

(2) State Exchanges must establish the form and manner for their web-brokers to demonstrate operational readiness and compliance with applicable requirements prior to the web-broker’s internet website being used to complete an Exchange eligibility application or a QHP selection, which may include

submission or completion of the following items to the State Exchange, in the form and manner specified by the Exchange:

- (i) Operational data including licensure information, points of contact and third-party relationships;
- (ii) Enrollment testing, prior to approval or renewal;
- (iii) website reviews performed by the State Exchange;
- (iv) Security and privacy documentation, including:
  - (A) Penetration testing results;
  - (B) Security and privacy assessment reports;
  - (C) Vulnerability scan results;
  - (D) Plans of action and milestones; and
  - (E) System security and privacy plans.
- (v) Agreements between the web-broker and the State Exchange.

■ 14. Section 155.221 is amended by—

- a. Revising paragraphs (a) introductory text; and
- b. Adding paragraphs (a)(1)(i) and (ii), (b)(6), and (j).

The revisions and addition read as follows:

**§ 155.221 Standards for direct enrollment entities and for third-parties to perform audits of direct enrollment entities.**

(a) *Direct enrollment entities.* All Exchanges may permit the following entities to assist consumers with direct enrollment in QHPs offered through the Exchange in a manner that is considered to be through the Exchange, to the extent permitted by applicable State law:

(1) \* \* \*

(i) For purposes of applying the requirements of § 156.1230(b) of this subchapter to State Exchanges, all references to “Federally-facilitated Exchange” and “HHS”, and “HealthCare.gov” will be understood to mean “the applicable State Exchange”, “the applicable State Exchange”, and “the applicable State Exchange website”, respectively.

(ii) [Reserved]

\* \* \* \* \*

(b) \* \* \*

(6) Implement and prominently display website changes in a manner consistent with display changes made to the Federally-facilitated Exchange website by meeting standards communicated and defined by HHS within a time period set by HHS, unless HHS approves a deviation from those standards. Direct enrollment entities may request a deviation by submitting a proposed alternative *display and* accompanying rationale to HHS for review.

\* \* \* \* \*

(j) *Application to State Exchanges that do not use the Federal platform.* A direct enrollment entity that enrolls qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through the State Exchange, or assists consumers with submission of applications for advance payments of the premium tax credit and cost-sharing reductions through the State Exchange, must comply with the Federally-facilitated Exchange standards in paragraphs (b)(1), (2), (3), and (d) of this section, including the exceptions in paragraph (c) of this section, where applicable; any additional State-specific standards under paragraph (j)(1) of this section; the State Exchange’s operational readiness standards under paragraph (j)(2) of this section; and the State Exchange’s website display change standards under paragraph (j)(3) of this section. Paragraph (d) references § 155.415(b), and § 155.415(b)(1) will be understood to also apply to State Exchanges.

(1) State Exchanges may add State-specific information to the standardized disclaimer under paragraph (b)(2) of this section that does not conflict with the HHS-provided language.

(2) State Exchanges must establish the form and manner for their direct enrollment entities to demonstrate operational readiness and compliance with applicable requirements prior to the direct enrollment entity’s internet website being used to complete an Exchange eligibility application or a QHP selection, which may include submission or completion of the following documentation to the State Exchange, in the form and manner specified by the Exchange:

(i) Business audit documentation including:

- (A) Notices of intent to participate including auditor information;
- (B) Documentation packages including privacy questionnaires, privacy policy statements, and terms of service; and
- (C) Business audit reports including testing results.

(ii) Security and privacy audit documentation including:

- (A) Interconnection security agreements;
- (B) Security and privacy controls assessment test plans;
- (C) Security and privacy assessment reports;
- (D) Plans of action and milestones;
- (E) Privacy impact assessments;
- (F) System security and privacy plans;
- (G) Incident response plans; and
- (H) Vulnerability scan results.

