Patient Protection and Affordable Care Act: Notice of Benefit and Payment Parameters for 2023 (CMS-9911-P); Summary of Proposed Rule

January 5, 2022

On January 5, 2022 the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services (HHS) published a proposed Notice of Benefit and Payment Parameters for 2023 (hereinafter referred to as the "proposed 2023 Payment Notice") in the Federal Register (FR) (87 FR 584). The proposed 2023 Payment Notice would make a number of changes and updates to the risk adjustment (RA) and risk adjustment data validation (RADV) programs and methodologies, update certain payment parameters, and make a number of changes in areas including adding specificity to non-discrimination provisions. It would re-establish standardized benefits as well as federal network adequacy requirements and reviews. In addition, the rule seeks comment on how HHS can advance health equity through Qualified Health Plan (QHP) certification standards and otherwise in the individual and group health insurance markets, and how HHS might address plan choice overload in the Exchanges. **Comments must be received no later than January 27, 2022.**

HHS proposes several payment parameters in this proposed rule but notes that it will issue the 2023 benefit year premium adjustment percentage index and related payment parameters in guidance consistent with the policy finalized in the 2022 Payment Notice.

I. Summary of Major Provisions

Risk Adjustment Program. The proposed 2023 Payment Notice would recalibrate risk adjustment parameters and make several updates to the risk adjustment model to improve prediction. It proposes changes related to mapping Hierarchical Condition Categories (HCCs) and new data elements for issuer reporting and research purposes. It would update user fees, eliminate the ability of states to request reduced risk adjustment transfer payments starting with 2024 with an exception, and make refinements to the HHS-RADV error estimation methodology.

Standardized QHP Options HHS proposes two sets of standardized QHP options that would be required to be offered alongside non-standardized options beginning in Plan Year (PY) 2023.

Guaranteed Availability. The proposed rule would prohibit issuers from applying a premium payment to an individual's or employer's past debt owed and refusing to effectuate enrollment in new coverage.

Essential Health Benefits. HHS would make changes to de minimis thresholds for certain plans, eliminate the annual reporting requirement of state-required benefits, and eliminate requirements to annually require essential health benefits (EHB) benchmark plan applications from states.

Network Adequacy. The proposed rule would re-institute federal network adequacy reviews, expand the provider list for time and distance standards, add requirements for tiered networks with respect to meeting Essential Community Provider (ECP) standards, and require data reporting on telehealth services.

Exchange User Fees. HHS proposes the following Exchange User fees: for issuers in Federally Facilitated Exchanges (FFEs), the 2023 user fee would be 2.75% of premium. For issuers in State-based Exchanges using the Federal Platform (SBE-FP), the 2023 user fee would be equal to 2.25% of monthly premium.

Quality Improvement Standards. HHS would update the quality improvement strategy (QIS) standards to require QHP issuers to address health and health care disparities as a specific topic area within their QIS beginning in 2023.

Verification of Eligibility for Insurance Affordability Programs. HHS proposes to provide flexibility for each Exchange to design its employer sponsored plan verification process based on its assessment of the risk of inappropriate and eliminate the requirement that an Exchange conduct random sampling of applicants for whom the Exchange does not have data.

Solicitation of Comments. HHS solicits comments in several areas:

- Ways to strengthen network adequacy requirements without creating a power imbalance between plans and providers that results in higher costs for consumers.
- How to incorporate the costs of a plan into the Exchange re-enrollment hierarchy and for HHS to ensure the Exchange hierarchy for re-enrollment aligns with plan generosity and consumer needs.

- Approaches for incentivizing QHP issuers to design plans that improve health equity and health conditions in enrollees' environments, as well as how QHP issuers could address other social determinants of health (SDOH) outside of the QHP certification process.

II. Background

HHS reviews the statutory and regulatory history related to the implementation of the Exchanges and related topics. HHS sought advice from stakeholders on policies related to the operation of Exchanges and risk adjustment programs, and held meetings with consumers, providers, employers, plans, advocacy groups and the actuarial community. It solicited input from states on topics including EHBs, state mandates and risk adjustment. It also consulted with the National Association of Insurance Commissioners, and held meetings with Tribal leaders, issuers, trade groups, consumer advocates and employers.

HHS states that it proposes changes to payment parameters and other provisions with a focus on maintaining a stable regulatory environment, to provide issuers with greater predictability for upcoming plan years (PYs), while increasing flexibilities and reducing unnecessary regulatory burdens on states and stakeholders.

The policies in the proposed 2023 Payment Notice reflect HHS' review as required by Executive Order (EO) 13988 on preventing and combating discrimination based on gender identity and sexual orientation.[1] Proposed changes conform with HHS' Notice, released on May 10, 2021, that HHS interprets and enforces the section 1557 of the Affordable Care Act (ACA and Title IX (of the Education Amendments of 1972) prohibitions on discrimination on the basis of sex to include: (1) Discrimination on the basis of sexual orientation; and (2) discrimination on the basis of gender identity, based on the Supreme Court's decision in Bostock v. Clayton County.[2]

III. Provisions of Proposed HHS Notice of Benefit and Payment Parameters for 2023

A. Part 144 – Requirements Relating to Health Insurance Coverage

HHS proposes to remove unneeded language from the definition of "large group market" and in doing so would also make the definition consistent with the definition of the same term as provided by the Health Insurance Portability and Accountability Act (HIPAA).[3] The amended definition for large group market would be the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

[1] Executive Order 13988 on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation, January 20, 2021, see 86 FR 7023.
[2] U.S. Dep't of Health & Hum. Servs., Notification of Interpretation and Enforcement of Section 1557 of the Affordable Care Act and Title IX of the Education Amendments of 1972, 86 FR 27984 (May 25, 2021). Also see, Bostock v. Clayton County, 140 S. Ct. 1731 (2020). https://www.supremecourt.gov/opinions/19pdf/17-1618_hfci.pdf,
[3] P.L. 104-191.

B. Part 147 – Requirements for the Group and Individual Health Insurance Markets

1. Guaranteed Availability of Coverage (§147.104)

(a) Past-Due Premiums

HHS proposes to revert to an earlier interpretation of the guaranteed availability requirement under section 2701 of the Public Health Service (PHS) Act. Under that requirement, health insurance issuers offering non-grandfathered coverage in the individual or group market must accept every individual and employer in the state that applies for such coverage unless an exception applies. In the current interpretation of that requirement, an issuer does not violate the guaranteed issue requirement where it attributes a premium payment for new coverage to any past-due amount owed for coverage for the prior 12-month period before effectuating the new coverage.

HHS proposes to require issuers to accept individuals and employers who apply for coverage, even where the individual or employer owes past-due premiums. HHS explains that under EO 14009, "Strengthening Medicaid and the Affordable Care Act" HHS has examined the policy and determined it to be inconsistent with its priority to make high-quality health care accessible and affordable. The existing interpretation is believed to be a barrier to enrollment in health coverage which disproportionately impacts low-income individuals. HHS states that the public health crises caused by the COVID-19 pandemic underscore the critical need for access to continuous health coverage. HHS believes that the potential negative impact on low-income populations outweighs the concern that an individual may take advantage of guaranteed availability rules by declining to make premium payments for coverage at the end of a benefit year.

HHS seeks comment on the frequency of any potential gaming behavior that plans have experienced, as well as information on the primary diagnoses and services that may be involved in suspected gaming situations so that it can assess the contributing causes of such non-payment.

(b) Nondiscrimination based on sexual orientation and gender identity

HHS proposes to amend §147.104(e) to revert to a prior interpretation that would explicitly prohibit a health insurance issuer and its officials, employees, agents, and representatives from discriminating in its marketing practices or benefit designs on the basis of sexual orientation and gender identity. This would reverse the current policy, adopted in the 2020 Rule that had removed reference to sexual orientation and gender identity.[4]

HHS describes existing regulations and statutory prohibitions on discrimination in marketing practices and benefits design based on an individual's race, color, national origin, disability, age, sex, expected length of life, degree of medical dependency, quality of life, or other health

[4] HHS notes that the 2020 section 1557 final rule is the subject of several lawsuits and refers readers to https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html for more information on those lawsuits.

conditions. It provides its interpretation of its rulemaking authority that permit specifying that discrimination based on sex includes discrimination based on sexual orientation and gender identify. It describes the Supreme Court finding in Bostock v. Clayton County (140 S. Ct. 1731, (2020)), that concluded that discrimination on the basis of sex under Title VII of the Civil Rights Act of 1964 includes discrimination on the basis of sexual orientation and gender identity. Further, HHS states that the proposal is consistent with E.O. 13988 which described the current Administration's policy to prevent and combat discrimination based on gender identity and sexual orientation.

C. Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

Standards for the administration of the risk adjustment program created by the ACA are set out in subparts of 45 CFR Part 153. In brief, the risk adjustment program transfers funds from non-grandfathered plans in the individual and small group markets (within and outside of the Exchanges) with lower-cost enrollees to those with higher-cost enrollees. A state may establish a risk adjustment program (with HHS approval) or have HHS do so on its behalf. Currently, HHS is operating risk adjustment in every state and did not receive any applications from states to operate risk-adjustment for the 2023 benefit year.

1. Sequestration

The risk adjustment program is subject to the fiscal year 2022 sequestration and will therefore be sequestered at a rate of 5.7 percent for payments made from fiscal year 2022 resources (that is, funds collected during the 2022 fiscal year). Consistent with prior years, however, the funds that are sequestered in fiscal year 2022 from the risk adjustment program will become available for payment to issuers in fiscal year 2023 without further Congressional action. HHS also notes that the Coronavirus Aid, Relief, and Economic Security (CARES) Act amended section 251A (6) of the Balanced Budget and Emergency Deficit Control Act of 1985 and extended sequestration for the risk adjustment program through fiscal year 2030 at a rate of 5.7 percent per fiscal year.[5]

2. HHS Risk Adjustment (§153.320)

The HHS risk adjustment model predicts plan liability for an average enrollee based on age, sex, and diagnoses (risk factors). Separate models are used to predict and account for cost differences for adults, children, and infants. In each of the adult and child models, the relative risks assigned to an individual's age, sex, and diagnoses are added together to produce an individual risk score. In the adult models, enrollment duration factors and prescription drug utilization factors (RXCs) are also added. 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 adjustment.

[5] PL 116-136.

The enrollment-weighted average risk score of all enrollees in a particular risk adjustment covered plan (i.e., the plan liability risk score) within a geographic rating area is one of the inputs into the risk adjustment payment transfer formula, which determines the payment or charge that an issuer will receive or be required to pay for that plan. Thus, to account for risk across plans, the HHS risk adjustment model predicts average group costs.

(a) Data for Risk Adjustment Model Recalibration for 2023 benefit year and Beyond

HHS proposes to recalibrate risk adjustment models consistent with the methodology used for earlier benefit years as described in the 2020 Payment Notice – that is, using only enrollee-level External Data Gathering Environment (EDGE) data rather than a combination of EDGE and MarketScan data.[6] It will continue to use blended, or averaged coefficients from the 3 years of separately solved models for the 2023 benefit year model recalibration.

HHS proposes to incorporate the three most recent years of data available for recalibration (2016 – 2018) and will not update the coefficients between the proposed and final 2023 Payment Notices. Proposed recalibrated coefficients are displayed in Tables 1 through 6 in the preamble of the proposed 2023 Payment Notice. HHS notes that those coefficients could change if an error is identified or if changes are made in the final rule based on public comments.

HHS seeks comments on the use of the 2020 enrollee-level EDGE data because of the potential impact of the COVID-19 Public Health Emergency (PHE). Under current policy, 2020 enrollee-level EDGE data would be used to recalibrate the HHS risk adjustment models for the 2024 benefit year and that data would continue to be used for the 2025 and 2026 benefit year models. HHS is interested in the extent that the PHE may impact 2020 data and risk adjustment transfers.

(b) Risk Adjustment (RA) Model Updates (§153.320)

Last year HHS proposed several updates to the HHS RA models for the 2022 benefit year that were not finalized. It proposes those same model updates to the models for the 2023 benefit year and proposes to continue the market pricing adjustment for Hepatitis C drugs as has been in place since the 2020 benefit year.

The proposed model updates were described in prior rulemaking and in the 2021 RA Technical Paper.[7] They are intended to improve prediction at the low and high ends of the spending distribution in both adult and child models and to improve the enrollment duration factors in the adult model. Based on concerns that the existing linear HHS Hierarchical Condition

[6] Beginning in 2021, HHS transitioned to using three years of actual claims level data submitted by states through EDGE servers (which refers to distributed data computing environments) as opposed to past years in which HHS had to rely on one or more years of data from a research database (MarketScan) for risk adjustment modeling. EDGE data refers to the data states submit through the HHS EDGE servers.
[7] See the 2021 HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes, https://www.cms.gov/files/document/2021-ra-technical-paper.pdf

Category (HHS-HCC) models underpredict plan liability for enrollees without HCCs and underpredict plan liability for enrollees with the highest HCC counts, HHS proposes to:

- Add a two-stage weighted model specification to the adult and child models. By calibrating the models in two stages, healthier enrollees could be reweighted more heavily improving prediction for the lowest-risk enrollees. HHS considered alternative approaches and settled on the approach because it would limit trade-offs in other parts of the model's performance. HHS believes that by addressing the underprediction of costs associated with the lowest-risk enrollees, it can encourage retention of plans and greater enrollment among this population resulting in healthier and more stable insurance markets. Comments are sought on whether this change should be implemented without the additional changes (described below) and whether any change is need to improve the model's prediction for low-risk enrollees.
- Address the current models' underprediction of plan liability for the highest-risk enrollees, by removing the severity illness factors in the adult and child models and replacing them with new severity and transplant indicators interacted with HCC count factors in the adult and child models. Table 3 in the preamble identifies the severity and transplant HCCs for which a severity and transplant interaction factor would be counted toward the applicable risk score. Ten severity-HCC-count-interaction factors were calculated for addition in the adult models and seven for the child models. HHS seeks comment on whether only the interacted factors should be adopted independent of the two other proposed model changes, or whether it should not be adopted at all, the methodology for applying the interacted factors, and the proposed list of HCCs for which the interacted factors would be applied.
- To improve the adult models' prediction for partial-year adult enrollees with and without HCCs, HHS proposes to remove the current monthly enrollment duration factors of up to 11 months for all enrollees in the adult models, and replace them with monthly enrollment duration factors of up to 6 months that would only apply to adult enrollees with HCCs. The changes are being proposed because HHS has found that the predictive value of the model's existing enrollment duration factors has been declining since first implemented for the 2017 benefit year. They underpredict plan liability for partial-year enrollees with HCCs and overpredict plan liability for partial-year enrollees without HCCs. Under the proposal, there would be no enrollment duration factors for adult enrollees without HCCs nor enrollment duration factors for adults with HCCs who have more than 6-months of enrollment. HHS seeks comment on whether only the changes to monthly duration factors should be adopted independent of the two other proposed model changes, and whether the duration factor changes should be adopted at all.

HHS declined to finalize those changes for 2022 based on commenters' concerns that more time and analysis could help stakeholders evaluate the changes and prevent inadvertent volatility in the markets. In response HHS released the 2021 RA Technical Paper. HHS again describes its belief that the combination of proposed model changes will improve the models' predictive accuracy for the lowest-risk enrollees, certain partial-year adult enrollees, and the very highest risk enrollees, while limiting trade-offs in other areas of model performance and

complexity. The preamble of the proposed 2023 Payment Notice describes in greater detail each of those model changes, the estimated impact of the changes on model prediction, alternative adjustments that were considered, and other considerations such as the potential for issuers to game the new factors and whether the factors could introduce other biases in the models.

To assist issuers and stakeholders with analyzing the impact of the proposed model changes, HHS conducted a transfer simulation and provides summary-level and issuer-specific risk score transfer estimates.[8]

HHS tested combining the changes proposed above and concluded that the combined approach generally improved prediction for enrollees at both the low and high ends of expected spending and raised R-squared statistics (i.e., a measure of a model's predictive accuracy) across plans across metal levels among other improvements

(c) Pricing Adjustment for Hepatitis C Drugs

HHS proposes to continue to incorporate a pricing adjustment for Hepatitis C Drugs. It continues to believe that it is necessary and appropriate to use a pricing adjustment for those drugs for the 2023 benefit year since the data used to recalibrate the risk adjustment models do not reflect the more recent declines in prices for such drugs. Because the cost of these drugs was reflected in the 2017, 2018 and 2019 enrollee-level EDGE datasets without a pricing adjustment to plan liability, the Hepatitis C RXC in the 2023 benefit year based on this data would overcompensate issuers and incentivize them to encourage overprescribing. The pricing adjustment helps avoid such incentives. HHS will continue to reassess this adjustment in future benefit years' model recalibrations.

(d) Risk adjustment RXC mapping for recalibration

Each year, HHS recalibrates the adult risk adjustment models' RXC coefficients using data from the applicable prior benefit years trended forward to reflect the applicable benefit year of risk adjustment. Drugs that appear on claims data are cross walked to RxNorm Concept Unique Identifiers (RXCUIs). RXCUI mappings are always matched to the NDCs and HCPCS applicable to the particular EDGE data year as the NDC and HCPCS reflect the drugs that were available in the market during the benefit year.

HHS conducts quarterly reviews of those RXCUI mappings to evaluate whether there are changes that should be accounted for such as whether costs of drugs are comparable to others within the same class, whether a drug is a good predictor of the presence of diseases that map to the HCCs that the RXC indicates, whether clinical practice or prescribing patterns are

[8] See the 2021 HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes, available at https://www.cms.gov/files/document/2021-ra-technical-paper.pdf; and HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes: Summary Results for Transfer Simulations, available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs.

consistent with the treatment of a particular condition, and to take into account stakeholder feedback. The review can result in changes to the mapping, or the addition or removal of drugs based on market availability or other factors.

HHS proposes a change to the mapping document used for recalibration. Beginning for the 2024 adult risk adjustment model, instead of using the most recent RXC mapping that is available when HHS first processes the enrollee-level EDGE data for recalibration, HHS will use the final, fourth quarter RXC mapping document that was applicable for each benefit year of data included in each benefit year model calibration. For example, if data from 2018, 2019, and 2020 are being used to recalibrate the adult RHC risk model, the mapping for the 2018 data would be the document from Q4, 2018; mapping for 2019 would be from Q4, 2019; and mapping for 2020 would be from Q4, 2020. For 2023 – a transition year – HHS will adopt the new approach for 2018 and 2019 data, but for 2017 it proposes using Q2, 2018 mapping since there was not Q4, 2017 mapping available for the 2017 benefit year. HHS believes this approach would provide for more stability of coefficients from year to year since the same mapping would always be used for each individual year's data.

HHS also offers an alternative approach for consideration in which it would instead use the most recent RXCUI to RXC mapping document available at the time of developing a benefit year's proposed model factors for publication in the applicable benefit year's Payment Notice. As the recalibration process typically begins several months prior to the proposed Payment Notice being released, the most recently available RXCUI to RXC mapping document available at the time of developing a benefit year's proposed model factors would generally be either the Q4 mapping from the prior benefit year (for 2023 benefit year (BY) model recalibration that would have been the Q4 mapping for BY 2020), or the Q1 or Q2 mapping document from the year in which recalibration is occurring (for 2023 benefit year model recalibration that would have been the Q1 or Q2 mapping for BY 2021). HHS notes that the disadvantage of this alternative would be that the RXC mapping document would still lag behind the mapping document for the applicable benefit year because of the lag between when recalibration occurs for a benefit year and the actual benefit year and may still introduce some volatility.

HHS also describes circumstances under which a small number of drugs' mappings require additional analysis beyond the routine annual risk adjustment model recalibration. For most drugs, the removal or addition of an RXCUI from the RXC mappings has a small impact on recalibration because most drug removals are not associated with large enough utilization or costs to meaningfully change model coefficients. Sometimes, however, circumstances such as significant off-label prescribing, abnormally large changes in practice patterns or clinical indications, or large changes in the cost of a drug than is typical for drugs in the same category can occur and can cause HHS to consider making targeted changes to the mapping of select RXCUIs to RHCs. For 2023, such consideration occurred for two drugs:

- Descovy® – a product that had been used as an anti-HIV agent was approved for use for pre-exposure prophylaxis (PrEP). HHS removed Descovy® from the RXCUI to RXC mappings to be consistent with the treatment of other PrEP drugs and considered

removing it from the mappings for the 2019 data as some enrollees in 2019 may have used Descovy® for PreEP in that year. After an analysis of 2019 claims, however, HHS found that doing so was not necessary as most 2019 use was as part of an active HIV treatment.

- Hydroxychloroquine sulfate – was initially mapped to RXC 09 (Immune Suppressants Immunomodulators) but in Q4 BY 2020 it was removed because of concerns including off-label prescribing. After additional analysis, HHS made the determination that it should be removed. Therefore, to effectuate the targeted removal of hydroxychloroquine sulfate for the recalibration of the 2022 benefit year adult risk adjustment models, HHS only used 2016 and 2017 enrollee-level EDGE data, where hydroxychloroquine sulfate was not mapped to RXC 09, for the limited purpose of developing the coefficients for RXC 09 (Immune Suppressants and immunomodulators) and its related RXC 09 interactions. HHS finds that its removal for the 2023 BY again is appropriate.

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(e) Factors for Risk Adjustment Models

Tables 1–6 of the proposed 2023 Payment Notice lists the proposed 2023 benefit year risk adjustment model factors incorporating all of the model specification changes and recalibration proposals described above. Table 1 contains factor coefficients for each adult model, including the age-sex, HCCs, RXCs, RXC–HCC interactions, interacted HCC counts, and enrollment duration coefficients. Table 2 contains the factor coefficients for each child model, including the age-sex, HCCs, and interacted HCC counts coefficients. Table 3 lists the proposed HHS–HCCs that have been selected for the proposed interacted HCC counts factors that would apply to the adult and child models. Table 4 contains the factors for each infant model. Tables 5 and 6 contain the HCCs included in the infant models' maturity and severity categories, respectively.

(f) Cost-sharing Reduction Adjustments

HHS proposes**,** consistent with prior years, to include cost-sharing reductions in the risk adjustment models to account for increased plan liability due to higher utilization of health care services by individuals receiving cost-sharing reductions. Table 7 of the proposed 2023 Payment Notice provides the Cost-Sharing Reduction Adjustment Factors for plans at each metal level. For Massachusetts, HHS proposes to continue to use a cost-sharing reduction factor of 1.12 for all Massachusetts wrap-around plans.

(g) Model Performance Statistics

HHS reports the R-squared statistic, which calculates the percentage of individual variation explained by a measure, to show the predictive accuracy of the risk adjustment models overall. HHS provides the R-squared statistics for each proposed model and benefit year separately in Table 8. HHS notes that the proposed model updates together demonstrate improvements in R-squared metrics as well as predictive ratios.