(3) State Exchanges must require their direct enrollment entities to implement

and prominently display changes adopted for display on the State Exchanges' websites, consistent with the process of defining and communicating standards and setting advance notice periods in paragraph (b)(6) of this section, except that all references to "Federally-facilitated Exchange website" would be understood to mean "State Exchange website" and references to "HHS" would be understood to mean "State Exchange" in paragraph (b)(6) of this section.

■ 15. 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 contracting arrangements in accordance with § 155.110(a) under which the Exchange carries out all eligibility determinations for QHP coverage and related insurance affordability programs; or, as 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; or

\* \* \* \* \*

■ 16. Section 155.305 is amended by adding paragraphs (f)(4)(i) and (ii) to read as follows:

**§ 155.305 Eligibility standards.**

\* \* \* \* \*

(f) \* \* \*

(4) \* \* \*

(i) If HHS notifies the Exchange as part of the process described in § 155.320(c)(3) that APTC payments were made on behalf of either the tax filer or spouse, if the tax filer is a married couple, for 1 year for which tax data would be utilized for verification of household income and family size in accordance with § 155.320(c)(1)(i), and the tax filer or the tax filer's spouse did not comply with the requirement to file an income tax return for that year as required by 26 U.S.C. 6011, 6012, and their implementing regulations and reconcile APTC for that period, the Exchange must send a notification, consistent with the standards applicable to the protection of Federal Tax Information to the tax filer, 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 part of a married couple, has failed to file and reconcile, and educate the tax filer that they need to file and reconcile or risk being determined ineligible for APTC if they fail to file and reconcile for a second consecutive tax year. Only the FTR Open Enrollment notices sent

directly to the tax filer may directly state that the IRS data indicates the tax filer failed to file and reconcile.

(ii) [Reserved]

\* \* \* \* \*

■ 17. Section 155.315 is amended by revising paragraph (e) to read as follows:

**§ 155.315 Verification process related to eligibility for enrollment in a QHP through the Exchange.**

\* \* \* \* \*

(e) *Verification of incarceration status.* The Exchange must verify an applicant's attestation that the applicant meets the requirements of § 155.305(a)(2) by—

(1) Accepting an applicant's attestation that they are not currently incarcerated; or

(2) Verifying an applicant's attestation of incarceration status using any electronic data source that is available to the Exchange and which has been approved by HHS for this purpose. HHS will approve an electronic data source for incarceration verification if it provides data that are current and accurate, and if its use minimizes administrative costs and burdens.

(3) If an Exchange verifies an applicant's attestation of incarceration status using an approved data source under paragraph (e)(2) of this section, to the extent that an applicant's attestation is not reasonably compatible with information from the approved data source or other information provided by the applicant or in the records of the Exchange, the Exchange must follow the procedures specified in § 155.315(f).

\* \* \* \* \*

■ 18. Section 155.320 is amended by adding paragraph (c)(1)(iii) to read as follows.

**§ 155.320 Verification process related to eligibility for insurance affordability programs.**

\* \* \* \* \*

(c) \* \* \*

(1) \* \* \*

(iii) *Payment to use income data through the Verify Current Income Hub service.* Beginning July 1, 2024, State Exchanges that elect the option to access the Verify Current Income service through the Federal Data Services Hub ("the Hub") to verify an individual's income as described in paragraph (c)(3)(vi)(A) of this section, must pay an annual advanced payment to HHS, in the timeframe and manner established by HHS, for use of the income data provided by the Verify Current Income Hub service equal to the product of the anticipated number of purchased transactions returned from the Verify Current Income Hub service and the

price per transaction established under the contract maintained by HHS to provide the VCI Hub service.

Participating States would be required to reconcile with HHS on an annual basis the anticipated utilization of CSI data provided by the VCI Hub service with the actual utilization.