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

In the 2022 Payment Notice HHS finalized its proposal to continue the payment transfer formula finalized in the 2021 Payment Notice and only publish RA transfer formulas if a change was being proposed. In the 2023 Proposed Payment Notice, HHS makes no proposed changes to the formulas and does not republish the formulas. In addition, it proposes no changes to the high-cost risk pool parameters for the 2023 benefit year, maintaining the $1 million threshold and 60 percent coinsurance rate.

4. Risk Adjustment State Flexibility Requests (§153.320(d))

In the 2019 Payment Notice (83 FR 16930), HHS provided to states, starting with the 2020 benefit year, the flexibility to request a reduction to the otherwise applicable risk adjustment transfers calculated under the HHS-operated methodology. Under the policy, states have the flexibility to request a reduction to the otherwise applicable risk adjustment transfers in the individual, small group or merged market by up to 50 percent.

Flexibility Requests for Plan Year 2023. As in past years, HHS received requests from Alabama to reduce by 50% risk adjustment state transfers for the 2023 plan year for its individual and small group markets. Consistent with past years, Alabama believes that the presence of a dominant issuer in those markets precludes the HHS operated risk adjustment program from working as intended and that the reduction in risk adjustment payments would impact premiums by no more than 1 percent – a de minimis premium increase. HHS seeks comment on the application and directs those interested to additional documentation submitted by Alabama posted under the "State Flexibility Requests" heading at Premium Stabilization Programs | CMS.

Flexibility Requests for Plan Years 2024 and Thereafter. Beginning with the 2024 benefit year, HHS proposes to eliminate the flexibility for states to request reductions in risk adjustment transfers unless for a state that has previously submitted a risk adjustment flexibility request for any market. Alabama is the only state that has done so.

HHS has reviewed the policy, consistent with its requirement under EO 14009 to review policies to ensure they are consistent with strengthening the ACA and making high quality health coverage affordable and accessible. HHS now believes the flexibility is not consistent with those priorities because it could potentially result in increased risk selection, market destabilization, increased premiums, smaller networks and worse plan options.

Under the policy, Alabama would still need to submit a request for any market and for each such year that it seeks the flexibility in the timeframe, form, and manner as set forth under (§153.320(d)). HHS believes these changes would ensure that consumers would not experience an increase in premiums greater than 1 percent as the result of a state requested reduction in transfers.

Beginning with 2024, a state requesting the flexibility may only do so based on the criterion that the requested reduction would have a de minimis impact on the necessary premium increase to cover the transfers for issuers that would receive reduced transfer payments.

HHS seeks comment on whether it should only repeal the flexibility with respect to the individual market risk pools, on the proposed definition of a prior participant with respect to the proposed exceptions, and on the health equity impacts of the proposals, especially for underserved and minority communities.

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

In the 2018 and 2020 Payment Notices, HHS finalized policies for collecting and extracting enrollee-level EDGE data to allow HHS to use for recalibrating the HHS risk adjustment models, to inform the development and methodology of the AV Calculator, to operationalize other policies connected to the individual and small group markets, and to permit additional policy analysis related to the individual and small group markets. In addition, qualified researchers are permitted to access a limited data set file upon request.

Proposed Collection and Extraction of New Data Elements and Extraction of Current Data Elements. In the proposed 2023 Payment Notice, HHS proposes to collect and extract five new data elements from issuers' EDGE servers:

- ZIP code
- Race
- Ethnicity
- Subsidy Indicator
- Individual coverage health reimbursement arrangement (ICHRA) indicator

The additional data elements would allow HHS to better analyze subpopulations at a granular level, examine more areas of health equity, and better address discrimination in health care and health disparities. The data elements would be required to be made accessible in states where HHS operates the risk adjustment programs beginning with the 2023 benefit year.

In addition, HHS proposes to begin extracting additional data elements from issuers' EDGE data beginning with the 2022 benefit year. These three data elements are already required to be submitted to EDGE servers:

- Plan ID
- Rating area
- Subscriber indicator

HHS provides several examples of the kind of analysis it plans to undertake using the new data elements. For example, it proposes to collect and extract the ICHRA indicator to conduct analysis on whether there are any unique actuarial characteristics among that population and

whether employers offering such plans employ sicker employees compared to other employers. HHS could also examine risk patterns or impacts using zip codes, race, ethnicity, and the subsidy indicator such as differences in health risk among geographic areas.

The analyses that would be facilitated by the additional data elements would serve the government interest of promoting equity in health coverage and improving access to high-quality health care as required by EO 13985, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government".

HHS reviews some of the feedback it received when it sought comment on the advantages and disadvantages of extracting state and rating area data for these purposes (in the proposed 2020 Payment Notice). At the time, it did not finalize any additional data elements or extractions concluding that the increased issuer burden would outweigh the benefit of the additional data and analyses. Now, however, in light of EOs 13985 and 14009, HHS has reconsidered and determined that their use aligns with the policy goals of those EOs. Consistent with the priorities identified in those EOs, the data could be used to inform future policy to better address discrimination and other systemic barriers in health care and health care disparities.

HHS notes that any future risk adjustment methodology changes or other policy changes based on these analyses would be set forth in notice and comment rulemaking.

Limited Data Set. Existing policy permits qualified researchers to have access to a limited data set of enrollee-level data for research purposes. In the proposed 2023 Payment Notice, HHS would exclude plan ID, Zip Code, and Rating Area from the data set available to qualified researchers. Other elements that would be available to researchers would be race, ethnicity, ICHRA indicator, subsidy indicator, and subscriber indicator. If finalized as proposed, most of those data would be included beginning with the 2023 benefit year enrollee-level EDGE limited data set. Subscriber indicator would be included beginning with the 2022 benefit year enrollee-level.

HHS seeks comments on these proposals including feedback on privacy or confidentiality concerns related to providing these data elements to qualified researchers upon request.

Proposal to Expand Permissible Uses of EDGE Data. HHS proposes to expand the permitted uses of the data and reports extracted from issuers' EDGE servers to include other HHS federal health-related programs outside of the commercial individual and small group markets. This proposed expansion would apply upon the effective date of the final rule and would include the new data elements, if finalized.

HHS provides an example of such an expanded use – in the case where a state Medicaid program enrolls Medicaid expansion population in QHPs – the EDGE data could be used to inform analysis and improve the integrity of the Medicaid expansion approach. In addition, HHS notes that any policy changes that result from analyses of these data would be subject to notice and comment rulemaking and thorough data quality checks would be conducted before use of any additional data elements or analysis.

Burden for Collecting and Extracting Additional Data Elements. HHS discusses the burden of the proposals noting that extraction of the three data elements: plan ID, rating area, and subscriber indicator – would have minimal additional burden for issuers since those data are already required to be submitted as part of risk adjustment submission.

For the five new data elements, HHS believes:

- There would be a small burden associated with submission of zip codes as issuers currently collect that information. The only additional expense would be for issuers to compile and submit the element to their EDGE server and retain it as part of their risk adjustment records.
- Because issuers do not likely already collect the ICHRA indicator, HHS proposes that submission of this element would be optional for the 2023 and 2024 benefit years. This would allow issuers time to develop a collection, validation, and submission process before the element is required.
- HHS believes that issuers already collect race and ethnicity data in some manner, so it expects a small additional collection burden for issuers to compile and submit the data elements as part of their risk adjustment records. It seeks comments on whether those data are currently collected and whether HHS should take additional considerations into account with their collection. HHS is aware that the elements are often collected through other processes such as Exchange enrollment or payment files, but believes those data would not be uniform, comprehensive, or as usable as data collected through EDGE servers.

HHS seeks comment on the relative value of the additional data elements, whether HHS should consider alternatives to the proposed elements, and how issuers currently collect data on race and ethnicity.

HHS also clarifies that issuers will have the option of selecting "unknown" for the race and ethnicity data element to better align with the approach taken for application and enrollment forms.

Encouraging the Use of Z Codes. HHS seeks comment on the collection and extraction of z codes (particularly Z55-Z65), a subset of ICD-10-CM encounter reason codes used to identify, analyze, and document social determinants of health. Z codes are currently collected via the enrollee-level EDGE data. HHS, which has recently begun analyzing the codes, describes reports of a lack of consistent use of z codes by providers. It seeks feedback on how to encourage the consistent use of the codes and to learn about the potential use of the codes in analyzing the relationship between risk and social determinants of health.

6. Risk Adjustment User Fee for 2023 Benefit Year (§153.610(f))

HHS proposes a risk adjustment user fee for the 2023 benefit year of $0.22 per member per month (PMPM), slightly lower than the amount for the 2022 benefit year ($0.25 per member per month). That amount is based on the same methodology as used for 2022 and reflects a total cost of approximately $60 million to operate the program but a small increase in billable member months in the individual and small group markets for the 2023 plan year.

7. Compliance with Risk Adjustment Standards; High-Cost Risk Pool Funds – Audits of Issuers of Risk Adjustment Covered Plans (153.620(c))

HHS proposes that whenever HHS recoups high-cost risk pool funds as a result of audits of risk adjustment covered plans, those funds would be used to reduce high-cost risk pool charges for the national high-cost risk pool beginning for the current benefit year unless those amounts have already been calculated, in which case they would be applied to the next benefit year. The policy would result in those funds reducing high-cost risk pool payments for the next benefit year for which they have not already been calculated. HHS had proposed this policy in the proposed 2022 Payment Notice but did not finalize it. HHS provides an example of how the policy would work. If a 2018 high-cost risk pool audit results in funds being recouped for the national high-cost risk pool for the individual market in March 2022, then these recouped funds would be disbursed in the form of reduced 2021 benefit year high-cost risk pool charges for issuers in the national high-cost risk pool for the individual market because high-cost risk pool payments for the 2021 benefit year are not calculated until June 2022.

HHS notes that the policy would not impact the amount of high-cost risk pool payment made to eligible issuers, because the reduction in charges is due to the recoupment of funds as a result of an audit of a prior benefit year rather than a change in payments for the current benefit year.

HHS would also clarify that when HHS recoups funds as a result of an audit, the issuer subject to the audit is responsible for reporting that adjustment to its high-cost risk pool payments or charges in the next medical loss ratio (MLR) reporting cycle.

8. Risk Adjustment Data Validation Requirements (§153.630)

HHS conducts risk adjustment data validation (RADV) in any state where HHS is operating risk adjustment on a state's behalf. The validation consists of an initial validation audit and a second validation audit. Each issuer of a risk adjustment covered plan must engage an independent audit entity for the initial validation. The issuer provides demographic, enrollment, and medical record documentation for a sample of enrollees selected by HHS to its initial validation auditor for data validation. The second validation audit is conducted by an entity that HHS retains to verify the accuracy of the findings of the initial validation audit.

In the 2020 HHS-RADV Amendments Rule, HHS described and finalized the error rate calculation methodology for RADV applicable for benefit years 2019 and thereafter. In the proposed 2023 Payment Notice, HHS proposes additional refinements to the error rate

calculation methodology beginning with the 2021 benefit year. The refinements would (1) extend the application of Super HCCs to also apply to coefficient estimation groups throughout the HHS-RADV error rate calculation process, (2) specify that the Super HCC would be defined separately according to the age group model to which an enrollee is subject, and (3) constrain to zero any outlier negative failure rate in a failure rate group, regardless of whether the outlier issuer has a negative or positive error rate.

(a) Coefficient Estimation Groups in Error Estimation

HHS proposes to modify its process for grouping coefficient estimation groups in error estimation. This amendment is intended to conform the process for the risk adjustment risk score calculation for individuals with two conditions that fall into the same coefficient estimation groups with the way the process is used for HHS-RADV failure rates, and other HHS-RADV calculations for such individuals. The preamble describes in detail, the dissimilarity in the treatment of such individuals for the different calculations and the solution of applying the same approach used for risk adjustment to the RADV calculations.

(b) Defining Super HCCs Separately for Adults, Children, and Infants

Super HCCs are a step where HHS aggregates any HCCs that share a coefficient estimation group before applying the HHS-RADV failure rate group sorting algorithm. In the proposed 2023 Payment Notice, HHS would apply coefficient estimating groups according to the risk adjustment model to which they are subject. Under the current policy, coefficient estimation group logic from the adult models is applied to all enrollees. The policy was adopted because there were concerns that some of the groups in the infant models would have very small sample sizes and the adult models' estimation groups were thought to be likely applicable to the vast majority of enrollees. HHS now believes that there are some differences in the structure of the risk adjustment model coefficient estimation groups across the models that will be better accounted for under the proposal. Table 9 provides a comparison of the Coefficient Estimation Groups used in the Adult and Child models to help illuminate the proposal, additional detail on the proposal's definitions of Supper HCCs for the relevant models, and results of HHS analysis of the proposal is provided in the preamble.

(c) Negative Failure Rate Constraint

In the 2020 HHS-RADV Amendments Rule[9], HHS finalized a policy to constrain outlier issuers' error rate calculations to zero in cases when an issuer is a negative error rate outlier and its failure rate is negative, beginning with 2019 benefit year. The approach is intended to distinguish between low failure rates due to accurate data submission and failure rates that have been depressed through the presence of HCCs in the audit data that were not present in the EDGE data. If a negative failure rate is due to a large number of found HCCs, it does not reflect accurate reporting through the EDGE server for risk adjustment.

[9] 85 FR 76979.

HHS proposes to modify the application of that policy beginning with the 2021 benefit year to constrain to zero the failure rate of any issuer who is a negative failure rate outlier in a failure rate group, regardless of whether the outlier issuer has a negative or positive error rate.

9. Disbursement of Recouped Hight-Cost Risk Pool Funds – Discrepancies of Issuers of Risk Adjustment Covered Plans (§153.710(d))

Consistent with the disbursement policy described above, HHS proposes that any funds recouped as a result of an actionable high-cost risk pool discrepancy under §153.710(d) would be used to reduce high cost-risk pool charges for the national high-cost risk pool for the current benefit year if high-cost risk pool payments have not already been calculated for that benefit year. If high-cost risk pool payments have already been calculated for that benefit year, HHS would reduce the next applicable benefit year's high-cost risk pool charges for all issuers owing high-cost risk pool charges for that national high-cost risk pool. HHS also clarifies that an issuer that has filed the discrepancy would be responsible for reporting the adjustment to its high-cost risk pool payment or charges in the next MLR reporting cycle consistent with the requirements under §153.710(h).

10. Medical Loss Ratio Reporting Requirements (§153.710(h))

HHS proposes to clarify that HHS expects issuers to report HHS-RADV adjustments as part of their MLR reports in the same manner as they report risk adjustment payment and charge amounts. Where an issuer experiences subsequent changes to HHS-RADV adjustments calculated by HHS in the applicable benefit year's HHS-RADV Summary Report of Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers, such modifications would be required to be reported during the current MLR reporting year if approved by HHS before August 15, or the next applicable business day, of the current reporting year unless otherwise instructed by HHS. Issuers would be required to report any adjustment to an HHS-RADV adjustment made or approved by HHS where such adjustment has not been accounted for in a prior MLR Reporting Form, in the following reporting year.

11. Deadline for Submission of Data (§153.730)

Under existing rules, the deadline for issuers to submit their required risk adjustment data is April 30 of the year following the applicable benefit year. HHS proposes to add to the deadline to address situations where April 30 does not fall on a business day. Under the proposed rule, the deadline for submission would be on April 30th or if April 30th is a non-business day, the deadline would be the next applicable business day.

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

1. Non-discrimination Standards (§155.120(c))

HHS proposes to amend its nondiscrimination protections at §155.120(c) to explicitly prohibit discrimination based on sexual orientation and gender identity. In a 2020 final rule modifying the

implementation of section 1557 of the ACA, HHS struck from the nondiscrimination protection language referring to sexual orientation and gender identity, and its proposal would restore that language.

In the proposed rule, HHS states that it has authority independent of section 1557 to prohibit discrimination in the Exchanges, noting that it has previously cited section 1321(a)(1)(A) of the ACA as authority to prohibit discrimination in the operation of the Exchanges. HHS cites the same authority here for its proposal and uses the same rationale described above for its proposal to amend 45 CFR 147.104(e) to explicitly provide that its nondiscrimination protections apply to discrimination based on sexual orientation and gender identity in that section of the regulations. (See summary of section III.B.1 above.) **HHS seeks comment on this proposal.**

2. Civil Money Penalties for Violations of Applicable Exchange Standards by Consumer Assistance Entities in Federally-facilitated Exchanges (§155.206)[10]

HHS proposes to make a technical correction to §155.206(i) to add language to adjust the amount of civil money penalties for inflation pursuant to the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015. It notes that no CMPs have been imposed under this authority, but going forward the amount of the CMPs under §155.206 will be increased annually for inflation.

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

(a) Required QHP Comparative Information on Web-broker Websites and Related Disclaimer

HHS proposes to amend it regulations at §155.220(c)(3)(i)(A) to include a list of the specific QHP comparative information that web-broker non-Exchange websites must display as the minimum QHP comparative information that must be displayed for all available QHPs. Under the proposal, web-broker non-Exchange websites would have to display (i) premium and cost-sharing information, (ii) the summary of benefits and coverage established under section 2715 of the PHS Act; (iii) identification of the metal level of the QHP or whether it is a catastrophic plan; (iv) the results of the enrollee satisfaction survey (under section 1311(c)(4) of the ACA); (v) quality ratings assigned (under section 1311(c)(3) of the ACA); and (vi) the provider directory made available to the Exchange.

It also proposes to revise the disclaimer requirement in §155.220(c)(3)(i)(A) to require web-broker non-Exchange websites that do not support enrollment in all available QHPs to provide notice to consumers of that fact, and to direct consumers to the Exchange website where they

[10] In the preamble to the proposed rule for section III.D., paragraph 2 was apparently omitted. Thus, in this summary of proposals contained in section III.D. of the proposed rule, paragraph numbers 2 through 9 in this summary correspond to paragraph numbers 3 through 10 in the preamble of the final rule. Note also the preamble in the final rule contains two paragraphs 10. Paragraph 10 of this section of the summary corresponds to the second paragraph 10 of the preamble.

may obtain enrollment support. Thus, web-broker non-Exchange websites would be required to prominently display a standardized disclaimer provided by HHS stating that enrollment support is available on the Exchange website and would be required to provide a web link to the Exchange website in cases where enrollment support for a QHP is not available using the web-broker's non-Exchange website. **HHS seeks comment on these proposals.**

(b) Prohibition of QHP Advertising on Web-broker Websites

HHS proposes to clarify that when a web-broker website is used to complete the QHP selection, the website must not display QHP advertisements or recommendations, or otherwise provide favored or preferred placement in the display of QHPs, based on compensation the agent, broker, or web-broker receives from QHP issuers. It clarifies that the term advertisements would include any form of marketing or promotion of QHPs based on compensation from QHP issuers, as opposed to the application of a neutral filter or sorting methodology that may promote particular QHPs and that are not based on compensation an agent, broker, or web-broker receives from QHP issuers.

This proposal is intended to prohibit these web-brokers from marketing the option for QHPs to receive preferred placement on the web-broker website for a fee. HHS does not believe that QHP advertising on web-broker websites, whether or not characterized as such or using other terms such as preferred placement, is in the best interest of consumers. **HHS seeks comment on this proposal.**

(c) Explanation of Rationale for QHP Recommendations on Web-broker Websites

HHS also proposes to require web-broker websites to prominently display a clear explanation of the rationale for explicit QHP recommendations and the methodology for the default display of QHPs on their websites.

Some web-brokers use the information collected in response to preliminary screening questions to recommend one or more QHPs to consumers, or to rank all available QHPs from most to least recommended. Web-broker websites may recommend QHPs so long as it is not done based on compensation an agent, broker, or web-broker receives from QHP issuers. However, current rules do not require an explanation of the rationale for the recommendations. **HHS seeks comment on this proposal.**

(d) Federally-facilitated Exchange Standards of Conduct (§155.220(j))

Consistent with other proposals in this rule, HHS would amend the regulations on FFE standards of conduct (at §155.220(j)(2)(i)) relating to nondiscrimination protections to explicitly prohibit discrimination based on sexual orientation and gender identity. Under 155.220(j)(2)(i) as revised by the 2020 section 1557 final rule, correct information must be provided to consumers, without omission of material fact, regarding the FFE, QHPs offered through the FFE, and insurance affordability programs; these individuals or entities must refrain from marketing or conduct that is misleading (including by having a direct enrollment website that HHS determines could

mislead a consumer into believing they are visiting HealthCare.gov), coercive, or discriminates based on race, color, national origin, disability, age, or sex.

If finalized, the regulations would revert to the nondiscrimination protections in effect before the 2020 section 1557 final rule by reinserting language explicitly prohibiting discrimination based on sexual orientation and gender identity. **HHS seeks comment on this proposal and on all of the following additional proposals.**

i. Providing Correct Information to the FFEs

§155.220(j)(2)(ii) requires agents, brokers, or web-brokers to provide the FFEs with correct information under section 1411(b) of the ACA sufficient for the Exchange to determine eligibility for Exchange coverage, APTC, CSRs, and individual responsibility exemptions, including the applicant's name, address, and information regarding household income. HHS proposes to codify additional details regarding this requirement to capture a non-exhaustive list of specific examples of what it means to provide correct information to the FFEs and SBE-FPs with respect to the consumer's email address, mailing address, telephone number, and household income projection. The genesis of this proposal is concern over applications submitted to the FFEs that contain incorrect consumer information (name and contact information) and incorrect consumer household income projections that do not accurately reflect future consumer household income.

Email addresses. Email addresses on applications for Exchange coverage would have to be secure, not disposable, and belong to the consumer (or the consumer's authorized representative). Email addresses could only be entered on Exchange applications with the consent of the consumer (or authorized representative) and must meet all of the following guidance. The email addresses:

- May not have domains that remove email from an inbox after a set period of time;
- Must be accessible by the consumer (or authorized representative), and may not be accessible by the agent, broker, or web-broker; and
- May not have domains that belong to the agent, broker, or web-broker or their business or agency.

Telephone numbers. Telephone numbers on an application for Exchange coverage would have to belong to the consumer (or authorized representative). Additionally, the telephone number on the application could not be the personal number or business number of the agent, broker, or web-broker assisting with or facilitating enrollment through an FFE or assisting the consumer in applying for APTC and CSRs for QHPs, or their business or agency, unless the telephone number is actually that of the consumer (or authorized representative). A telephone number is considered to belong to the consumer if they (or their authorized representative) are accessible at the number and have access to the number.

Mailing address. The mailing address on an application for Exchange coverage would have to belongs to, or be primarily accessible by, the consumer (or authorized representative). A mailing address entered on the Exchange application could not be for the exclusive or convenient use of

the agent, broker, or web-broker; it would have to be an actual residence or a secure location where the consumer (or authorized representative) may receive correspondence. Additionally, HHS proposes to specify that a mailing address entered on Exchange applications may not be that of the agent, broker, or web-broker, or their business or agency, unless it is the rare situation where that address is the actual residence of the consumer (or authorized representative).