\* \* \* \* \*

■ 19. Section 155.330 is amended by revising paragraph (d)(3) to read as follows:

**§ 155.330 Eligibility redetermination during a benefit year.**

\* \* \* \* \*

(d) \* \* \*

(3) *Definition of periodically.* (i) Beginning with the 2021 calendar year, the Exchange must perform the periodic examination of data sources described in paragraphs (d)(1)(ii) of this section at least twice in a calendar year. State Exchanges that have implemented a fully integrated eligibility system with their respective State Medicaid programs, that have a single eligibility rules engine that uses MAGI to determine eligibility for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and the BHP, if a BHP is operating in the service area of the Exchange, will be deemed in compliance with the Medicaid/CHIP PDM requirements and, if applicable, BHP PDM requirements, in paragraphs (d)(1)(ii) and (d)(3) of this section.

(ii) Beginning with the 2025 calendar year, the Exchange must perform the periodic examination of data sources described in paragraph (d)(1)(i) of this section at least twice in a calendar year.

(iii) Notwithstanding the requirements of paragraphs (d)(3)(i) and (ii) of this section, the Secretary has authority to temporarily suspend the requirement that Exchanges conduct the PDM processes described at paragraphs (d)(3)(i) or (ii) of this section during certain situations or circumstances that lead to the unavailability of data needed to conduct PDM.

\* \* \* \* \*

■ 20. Section 155.335 is amended by—

■ a. Revising paragraphs (j)(1)(ii) through (iv);

■ b. Adding paragraph (j)(1)(v);

■ c. Revising paragraphs (j)(2)(i) through (iii); and

■ d. Adding paragraphs (j)(2)(iv) and (j)(5).

The revisions and additions read as follows:

**§ 155.335 Annual eligibility redetermination.**

\* \* \* \* \*

(j) \* \* \*



(1) \* \* \*

(ii) If the enrollee's current QHP is not available through the Exchange, the Exchange will re-enroll the enrollee in a QHP within the same product at the same coverage level as described in sections 1302(d) or (e) of the ACA as the enrollee's current QHP that has the most similar network compared to the enrollee's current QHP;

(iii) If the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP at the same coverage level as described in sections 1302(d) or (e) of the ACA as the enrollee's current QHP and—

(A) The enrollee's current QHP is a silver level plan, the Exchange will re-enroll the enrollee in a silver level QHP under a different product offered by the same QHP issuer that is most similar to the enrollee's current product and that has the most similar network compared to the enrollee's current QHP. If no such silver level QHP is available for enrollment through the Exchange, the Exchange will re-enroll the enrollee in a QHP under the same product that is coverage level higher or lower than the enrollee's current QHP and that has the most similar network compared to the enrollee's current QHP; or

(B) The enrollee's current QHP is not a silver level plan, the Exchange will re-enroll the enrollee in a QHP under the same product that is one coverage level higher or lower than the enrollee's current QHP and that has the most similar network compared to the enrollee's current QHP;

(iv) If the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP that is at the same coverage level as described in sections 1302(d) or (e) of the ACA as, or one coverage level higher or lower than, the enrollee's current QHP, the Exchange will re-enroll the enrollee in any other QHP offered under the product in which the enrollee's current QHP is offered in which the enrollee is eligible to enroll and that has the most similar network compared to the enrollee's current QHP; or

(v) Notwithstanding the other provisions in paragraph (j)(1) of this section, if the enrollee's current QHP is a catastrophic plan as described in section 1302(e) of the ACA, and the enrollee will no longer meet the criteria for enrollment in a catastrophic plan as described in section 1302(e)(2) of the ACA:

(A) The Exchange will re-enroll the enrollee in a bronze metal level QHP within the same product as the enrollee's current QHP that has the most

similar network compared to the enrollee's current QHP; or

(B) If no bronze plan is available through this product, the Exchange will re-enroll the enrollee in the QHP with the lowest coverage level offered under the product in which the enrollee's current QHP is offered in which the enrollee is eligible to enroll and that has the most similar network compared to the enrollee's current QHP.