Household income projections. HHS proposes that agents, brokers, or web-brokers may only enter a household income projection for a consumer that the consumer (or authorized representative) has authorized and confirmed is an accurate estimate. Specifically, the consumer (or authorized representative) must attest to the estimate's accuracy. HHS proposes to clarify that the agent, broker, or web-broker may answer questions posed by the consumer (or authorized representative) related to household income projection, such as helping determine what qualifies as household income. HHS is concerned by agents, brokers, or web-brokers who intentionally or negligently enter inaccurate household income projections on a consumer's Exchange application because this may harm consumers and will prevent the efficient operation of the Exchange.

ii. Prohibited Business Practices

HHS proposes to add several new standards of conduct for agents, brokers, and web-brokers that assist consumers with applying for and enrolling in coverage through an FFE or SBE-FP, with or without APTC and CSRs. It would codify standards related to the use of scripting and other automation interactions with CMS Systems or the Direct Enrollment (DE) Pathways (including both Classic DE and EDE), identity proofing consumer accounts on HealthCare.gov, and providing assistance with SEP enrollments as described below.

iii. Prohibit Automated Interactions with CMS Systems

This proposal would prohibit scripting and other automation of interactions with CMS Systems or the DE Pathways, unless approved in advance in writing by CMS. These requirements are not codified in regulation but are included in the Agent Broker General Agreement for Individual Market Federally-Facilitated Exchanges and State-Based Exchanges on the Federal platform (IM General Agreement). It notes that codifying this requirement would clarify CMS' authority to take enforcement actions against agents, brokers, and web-brokers for violations of the requirement.

The proposal is made in response to concerns with increases in unauthorized enrollments (because of automated browser-based interactions with Exchange systems), unauthorized application changes, or unauthorized access to consumer PII. The concern with respect to PII is because agents, brokers, and web-brokers could find far more consumer information using automation, which may result in the unauthorized taking, use, or sale of significant amounts of consumer PII for unlawful purposes. **Comment is sought on these concerns as well as on concerns relating to creating significant traffic in the system because automated interactions may cause more system activity per user than anticipated and planned for**. **It**

also seeks comment on appropriate uses of automation that may contribute to the efficient operation of the FFEs and SBE-FPs, and the DE Pathways.

iv. Identity Proofing

HHS proposes to require agents, brokers, and web-brokers to only use an identity that belongs to the consumer when identity proofing the consumer's account on HealthCare.gov. Identity proofing is currently required when a consumer creates an account on HealthCare.gov via an EDE site, and when a consumer works with an agent or broker in person. HHS has observed practices by agents who use the same identity information to complete the identity proofing process for multiple consumer Exchange accounts.

v. Providing Information to Federally-facilitated Exchanges in Connection with SEPs

When providing information to federally-facilitated Exchanges that may result in a determination of eligibility for a special enrollment period, HHS proposes to require agents, brokers, and web-brokers to:

- Obtain authorization from the consumer to submit the request for the determination of eligibility for the special enrollment period (the authorization need not be in writing); and
- Make the consumer aware of the specific triggering event and special enrollment period for which the agent, broker, or web-broker will be submitting an eligibility determination request on the consumer's behalf.

Agents, brokers, and web-brokers to would have to make reasonable, good faith efforts to ascertain the consumer's eligibility for the SEP, consistent with the existing standard under §155.220(j)(3). The proposal is made in reaction to circumstances where consumers apply for QHP enrollment through an SEP with the assistance of an agent, broker, or web broker who are not made aware of the basis upon which their QHP application claims entitlement to an SEP, or who otherwise did not authorize an agent, broker, or web-broker to enroll them in a QHP or make a change to their current QHP enrollment.

4. Premium Calculation (§155.240)

HHS proposes to add language at §155.240(e)(2) to apply the premium calculation methodology that currently applies in the FFEs and SBE-FPs to all Exchanges, beginning with PY 2024. This is intended as a conforming clarification to the policy proposal (described in paragraph (9) below) that an Exchange is required to prorate the calculation of premiums for individual market policies and the calculation of APTC in cases where an enrollee is enrolled in a particular policy for less than the full coverage month, including when the enrollee is enrolled in multiple policies within a month, each lasting less than the full coverage month. **HHS seeks comment on this proposal.**

5. Eligibility Standards (§155.305)

A technical amendment to §155.305(f)(1)(i) is proposed to clarify that the income eligibility standards used by the Exchange for determining whether an individual is an applicable taxpayer for purposes of APTC eligibility are the same as the income thresholds at IRS regulation 26 CFR 1.36B-2(b). In practice, the federal and state Exchanges have always relied on thresholds outlined in 26 CFR 1.36B-2(b) to determine APTC eligibility; the proposal would provide greater regulatory consistency and would minimize the need to update §155.305(f)(1)(i) in case of legislative changes that may change FPL percentage thresholds.

6. Eligibility for Advance Payments of the Premium Tax Credit (§155.305(f)(5))

HHS proposes to require that the APTC must be calculated in accordance with 26 CFR 1.36B-3 and would be subject to the prorating methodology at proposed §155.340(i) (described in paragraph (9) below). The proposal is intended to clarify that an Exchange must prorate the calculation of premiums for individual market policies and the calculation of APTC in cases where an enrollee is enrolled in a particular policy for less than the full coverage month; this would include when the enrollee is enrolled in multiple policies within a month, each lasting less than the full coverage month. **HHS seeks comment on this proposal.**

7. Verification Process Related to Eligibility for Insurance Affordability Programs—Employer Sponsored Plan Verification (§155.320)

HHS proposes to provide flexibility for each Exchange to design its employer sponsored plan verification process based on its assessment of the risk of inappropriate payments of advance premium tax credit (APTC) and cost-sharing reductions (CSRs) based on the associated risk and composition of the enrolled population. Currently, when an Exchange does not reasonably expect to obtain sufficient verification data for a plan year, it must use an alternate procedure whereby it selects a random sample of applicants and meet the requirements under §155.320(d)(4).

If finalized, this proposal would eliminate the requirement that an Exchange select a random sample of applicants for whom the Exchange does not have data (as specified in §155.320(d)(2)(i) through (iii)) and would substitute the proposed alternate, more flexible procedure. The proposal would also eliminate requirements for an Exchange (i) to make reasonable attempts to contact an employer listed on an applicant's Exchange application to verify whether an applicant is enrolled in an employer sponsored plan or is eligible for qualifying coverage in an eligible employer sponsored plan and (ii) to redetermine eligibility for APTC and CSRs within 90 days if the Exchange is unable to obtain the necessary information from an applicant's employer regarding enrollment in or eligibility for qualifying coverage in an employer sponsored plan. HHS notes that nothing precludes a State Exchange from continuing to use the current random sampling methodology.

HHS reviewed the results of a 2019 study conducted to determine the potential risk and risk factors, if any, that may be associated with applicants that choose to enroll in an Exchange QHP with APTC/CSRs, rather than coverage offered through their employer. It found that the risk for

inappropriate eligibility or payment of APTC and CSRs based on applicant eligibility for or enrollment in qualifying employer sponsored coverage was low (2 percent of enrollees received inappropriate APTCs or CRSs). It also determined that random sampling was excessively burdensome and that employer response rates to HHS' requests for information were low.

Under the proposal, risk assessments would be informed by and identified through research and analysis of an Exchange's experiences with current and past enrollments—not solely based on previously published research or literature. Standards would apply to any Exchange using risk-based approaches for verification; these would include designing a process that ensures accuracy of the data and that is based on the activities or methods used by an Exchange such as studies, research, and analysis of an Exchange's own enrollment data. Several scenarios for Exchanges to conduct these validations are described in the proposed rule which vary based on access to accurate and up-to-date information on enrollment, on resource demands for manual verification, and on the level of risk for improper APTC/CSR payment. Exchanges could leverage current attestation questions on the single, streamlined application and accept attestation without further verification against other trusted data sources.

HHS clarifies that SBE-FPs would be required to follow the approach described above since SBE-FPs use the HealthCare.gov platform for eligibility and enrollment determinations. Current Federal platform agreements require that SBE-FPs adhere to the same policy and operations as Exchanges that use the federal eligibility and enrollment platform regarding eligibility for and enrollment in QHP coverage.

It is also noted that an Exchange's verification program may not be discriminatory in nature, and that State Exchange's verification processes will be monitored by HHS. Exchanges are cautioned to pay special attention to known risks, including risk pool manipulation or steering high risk employees from the group health market into the Exchanges. **It seeks comment on these proposals.**

8. Annual eligibility redetermination (§155.335)

HHS previously established its renewal and re-enrollment hierarchy at §155.335(j) to minimize potential enrollment disruptions.

Paragraph (1) of that section provides that if an enrollee remains eligible for enrollment in a QHP through the Exchange upon annual redetermination, and the product under which the QHP in which they were enrolled remains available for renewal, the enrollee will have his or her enrollment in a QHP through the Exchange under the product renewed unless they terminate coverage (including termination of coverage in connection with voluntarily selecting a different QHP). Renewal is done in the following priority order:

1. In the same plan as the enrollee's current QHP.
2. If the enrollee's current QHP is not available, coverage will be renewed in a plan at the same metal level as their current QHP.

3. If their current QHP is not available and the enrollee's product no longer includes a plan at the same metal level as the enrollee's current QHP, their coverage will be renewed in a plan that is one metal level higher or lower than their current QHP.
4. If their current QHP is not available and the enrollee's product no longer includes a plan that is at the same metal level as, or one metal level higher or lower than their current QHP, their coverage will be renewed in any other plan offered under the product in which the enrollee's current QHP is offered in which the enrollee is eligible to enroll.

Paragraph (2) of that section addresses re-enrollment in situations in which no plans under the product under which an enrollee's QHP is offered are available through the Exchange for renewal. In this case, the enrollee may be enrolled in a QHP under a different product offered by the same issuer (to the extent permitted by state law) unless the enrollee terminates coverage (including terminating coverage in connection with voluntarily selecting a different QHP). Re-enrollment occurs in the following priority order:

1. In a QHP through the Exchange at the same metal level as the enrollee's current QHP in the product offered by the issuer that is the most similar to the enrollee's current product.
2. If the issuer does not offer another QHP through the Exchange at the same metal level as the enrollee's current QHP, they will be re-enrolled in a QHP through the Exchange that is one metal level higher or lower than their current QHP in the product offered by the issuer through the Exchange that is the most similar to the enrollee's current product.
3. If the issuer does not offer another QHP through the Exchange at the same metal level as, or one metal level higher or lower than the enrollee's current QHP, they will be re-enrolled in any other QHP offered through the Exchange by the QHP issuer in which they are eligible to enroll.

Stakeholders have expressed concerns that enrollees in the FFEs may fail to return to the Exchange to make an active plan selection in situations where changing plans could be beneficial to the enrollee, and that re-enrollment rules may default enrollees into less beneficial plans than other available plans.

HHS seeks comment on whether factors like net premium, MOOP, deductible, and annual out-of-pocket costs of a plan should be reflected in a revised re-enrollment hierarchy. It also seeks comment on additional criteria or mechanisms it could consider to ensure the Exchange hierarchy for re-enrollment aligns with plan generosity and consumer needs beyond merely retaining the most similar plan available.

9. Administration of Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions (§155.340)

Currently, HHS regulations governing APTC eligibility and administration do not contain specific requirements on how APTC should be administered for a policy in which an enrollee is enrolled for less than the full coverage month. HHS proposes to clarify that an Exchange must prorate the calculation of premiums for individual market policies and the calculation of the APTC in cases where an enrollee is enrolled in a particular policy for less than the full coverage month. This would also apply when the enrollee is enrolled in multiple policies within a month,

each lasting less than the full coverage month. If finalized, the new proration policy would apply to all Exchanges (including state-based Exchanges) for plan year 2024 and each succeeding plan year.

HHS states that the proposal only applies to individual market policies because many SHOP Exchanges, particularly the federally-facilitated SHOP Exchanges, do not calculate premiums, and the APTC is not available through SHOPs. It also notes that state Exchanges are not currently required to prorate APTC for mid-month policy changes and, as a result, HHS may overpay APTC amounts to issuers in state Exchanges that do not currently prorate in this manner.

HHS proposes to add language in a new §155.340(i) that specifies for enrollees enrolled in a policy for less than the full coverage month that the amount of the advance payment of the premium tax credit paid to the issuer of the policy must equal the product of—

- The advance payments of the premium tax credit applied to the policy for one month of coverage divided by the number of days in the month; and
- The number of days for which coverage is being provided in the month under the policy.

HHS proposes similar, conforming amendments to §§155.240(e) and 155.305(f)(5). It clarifies that the proposed proration methodology would apply universally across all Exchange types (i.e., FFEs, SBE-FPs, and State Exchanges) and would ensure all Exchanges and issuers report and pay APTC similarly when enrollees are enrolled in a particular policy for less than the full coverage month.

HHS seeks comment on this proposal as well as whether it would be feasible to implement this for plan year 2023. It also seeks comment on implementation and operational costs and time for state Exchanges.

10. Special Enrollment Period Verification (§155.420)[11]

There is currently no requirement under federal regulations for state Exchanges to conduct verification of special enrollment periods. HHS notes that it did not establish such requirements previously to enable state Exchanges to have flexibility in the policies they adopt in this area but to date all state Exchanges conduct either pre- or post-enrollment verification for at least one special enrollment type and most have implemented a process to verify the vast majority of special enrollment periods requested by consumers.

HHS proposes to indicate in regulations that Exchanges may conduct pre-enrollment verification of eligibility for special enrollment periods, at the option of the Exchange, and that Exchanges may provide an exception to pre-enrollment special enrollment period verification for special circumstances. These special circumstances would include natural disasters or public health emergencies that impact consumers or the Exchange. The rationale for the proposal is to

[11] Paragraph 10 in this summary of section III.D. corresponds to the second paragraph 10 of this section of the preamble.

encourage state Exchanges to conduct special enrollment period verification but also allow the FFEs, SBE-FPs, and State Exchanges to maintain flexibility in implementing and operating special enrollment period verification.

It also proposes to specify in regulations that the Exchanges on the Federal platform would only continue to conduct pre-enrollment verification of eligibility for one type of special enrollment period: the special enrollment period for new consumers who attest to losing minimum essential coverage. **HHS seeks comment on these proposals.**

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

Under the Payment Integrity Information Act of 2019[12] (PIIA), federal agencies must annually identify, review, measure, and report on the programs they administer that are considered susceptible to significant improper payments. HHS determined that APTC payments may be susceptible to significant improper payments and thus they are subject to additional oversight. To address this, the Department will establish and implement, beginning with plan year 2023, a State Exchange Improper Payment Measurement (SEIPM) program which will be set out in a new subpart P and which is described at length in paragraph 12 immediately below.

The SEIPM program is designed to accurately calculate an improper payment rate by developing annual improper payment estimates and subsequent reporting of improper payments. The SEIPM program would require state Exchanges that operate their own eligibility and enrollment platform to provide HHS with access to certain data, including eligibility determinations and enrollment information. State Exchanges with significant improper payments may also be required to develop corrective action plans (CAP) to correct the causes of the identified improper payments.

State Exchanges must comply with certain program integrity and oversight requirements. These include a requirement (at §155.1200(c)) that each state Exchange engage or contract with an independent qualified auditing entity to perform annual independent external financial and programmatic audits. State Exchanges must provide HHS with the results of the audits, to inform HHS of any material weakness or significant deficiency identified in the audit, to develop and inform the Department of any CAPs for such material weakness or significant deficiency, and to make a public summary of the results of the external audit.

HHS proposes to permit a State Exchange that operates its own eligibility and enrollment platform to meet the requirement to conduct an annual independent external programmatic audit under §155.1200(c) by completing the required annual SEIPM program process. Thus, it would generally accept the state Exchange's completion of the SEIPM process for a given benefit year as meeting the annual programmatic audit requirement for that benefit year.

[12] Public Law 116-117 (Mar. 2, 2020).

12. State Exchange Improper Payment Measurement Program (§§155.1500 through 155.1540)

As noted above, HHS is establishing a State Exchange Improper Payment Measurement (SEIPM) Program with respect to APTC payments for certain state Exchanges. It will establish a pilot program and is proposing regulations governing the SEIPM program. The proposed regulations would pertain to state Exchanges that operate their own eligibility and enrollment platform; they would not apply to state Exchanges that use the Federal platform to conduct eligibility determinations and enrollment transactions. An SEIPM improper payment rate would be calculated for each benefit year, and HHS expects the first calculation would be for the 2023 benefit year. It anticipates that the 2023 benefit year improper payment rate would be published in November of 2025. The proposed regulations are as follows; **HHS seeks comment on the proposals with respect to the SEIPM Program contained in new subpart P**.

(a) Purpose and Definitions (§155.1500)

The purpose of the part is to set forth requirements for the SEIPM. Several terms are defined as follows:

- *SEIPM program*: The (SEIPM) program is the process for determining estimated improper payments and other information required under the PIAA, and implementing guidance, for advance payments of the premium tax credit. This includes a review of a state Exchange's determinations of eligibility for and enrollment in a QHP; the calculation of advance payments of the PTC; redeterminations of eligibility determinations during a benefit year; and annual eligibility redeterminations.
- *Review*: The term review means the process of analyzing and assessing data submitted by a state Exchange to HHS to determine a state Exchange's compliance with subparts D and E[13] as it relates to improper payments.
- *Error*: An error is a finding by HHS that a state Exchange did not correctly apply requirements with subparts D and E regarding eligibility for and enrollment in a QHP; advance payments of the PTC, including the calculation of advance payments of the PTC; redeterminations of eligibility determinations during a benefit year; or annual eligibility redeterminations, which have a payment impact.
- *Error findings decision*: An error findings decision is the enumeration of errors made by a State Exchange. This includes a determination of how the enumerated errors inform improper payment estimation and reporting requirements.
- *Redetermination of an error findings decision (or redetermination decision)*: This means a decision by HHS that results from a state Exchange's request for a redetermination of an error findings decision.
- *Appeal of redetermination decision (or appeal decision)*: This means the HHS appeal decision that results from an appeal by a state Exchange of the HHS redetermination decision.

[13] Requirements imposed under subparts D and E of part 155 relate to Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs, and Enrollment in QHPs.

- *Corrective action plan (CAP)*: A CAP is the plan a state Exchange develops to correct errors resulting in improper payments.

(b) Program Notification and Planning Process (§155.1505)

Before each measurement year, HHS would provide information to state Exchanges about the SEIPM program. This may include review criteria, major changes from previous measurement cycles, or other modifications of specific SEIPM activities. HHS would issue a Program schedule that sets forth the timeline for the data requests.

State Exchanges to which the Program applies must provide HHS with the operational and policy information required to perform the SEIPM review process, as well as any operational, policy, or other changes that may impact the SEIPM review process. This information must be provided by the deadline(s) set forth in the annual program schedule.

(c) Data Collection (§155.1510)

A state exchange would have to provide both pre-sampling data and sampled unit data for eligibility and enrollment information for a benefit year. While data submission would have to meet the deadline(s) in the Program schedule, HHS may consider extension requests for extreme circumstances. Any failure to provide the information in a timely manner may result in an error finding; the finding would be based on insufficient data provided during the review to support state compliance with APTC payments.

(d) Review Process and Improper Payment Rate Determination (§155.1515)

For each sampled record, HHS would review the information submitted by the state Exchange and would determine whether any errors were made in the state Exchange's determinations of any of the following:

- Eligibility for and enrollment in a QHP,
- Advance payments of the PTC, including the calculation of those payments,
- Redeterminations of eligibility determinations during a benefit year, and
- Annual eligibility redeterminations.

HHS would notify the state Exchange of the error findings decisions with respect to the state Exchange determinations and would also estimate the improper payment rate of that state Exchange.

HHS would maintain a record of status of receipt for the information requested from each state Exchange for a minimum of 10 years.

(e) Error Findings Decisions (§155.1520)

After completing review, HHS would issue the error findings decision to the state Exchange. Each error finding decision would include (at a minimum) review findings regarding any errors made by the state Exchange and information on the right to request a redetermination of the HHS error findings decision.

Error findings decisions would be issued at regular and recurring points of time within the measurement year during each review cycle; however, HHS recognizes that certain events could result in necessary delays (e.g., public health emergencies, natural disasters, interruptions in business practices, or other extenuating circumstances). If these types of events warrant additional time, HHS would notify state Exchanges of any delay via the CMS website. The same policies apply with respects to redeterminations and appeals of error findings decisions described below.

(f) Redetermination of Error Findings Decisions (§155.1525)

A state Exchange would be able to seek a redetermination of an HHS error findings decision. The deadline(s) to submit a redetermination request would be set forth in the annual Program schedule, and HHS may consider requests for extensions in extreme circumstances (e.g., natural disasters or major systems failures). Any redetermination request would have to identify the errors in question and include data and information to support the redetermination request, including an explanation of how the data or information applies to the identified error(s).

HHS would issue its decision by the deadline(s) set forth in the annual Program schedule. The decision would include the Department's findings on the impact of the data and information provided by the state Exchange on the error(s) as well as the state Exchange's right to request an appeal of the decision.

(g) Appeal of Redetermination Decision (§155.1530)

A state Exchange would be able to appeal an adverse redetermination decision within the deadline(s) set forth in the annual Program schedule; the appeal request would have to identify the specific error(s) in dispute. HHS would conduct an on-the-record review; it would not consider additional information or data submitted after the redetermination request.

HHS would issue its decision on the appeal by the deadline(s) set forth in the annual Program schedule. The decision would include the Department's findings on the error(s) for which the appeal was requested as well as the final disposition of the appeal request. Upon closure of all appeals, HHS would issue a report containing the error findings and the estimated improper payment rate. The estimated improper payment rates for each state Exchange would be used to estimate an aggregate improper payment rate across all state Exchanges, and that aggregate rate would be published in the agency's Annual Financial Report.

(h) Corrective Action Plan (§155.1535)

Taking into account a state's error rate for a benefit year, HHS could require the state to develop and implement a corrective action plan (CAP). CAPs would have to be developed according to OMB standards[14], be implemented pursuant to a schedule developed by the state, and be regularly evaluated for effectiveness.

State Exchanges would have the flexibility to tailor CAP activities to their specific needs, including any standard practices, policies and procedures, or business needs. HHS also anticipates that HHS and the state Exchange would collaborate to ensure the effectiveness of any CAP. The Department may detail CAP parameters or requirements in future rulemaking.

(i) Failure to comply (§155.1540)

The failure by a state Exchange to substantially comply with the data collection requirements or the CAP provisions under new subpart P could result in enforcement actions authorized under title I of the ACA or other federal law to ensure the state Exchange's compliance with those requirements or provisions.

HHS notes that the ACA grants HHS broad discretion to ensure the effective and efficient administration of Exchange activities through audits and other authorized means. It cites section 1313(a)(5) of the ACA that authorizes HHS to implement any measure or procedure it determines appropriate to reduce fraud and abuse in the administration of title I of the ACA, which includes the conduct of APTC eligibility determinations and the administration of APTCs. It may exercise authority under this section and **seeks comment on that possibility**. However, HHS would not anticipate broad or willful noncompliance with data collection and CAP requirements if the proposed SEIPM program requirements are finalized. Instead, it expects that HHS and State Exchanges would continue to work collaboratively to ensure the accuracy and integrity of APTC eligibility determinations and payments during SEIPM audits. It would not anticipate regularly imposing financial penalties; those penalties would be reserved for the most egregious situations that would amount to serious misconduct in a state Exchange's administration of APTCs and its failure to comply with audit requirements.