(2) \* \* \*

(i) The Exchange will re-enroll the enrollee in a QHP at the same coverage level as the enrollee's current QHP in the product offered by the same issuer that is the most similar to the enrollee's current product and that has the most similar network compared to the enrollee's current QHP;

(ii) If the issuer does not offer another QHP at the same coverage level as the enrollee's current QHP, the Exchange will re-enroll the enrollee in a QHP that is one coverage level higher or lower than the enrollee's current QHP and that has the most similar network compared to the enrollee's current QHP in the product offered by the same issuer through the Exchange that is the most similar to the enrollee's current product;

(iii) If the issuer does not offer another QHP through the Exchange at the same coverage level as, or one metal level higher or lower than the enrollee's current QHP, the Exchange will re-enroll the enrollee in any other QHP offered by the same issuer in which the enrollee is eligible to enroll and that has the most similar network compared to the enrollee's current QHP in the product that is most similar to the enrollee's current product; or

(iv) Notwithstanding the other provisions in paragraph (j)(2) of this section, if the enrollee's current QHP is a catastrophic plan as described in section 1302(e) of the ACA, and the enrollee will no longer meet the criteria for enrollment in a catastrophic plan as described in section 1302(e)(2) of the ACA:

(A) The Exchange will re-enroll the enrollee in a bronze metal level QHP offered by the same issuer in which the enrollee is eligible to enroll and that has the most similar network compared to the enrollee's current QHP in the product that is most similar to the enrollee's current product; or

(B) If no bronze plan is available through this product, the Exchange will re-enroll the enrollee in the QHP with the lowest coverage level offered under the product in which the enrollee's current QHP is offered in which the enrollee is eligible to enroll and that has

the most similar network compared to the enrollee's current QHP.

\* \* \* \* \*

(5) For purposes of this section, catastrophic coverage is not a coverage level that is considered higher or lower than metal level coverage when re-enrolling an enrollee to a plan that is a metal level higher or lower than their current plan, and an Exchange may not re-enroll an enrollee that has coverage under section 1302(d) into catastrophic coverage.

\* \* \* \* \*

■ 21. Section 155.400 is amended by revising paragraph (e)(2) to read as follows:

**§ 155.400 Enrollment of qualified individuals into QHPs.**

\* \* \* \* \*

(e) \* \* \*

(2) *Premium payment deadline extension.* Exchanges may, and the Federally-facilitated Exchanges and State-based Exchanges on the Federal platform will, allow issuers experiencing billing or enrollment problems due to high volume or technical errors, or issuers directed to do so by applicable State or Federal authorities, to implement a reasonable extension of the binder payment and other premium payment deadlines.

\* \* \* \* \*

■ 22. Section 155.410 is amended by revising paragraph (e)(4)(ii) to read as follows:

**§ 155.410 Initial and annual open enrollment periods.**

\* \* \* \* \*

(e) \* \* \*

(4) \* \* \*

(ii) For State Exchanges, for the benefit years beginning on or after January 1, 2025, a longer annual open enrollment period end date may be adopted, such that the open enrollment period begins on November 1 of the calendar year preceding the benefit year and ends no earlier than January 15 of the benefit year.

\* \* \* \* \*

■ 23. Section 155.420 is amended by revising paragraphs (b)(1), (b)(3)(i) and (d)(16) to read as follows:

**§ 155.420 Special enrollment periods.**

\* \* \* \* \*

(b) \* \* \*

(1) *Regular effective dates.* Except as specified in paragraphs (b)(2) and (3) of this section, for a QHP selection received by the Exchange from a qualified individual, the Exchange must ensure a coverage effective date of the first day of the month following the QHP selection; except that before

January 1, 2025, for a QHP selection received by the Exchange from a qualified individual between the sixteenth and the last day of any month, the Exchange may ensure a coverage effective date of the first day of the second month following QHP selection.

\* \* \* \* \*

(3) \* \* \*

(i) For a QHP selection received by the Exchange under a special enrollment period for which the effective dates of coverage specified in paragraph (b)(1) or (b)(2)(i) of this section would apply, the Exchange may provide a coverage effective date that is earlier than specified in such paragraph.

\* \* \* \* \*

(d) \* \* \*

(16) At the option of the Exchange, a qualified individual or enrollee, or the dependent of a qualified individual or enrollee, who is eligible for advance payments of the premium tax credit, and whose household income, as defined in 26 CFR 1.36B–1(e), is expected to be at or below 150 percent of the Federal poverty level, may enroll in a QHP or change from one QHP to another one time per month.