E. Part 156 –Health Insurance Issuer Standards, Standards Related to Exchanges

1. User Fee Rates for the 2023 Benefit Year (§156.50)

HHS proposes user fee rates for the 2023 plan year for all participating FFE issuers of 2.75 percent of premiums. This fee reflects the costs of certifying plans as QHPs and selling coverage through the Federally-facilitated Exchange (FFE) for those determined eligible to enroll in a QHP. Other benefits that issuers receive via federal Exchanges are consumer assistance tools, consumer outreach and education, the Navigator program, regulation of agents and brokers, eligibility determinations, and enrollment processes.

[14] Appendix C to Office of Management and Budget Circular No. A-123.

To provide stakeholders with additional information on the user fee calculations, HHS provides the following estimates:

- Spending on consumer outreach, education, eligibility determinations and enrollment processes for the 2023 plan year will increase by $140 million over 2022 costs; and
- Spending on consumer assistance tools, management of a Navigator program, regulation of agents and brokers, and certification of QHP activities are expected to be similar to costs for the 2022 year.

HHS also considered a range of premium and enrollment projections in developing the estimates and notes that it expects that the expiration of the enhanced premium subsidies under the American Rescue Plan will result in enrollment and premium projections reverting to levels similar to those for the 2020 benefit year.

For issuers offering coverage through State-based Exchanges using the Federal Platform (SBE-FP) for Exchange functions (in which a state chooses to use the federal information technology platform for certain Exchange functions), HHS proposes user fees 2.25 percent of premium for 2023. That amount reflects the proportion of FFE costs associated with FFE information technology infrastructure, the consumer call center, and eligibility and enrollment services.

HHS proposes a number of technical changes to conform provisions in §155.221(j) with the repeal of the Exchange Direct Enrollment (DE) option as finalized in part 3 of the 2022 Payment Notice.

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

(a) States' EHB-Benchmark Plan Options

In past years, HHS has required annual reporting for states to submit their EHB-benchmark plans. The deadline has generally been set in early May of the year that is two years before the effective date of the new EHB-benchmark plan. Feedback on those dates from states has indicated the timeline works for states, and CMS finds the timeline to be sufficient for reviewing and responding to those changes if needed.

HHS proposes that it will no longer propose deadlines for EHB-benchmark submission in each annual Notice of Benefit and Payment Parameters and instead proposes to adopt a consistent, permanent annual deadline for the submission of EHB-benchmark plans on the first Wednesday in May that is two years before the effective date of the new EHB-benchmark plan.

(b) Annual Reporting of State-Required Benefits (§156.111)

In the 2021 Payment Notice, HHS required states to report annually on those state-required benefits applicable to QHPs in the individual and small group markets that are "in addition to EHB" as well as those state-required benefits that were withdrawn and other related information.

Under the ACA, states are required to defray the costs of those benefits. HHS established the first reporting deadline to be July 1, 2021 and the 2022 Payment Notice established the second annual deadline as July 1, 2022, although HHS announced enforcement discretion with regard to the first reporting deadline. It was to begin enforcing the reporting requirements on July 1, 2022.

HHS has continued, however, to receive feedback from states and stakeholders raising concerns about those reporting requirements – that they're unnecessary, burdensome, and there isn't sufficient justification for the reports.

As a result of the feedback, HHS has reassessed the value of the annual reporting policy and is proposing to eliminate the annual reporting requirement.

HHS notes that it intends to continue to provide technical assistance to states to ensure their understanding of when a state-benefit mandate requires defrayal and will provide information on how HHS analyzes and expects states to analyze when benefits are in addition to EHB. In addition, HHS clarifies that the elimination of annual reporting does not impact the applicability of the requirement on states to defray the costs of those state-mandated benefits and issuers continue to be responsible for quantifying the cost of the benefits for states.

3. Provision of EHB (§156.115)

Under existing rules, HHS provides states with the flexibility to permit issuers to substitute benefits between EHB categories. The policy was established to promote flexibility, consumer choice and plan innovation. To date, however, no state has ever sought the flexibility and feedback from consumer advocates has raised concerns that such between-category substitutions could be particularly harmful for people living with chronic conditions or disabilities.

In light of the lack of interest among states in the flexibility and the potential for consumer harm, HHS proposes to eliminate the state option for between-category substitution.

Should the proposal not be finalized, HHS proposes to establish a permanent, annual deadline for states seeking such flexibility to notify HHS of their intent. The proposal, consistent with the above proposal on submitting EHB-benchmark plans, would require states to notify HHS of their intent to permit issuers to substitute benefits between EHB categories by the first Wednesday in May for the PY that is two years before the PY for which the state would apply the flexibility.

4. Prohibition on Discrimination (§156.125)

Under this section of the regulations, health plan issuers providing EHB are required to comply with nondiscrimination requirements as described in §156.200(e). Should the proposal amending §156.200(e) to prohibit discrimination based on sexual orientation and gender identity be finalized, issuers would be subject to those prohibitions by cross reference.

HHS reviews its statutory authority to prohibit discrimination in the small group and individual markets including under section 1557 of the ACA as well as via its authority to define EHB that

must take into account the health care needs of diverse segments of the population. It refers readers to the discussion of §147.104(e) (summarized in section III.B.1.(b) above) for more background on the nondiscrimination provisions.

Refine EHB nondiscrimination policy for health plan designs (§156.125). HHS proposes additions to requirements applicable to issuers providing EHB to clarify what is considered to be a nondiscriminatory benefit design. Section 156.125 establishes that an issuer does not provide for EHB if the benefit design discriminates on the basis of age, expected length of life, present or predicted disability, degree of medical dependency, quality of life or other health conditions. The proposed rule would add that nondiscriminatory benefits must be clinically based, incorporate evidence-based guidelines into coverage and programmatic decisions, and rely on current and relevant peer-reviewed medical journal articles, practice guidelines, recommendations from reputable governing bodies, or similar sources.

HHS states that while these clarifications apply only to issuers providing EHB it expects that states may adopt these standards for other coverage offered within the state. In addition, since states are the primary enforcers of EHB requirements, CMS would be available to states to assist with enforcement efforts. It also plans to monitor compliance with EHB nondiscrimination requirements and states' oversight and enforcement activities.

In the preamble, HHS provides examples of peer-reviewed medical journals and other acceptable sources that would be considered reputable and credible for benefit design as well as sources it does not consider to be reputable. **It seeks comment on whether it should further define the types of acceptable clinical evidence.**

In addition, HHS provides a number of examples of benefits that illustrate discriminatory practices under §156.125 and for each, the rationale of why such a benefit design would be considered discriminatory. HHS notes that a state EHB-benchmark plan could potentially have a discriminatory benefit design. If that is the source of the discriminatory design, it must be addressed either by a state revising the mandate, issuing new guidance, or by plans altering their benefit design to meet the nondiscrimination standards. **HHS seeks comment on whether there are any unforeseen barriers to addressing inconsistencies with proposed clarifications.**

HHS also warns issuers to not inadvertently discriminate based on service delivery model – for example by providing for significantly different copay requirements for in-person versus virtual visits which could inadvertently influence enrollees to avoid in-person care. It intends to monitor for this potential concern.

Examples of discriminatory benefit design that are discussed in the preamble include:

- Limitations on hearing aid coverage based on age. Such a limitation would be discriminatory because hearing loss can occur at any stage of life.
- Limitations on coverage for Autism Spectrum Disorder (ASD) based on age. HHS notes that some individuals with ASD are not diagnosed until they are an adult.
- Age limits for infertility treatment coverage when treatment is clinically effective for the age group.

- Limitations on foot care coverage based on diagnoses. HHS notes specifically that some plans restrict coverage for routine foot care to individuals diagnosed with diabetes. Individuals with other conditions associated with metabolic, neurologic, or peripheral vascular disease, however, may also need routine foot care.
- Restrictions on coverage of EHB due to gender identity.

5. Access to Prescription Drugs for Chronic Health Conditions: Adverse Tiering

Adverse tiering, or the practice of structuring a prescription drug formulary by assigning all or the majority of drugs to treat certain medical conditions to a high-cost prescription drug tier, is considered a discriminatory plan design structured to discourage enrollment by consumers with certain conditions. HHS points out that such practices may discriminate based on a person's present or predicted disability or other health conditions in a manner prohibited by §156.125(a).

HHS proposes that it will consider such practices to be presumptively discriminatory even when all drugs to treat a particular condition are high cost. Issuers and pharmaceutical benefit managers (PBMs) should weigh the cost of drugs on their formulary with clinical guidelines for such drugs to demonstrate that neutral principles were used in assigning tiers to drugs and that those principles were consistently applied across all types of drugs.

If finalized, the policy would become effective 60 days after publication in the final 2023 Payment Notice.

6. Publication of 2023 Payment Parameters in Guidance (§156.130)

As finalized in the 2022 Payment Notice, HHS will publish the following payment parameters in guidance: the premium adjustment percentage, the required contribution percentage, and maximum annual limitations on cost sharing and reduced maximum annual limitation on cost sharing. HHS plans to issue these parameters no later than January 2022.

7. Levels of Coverage (Actuarial Value) (§§156.140, 156.200, and 156.400)

Under the ACA, non-grandfathered plans offered in the individual and small group markets must have the following levels of coverage as specified by their actuarial values (AVs) based on providing those benefits to a standard population:

- A bronze plan must have an AV of 60 percent;
- A silver plan must have an AV of 70 percent;
- A gold plan must have an AV of 80 percent; and
- A platinum plan must have an AV of 90 percent.

A de minimis amount of variation around those AVs is permitted to account for differences in actuarial estimates so long as that difference doesn't result in a material difference in the value of the plan. Under current rules, the permitted amount of variation for each of those standard plan types is +2/-4. (Certain expanded bronze plans may vary by +5/-4 and individual market income-based silver cost sharing reduction (CSR) plan variations may vary by +1/-1 percentage points).

Those levels of variation were established to permit greater issuer flexibility to design new plans and promote competition.

Since those de minimis amounts were finalized in the 2017 and 2018 payment rules, HHS has observed declining numbers of individuals in silver level plans at the lower end of the AV range and increasing numbers of individuals in bronze plans at the higher end of the AV range. HHS is concerned that the data suggest that consumers are not able to distinguish plans that have similar AV percentages even though they have significantly different cost sharing. As a result, HHS is proposing the following reductions to the de minimis percentages.

- A standard silver plan QHP in the individual market would be permitted to vary from an AV of 70 percent by +2/0 percentage points;
- All other silver, standard bronze, gold, and platinum levels of coverage would be permitted to vary by +2/-2 percentage points;
- Expanded bronze plans could vary by +5/-2; and
- Individual market income-based silver CSR plan variations could vary by +1/0 percentage points.

By narrowing the permitted AV variation of individual market QHPs, HHS believes that the generosity of premium tax credits would increase because the generosity of the second lowest cost silver level plan, the plan used to set premium tax credit amounts, would become more generous. The proposal is expected to reduce the cost of coverage for subsidized enrollees and incentivize healthier subsidy eligible enrollees to participate in the Marketplaces. Similarly, limiting the permitted variation for silver CSR plan variations would increase the subsidies and generosity for individuals in those plans.

HHS also clarifies that while states are the primary enforcers of AV requirements and can apply stricter AV standards, a state may not apply an AV range that exceeds +2/-2 percentage points except with respect to expanded bronze plans.