\* \* \* \* \*

■ 24. Section 155.430 is amended by revising paragraph (b)(1)(iv) introductory text and adding paragraph (b)(1)(iv)(D) to read as follows:

**§ 155.430 Termination of Exchange enrollment or coverage.**

\* \* \* \* \*

(b) \* \* \*

(1) \* \* \*

(iv) The Exchange must permit an enrollee to retroactively terminate or cancel the enrollee's coverage or enrollment in a QHP in the following circumstances, and State Exchanges may permit an enrollee to retroactively terminate or cancel the enrollee's coverage or enrollment in a QHP in accordance with paragraph (D):

\* \* \* \* \*

(D) In a Federally-facilitated Exchange or a State-based Exchange on the Federal platform, the enrollee demonstrates to the Exchange that the enrollee enrolled in Medicare Part A or B coverage with a retroactive effective date, and requests retroactive termination within 60 days of the enrollment. The effective date of the retroactive termination must be no sooner than the day before the first day of coverage under Medicare Part A or B.

\* \* \* \* \*

■ 25. Section 155.1050 is amended by revising paragraph (a) to read as follows:

**§ 155.1050 Establishment of Exchange network adequacy standards.**

(a) Except with regard to multi-State plans:

(1) A Federally-facilitated Exchange must ensure that the provider network of each QHP meets the standards specified in § 156.230 of this subtitle.

(2) State Exchanges and State-based Exchanges on the Federal Platform must ensure that the provider network of each QHP meets applicable standards specified in § 156.230(a)(1)(ii), (a)(1)(iii) and (a)(4) of this subtitle.

(i) For plan years beginning on or after January 1, 2025, to comply with the requirement under paragraph (a)(2) of this section, State Exchanges and State-based Exchanges on the Federal platform must:

(A) Establish and impose network adequacy time and distance standards for QHPs that are at least as stringent as standards for QHPs participating on the Federally-facilitated Exchanges under § 156.230(a)(2)(i)(A) of this subtitle;

(B) Conduct, prior to QHP certification, quantitative network adequacy reviews to evaluate compliance with requirements under § 156.230(a)(1)(ii), (a)(1)(iii), and (a)(2)(i)(A) of this subtitle, while providing QHP certification applicants the flexibilities described under § 156.230(a)(2)(ii) and (a)(3) and (4) of this subtitle; and

(C) Require that all issuers seeking certification of a plan as a QHP submit information to the Exchange reporting whether or not network providers offer telehealth services.

(ii) HHS may grant an exception to the requirements described under paragraph (a)(2)(i) of this section to a State Exchange or State-based Exchange on the Federal platform that demonstrates with evidence-based data, in a form and manner specified by HHS, that:

(A) the Exchange applies 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 of this subtitle; and

(B) the Exchange evaluates whether plans comply with applicable network adequacy standards prior to certifying any plan as a QHP.

\* \* \* \* \*

■ 26. Section 155.1312 is amended by adding paragraph (c)(3) to read as follows:

**§ 155.1312 State public notice requirements.**

\* \* \* \* \*

(c) \* \* \*

(3) Such public hearings shall be conducted in an in-person, virtual (that is, one that uses telephonic, digital, and/or web-based platforms), or hybrid (that is, one that provides for both in-person and virtual attendance) format.

\* \* \* \* \*

■ 27. Section 155.1320 is amended by revising paragraph (c) introductory text to read as follows:

**§ 155.1320 Monitoring and compliance.**

\* \* \* \* \*

(c) *Post award.* Within at least 6 months after the implementation date of a section 1332 waiver and annually thereafter, a State must hold a public forum to solicit comments on the progress of a section 1332 waiver. The State must hold the public forum at which members of the public have an opportunity to provide comments and must provide a summary of the forum to the Secretary as part of the quarterly report specified in § 155.1324(a) that is associated with the quarter in which the forum was held, as well as in the annual report specified in § 155.1324(b) that is associated with the year in which the forum was held. The public forum shall be conducted in an in-person, virtual (that is, one that uses telephonic, digital, and/or web-based platforms), or hybrid (that is, one that provides for both in-person and virtual attendance) format.

\* \* \* \* \*

**PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES**

■ 28. 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.

■ 29. Section 156.111 is amended by revising paragraphs (a), (b)(2), and (e)(2) and (3) to read as follows:

**§ 156.111 State selection of EHB-benchmark plans for plan years beginning on or after January 1, 2020.**

(a)(1) Subject to paragraphs (b) through (e) of this section, for plan years beginning on or after January 1, 2020 through December 31, 2026, a State may change its EHB-benchmark plan by:

(i) Selecting the EHB-benchmark plan that another State used for the 2017 plan year under §§ 156.100 and 156.110;

(ii) Replacing one or more categories of EHBs established at § 156.110(a) in the State's EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State

used for the 2017 plan year under §§ 156.100 and 156.110; or

(iii) Otherwise selecting a set of benefits that would become the State's EHB-benchmark plan.

(2) Subject to paragraphs (b), (c), (d), and (e) of this section, for plan years beginning on or after January 1, 2027, a State may change its EHB-benchmark plan by selecting a set of benefits that would become the State's EHB-benchmark plan.

(b) \* \* \*

(2) *Scope of benefits.* (i) For plan years beginning on or after January 1, 2020 through December 31, 2026:

(A) Provide a scope of benefits equal to the scope of benefits provided under a typical employer plan (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)), defined as either:

(1) One of the selecting State's 10 base-benchmark plan options established at § 156.100, and available for the selecting State's selection for the 2017 plan year; or

(2) The largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State, as product and plan are defined at § 144.103 of this subchapter, provided that:

(i) The product has at least 10 percent of the total enrollment of the five largest large group health insurance products in the State;

(ii) The plan provides minimum value, as defined under § 156.145;

(iii) The benefits are not excepted benefits, as established under § 146.145(b), and § 148.220 of this subchapter; and

(iv) The benefits in the plan are from a plan year beginning after December 31, 2013.

(B) Not exceed the generosity of the most generous among a set of comparison plans, including:

(1) The State's EHB-benchmark plan used for the 2017 plan year, and

(2) Any of the State's base-benchmark plan options for the 2017 plan year described in § 156.100(a)(1), supplemented as necessary under § 156.110.

(ii) For plan years beginning on or after January 1, 2027, provide a scope of benefits that is equal to the scope of benefits of a typical employer plan in the State. The scope of benefits in a typical employer plan in a State is any scope of benefits that is as or more generous than the scope of benefits in the least generous plan (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)), and as or less generous

than the scope of benefits in the most generous plan in the State (supplemented by the State as necessary to provide coverage within each EHB category at § 156.110(a)), among the following:

(A) One of the selecting State's 10 base-benchmark plan options established at § 156.100, and available for the selecting State's selection for the 2017 plan year; or

(B) The largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State, as product and plan are defined at § 144.103 of this subchapter, provided that:

(1) The product has at least 10 percent of the total enrollment of the five largest large group health insurance products in the State;

(2) The plan provides minimum value, as defined under § 156.145;

(3) The benefits are not excepted benefits, as established under § 146.145(b), and § 148.220 of this subtitle; and

(4) The benefits in the plan are from a plan year beginning after December 31, 2013.

\* \* \* \* \*

(e) \* \* \*

(2) An actuarial certification and an associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies, that affirms that the State's EHB-benchmark plan complies with the applicable scope of benefits requirements at paragraph (b)(2) of this section.

(3) The State's EHB-benchmark plan document that reflects the benefits and limitations, including medical management requirements, a schedule of benefits and, if the State is changing the number of prescription drugs pursuant to § 156.122(a)(1)(ii), a formulary drug list in a format and manner specified by HHS; and

\* \* \* \* \*

■ 30. Section 156.115 is amended by revising paragraph (d) to read as follows:

**§ 156.115 Provision of EHB.**

\* \* \* \* \*

(d) An issuer of a plan offering EHB may not include routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB.

■ 31. Section 156.122 is amended by adding paragraphs (a)(3)(i)(E) and (f) to read as follows:

**§ 156.122 Prescription drug benefits.**

(a) \* \* \*

(3) \* \* \*

(i) \* \* \*

(E) For plan years beginning on or after January 1, 2026, include a consumer representative who must:

(1) Represent the consumer perspective as a member of the P&T committee.

(2) Have an affiliation with and/or demonstrate active participation in consumer or community-based organizations.

(3) Have experience in the analysis and interpretation of complex data and be able to understand its public health significance.

(4) Have no fiduciary obligation to a health facility or other health agency and have no material financial interest in the rendering of health services.

\* \* \* \* \*

(f) If a health plan covers prescription drugs in excess of the prescription drugs required to be covered under paragraph (a)(1) of this section, the additional prescription drugs are considered an essential health benefit and subject to the cost-sharing requirements at § 156.130, unless coverage of the drug is mandated by State action and is in addition to an essential health benefit pursuant to § 155.170, in which case the drug would not be considered an essential health benefit.

■ 32. Section 156.202 is amended by adding paragraphs (d) and (e) to read as follows:

**§ 156.202 Non-standardized plan option limits.**

\* \* \* \* \*

(d) For plan year 2025 and subsequent years, an issuer may offer additional non-standardized plan options per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area if it demonstrates that these additional plans' cost sharing for benefits pertaining to the treatment of chronic and high-cost conditions (including benefits in the form of prescription drugs, if pertaining to the treatment of the condition(s)) is at least 25 percent lower, as applied without restriction in scope throughout the plan year, than the cost sharing for the same corresponding benefits in an issuer's other non-standardized plan option offerings in the same product network type, metal level, and service area. The reduction must not be limited to a part of the year, or an otherwise limited scope of benefits, and the reduced cost sharing for these benefits cannot be conditioned on a consumer having a particular diagnosis. Chronic and high-cost

conditions that may qualify an issuer for this exception will be determined by HHS.

(e) An issuer that seeks to utilize this exceptions process is required to submit a written justification in a form and manner and at a time prescribed by HHS that:

(1) Identifies the specific condition(s) for which cost sharing is reduced;

(2) Explains which benefit(s) would have reduced annual enrollee cost sharing (as opposed to reduced cost sharing for a limited number of visits) for the treatment of the specified condition(s) relative to the same corresponding benefits in an issuer's other non-standardized plan offerings in the same product network type, metal level, and service area; and

(3) Explains how the reduced cost sharing for these benefits pertain to clinically indicated guidelines for treatment of the specified chronic and high-cost condition(s).

■ 33. Section 156.520 is amended by revising paragraph (f) to read follows:

**§ 156.520 Loan terms.**

\* \* \* \* \*

(f) *Conversions and voluntary terminations.* (1) The loan recipient shall not convert or sell to a for-profit or non-consumer operated entity at any time after receiving a loan under this subpart. The loan recipient shall not undertake any transaction that would result in the CO-OP implementing a

governance structure that does not meet the standards in this subpart.

(2) CMS may, in its sole discretion, approve a request by a loan recipient to voluntarily terminate its loan agreement with CMS, and cease to constitute a QNHII, for the purpose of permitting a loan recipient to pursue innovative business plans that are not otherwise consistent with the requirements of this subpart, provided that all outstanding CO-OP loans issued to the loan recipient are repaid in full prior to termination of the loan agreement, and CMS believes granting the request would meaningfully enhance consumer access to quality, affordable, member-focused, non-profit health care options in affected markets.

■ 34. 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, and administrative fees for utilizing the Federal Independent Dispute Resolution process in accordance with § 149.510(d)(2).

(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, and unpaid administrative fees for utilizing the Federal Independent Dispute Resolution process in accordance with § 149.510(d)(2), after HHS nets amounts owed by the Federal government under these programs, is a determination of a debt.

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