8. QHP Issuer Participation Standards (§156.200)

Consistent with the provisions described above, HHS proposes to amend the nondiscrimination protections applicable to QHP Issuers to explicitly prohibit discrimination based on sexual orientation and gender identity and refers readers to the preamble discussion in section III.B.1.(b) for a complete discussion of the proposal.

9. Standardized Options (§156.201)

HHS proposes to reinstate standardized benefit options for issuers of QHPs in FFEs and SBE-FPs beginning in PY 2023. Under the proposal, issuers in FFEs and SBE-FPs would need to offer a standardized option at each metal level, for each network type, and in each area for which they offer a non-standardized option. Issuers would continue to be permitted to offer non-standardized options, and the standardized option requirements would not apply to plans offered through State Exchanges.

Standardized options were formerly permitted to be offered in Exchanges (issuers were not required to offer them), but the regulation describing the options and permitting their offering was eliminated in the 2019 Payment Notice. Their elimination was subsequently challenged and the U.S. District Court for the District of Maryland vacated the portion of the 2019 Payment Notice eliminating standardized options. HHS subsequently stated its intent to resume standardized options for PY 2023.

HHS states that resuming standardized options will enhance consumer experience, increase consumer understanding and simplify the plan selection process, combat discriminatory benefit designs and advance health equity. The proposed standardized options are described in Tables 16 and 17 of the proposed 2023 Payment Notice which are duplicated below.

Standardized options would be mandatory for issuers offering plans through the FFE or SBE-FPs. The requirements would not apply to issuers in State Exchanges. HHS does not define a standard option for Indian CSR plan variations since most cost-sharing parameters for those plans are already standardized. Further, issuers subject to state laws in place on or before January 1, 2020 describing standardized plans would be exempt from the requirements. (HHS specifically identifies Oregon.) HHS states that the exception is intended to reduce duplicative efforts.

HHS describes two sets of standardized options. One set (Table 16) would be applicable to FFE and SBE-FP issuers in all states except for Delaware and Louisiana. A second set (Table 17) would be applicable to Delaware and Louisiana. Those options were constructed to accommodate those states' specialty tier prescription drug cost-sharing laws.

HHS notes that it is considering requiring differential display of those options as well as resuming enforcement of standardized option display requirements for approved web-brokers and QHP issuers using direct enrollment. If it were to resume enforcement of display requirements for issuers using a direct enrollment pathway, those issuers would only need to display those standardized options that they cover. HHS believes differential display would provide important and clear information for consumers enrolling in coverage.

While HHS is not proposing to limit the offering of non-standardized options in FFEs and SBE-FPs, it is considering whether to limit non-standardized options in the future. It presents information on the significant growth in the number of plan choices in recent years – potentially increasing consumer confusion in plan choice.

HHS reviews comments it received in response to part 3 of the 2022 Payment Notice where HHS stated its intent to resume the use of standardized options. Many commenters supported standardized options to simplify the complex process of purchasing insurance and to identify potentially discriminatory benefit designs among other reasons.

Consistent with earlier standardized benefit designs, HHS developed the proposed options to be similar to the most popular QHPs.

HHS seeks comment on (1) requiring FFE and SBE-FP issuers to offer standardized options at every product network type, metal level, and throughout every service area that they offer non-standardized options; (2) not limiting the number of non-standardized options that issuers can offer; (3) the feasibility, advantages, and disadvantages of gradually limiting the number of plan options; (4) whether standardized options should be differentially displayed; (5) whether web-brokers and issuers using direct enrollment pathways should remain subject to differential display requirements; (6) the exceptions process that allows these entities to deviate from the display of standardized options on HealthCare.Gov; (7) exempting State Exchange issuers and issuers subject to existing state standardized options requirements in place on or before January 1, 2020; (8) the methodology used to design the standardized options; (9) whether the standardized options are compliant with state cost-sharing laws; (10) the cost-sharing parameters and plan designs for these standardized options; (11) how these plans can be designed in a way that maximizes the likelihood that plans will be able to comply with mental health parity requirements; and (12) having two sets of standardized options (that is, a separate set for Delaware and Louisiana).

TABLE 16: 2023 Standardized Options Set One (For All FFE and SBE-FP States, Excluding Delaware and Louisiana)

	Bronze	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Actuarial Value	59.86%	64.06%	70.04%	73.10%	87.04%	94.02%	78.00%	88.00%
Deductible	$9,100	$7,500	$5,800	$5,700	$800	$0	$2,000	$0
Annual Limitation on Cost Sharing	$9,100	$9,000	$8,900	$7,200	$3,000	$1,700	$8,700	$3,000
Emergency Room Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$100*
Inpatient Hospital Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$350*
Primary Care Visit	No charge after deductible	$50*	$40*	$30*	$20*	$0*	$30*	$10*
Urgent Care	No charge after deductible	$75*	$60*	$45*	$30*	$5*	$45*	$15*
Specialist Visit	No charge after deductible	$100*	$80*	$60*	$40*	$10*	$60*	$20*
Mental Health/Substance Use Disorder Outpatient Office Visit	No charge after deductible	$50*	$40*	$30*	$20*	$0*	$30*	$10*
Imaging (CT/PET Scans, MRIs)	No charge after deductible	50%	40%	40%	30%	25%*	25%	$100*

	Bronze	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Speech Therapy	No charge after deductible	$50*	$40*	$30*	$20*	$0*	$30*	$10*
Occupational, Physical Therapy	No charge after deductible	$50*	$40*	$30*	$20*	$0*	$30*	$10*
Laboratory Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$30*
X-rays and Diagnostic Imaging	No charge after deductible	50%	40%	40%	30%	25%*	25%	$30*
Skilled Nursing Facility	No charge after deductible	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Facility Fee (Ambulatory Surgery Center)	No charge after deductible	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Surgery Physician and Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$150*
Generic Drugs	No charge after deductible	$25*	$20*	$20*	$10*	$0*	$15*	$5*
Preferred Brand Drugs	No charge after deductible	$50	$40*	$40*	$20*	$15*	$30*	$10*
Non-Preferred Brand Drugs	No charge after deductible	$100	$80	$80	$60	$50*	$60*	$50*
Specialty Drugs	No charge after deductible	$500	$350	$350	$250	$150*	$250*	$150*

*Benefit category not subject to the deductible

TABLE 17: 2023 Standardized Options Set Two (For Delaware and Louisiana)

	Bronze	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Actuarial Value	59.86%	64.07%	70.05%	73.01%	87.05%	94.02%	78.02%	88.01%
Deductible	$9,100	$7,500	$5,800	$4,100	$800	$0	$2,000	$0
Annual Limitation on Cost Sharing	$9,100	$9,000	$8,900	$7,200	$3,000	$1,800	$8,700	$3,000
Emergency Room Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$100*

	Bronze	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Inpatient Hospital Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$350*
Primary Care Visit	No charge after deductible	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Urgent Care	No charge after deductible	$75*	$60*	$60*	$30*	$5*	$45*	$15*
Specialist Visit	No charge after deductible	$100*	$80*	$80*	$40*	$10*	$60*	$20*
Mental Health/ Substance Use Disorder Outpatient Office Visit	No charge after deductible	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Imaging (CT/PET Scans, MRIs)	No charge after deductible	50%	40%	40%	30%	25%*	25%	$100*
Speech Therapy	No charge after deductible	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Occupational, Physical Therapy	No charge after deductible	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Laboratory Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$30*
X-rays and Diagnostic Imaging	No charge after deductible	50%	40%	40%	30%	25%*	25%	$30*
Skilled Nursing Facility	No charge after deductible	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Facility Fee (Ambulatory Surgery Center)	No charge after deductible	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Surgery Physician and Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$150*
Generic Drugs	No charge after deductible	$25*	$20*	$20*	$10*	$0*	$15*	$5*
Preferred Brand Drugs	No charge after deductible	$50	$40*	$40*	$20*	$5*	$30*	$10*
Non-Preferred Brand Drugs	No charge after deductible	$100	$80	$80	$60	$10*	$60*	$50*

	Bronze	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Specialty Drugs	No charge after deductible	$150	$125	$125	$100	$20*	$100	$75*

*Benefit category not subject to the deductible

10. Network Adequacy (§156.230)

HHS proposes to establish time and distance standards applicable for a specified set of health care providers and to re-establish FFE network adequacy reviews as were in place during 2015 through 2017 – before the Market Stabilization rule deferred those reviews to states. Under that rule, CMS deferred network adequacy reviews to states that had sufficient authority to enforce standards that were at least equal to the reasonable access standards specified in §156.230 and that had the means to assess the adequacy of plans' provider networks.

However, one of the policies vacated by the City of Columbus, et al. v. Cochran decision was the elimination of the federal network adequacy reviews of QHPs offered through the FFEs. Following that decision, HHS indicated its intent to resume the reviews.

For PYs beginning in 2023, HHS proposes to resume network adequacy reviews except where a state elects to perform the reviews and as long as the state enforces standards that are at least as strong as those specified in §156.230.

Time and Distance Standards. HHS proposes to adopt time and distance standards for the certification cycle for PYs beginning in 2023. Lists of provider specialties and facility types that would be subject to time and distance standards were informed by prior network adequacy requirements, consultation with stakeholders, Medicare Advantage, and Medicaid. Provider and Facility Specialty lists for time and distance standards are provided in Tables 18 and 19 and duplicated below.

TABLE 18: Proposed Individual Provider Specialty List for Time and Distance Standards

Individual Provider Specialty Types
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

HPA Note: Table 18 listed two provider types twice. Those duplicative listings have been removed from the table above.

TABLE 19: Proposed Facility Specialty List for Time and Distance Standards

Facility Specialty Types
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

HHS states that the lists are generally consistent with the standards used for Medicare Advantage with several proposed additions: emergency medicine, outpatient clinical behavioral health, pediatric primary care, and urgent care. Emergency medicine is added to incentivize contracting between emergency medicine physicians and issuers. County specific time and distance requirements for each of the providers and facility providers will be detailed in future guidance. To count toward the network adequacy requirements, individual and facility providers would have to be licensed, accredited, or certified to provide services in their state, and would need to have in-person services available.

HHS seeks comment on any flexibilities that may be needed in rural areas where there are provider or plan shortages; the parameters that should apply to behavioral health providers in order to ensure adequate access to these services; and whether additional specialties should be added to the lists in the future.

Appointment Wait Times. In addition to the time and distance standards, HHS is proposing to apply appointment wait time standards beginning with the certification cycle starting 2023 for a list of crucial service categories:

- Behavioral Health Services
- Primary Care (routine)
- Specialty Care (non-urgent)

The specific wait time parameters would be provided in future guidance, and they would be informed by industry standards. Attestation from the provider that they meet the standard would be a part of the certification process, and HHS would conduct post-certification reviews to monitor compliance. Such reviews could occur on the basis of complaints or through random sampling.

Tiered Networks. HHS proposes that, for plans that use tiered networks, to count toward the issuer's satisfaction of the network adequacy standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. For example, a QHP issuer would not be able to use providers contracted with their PPO network when certifying a plan with an HMO network. If a plan with two tiers of providers and lower cost sharing for preferred providers, then only preferred providers would count toward network adequacy standards.

Telehealth Services. HHS proposes to require issuers seeking FFE certification to submit information about whether network providers offer telehealth services beginning with the PY 2023 certification cycle. The data would be used to inform potential future telehealth standards. **It seeks comment on how HHS might incorporate telehealth availability into network adequacy standards in the future. Specifically, it is interested in comments on whether the Medicare Advantage approach – where issuers are offered a credit toward meeting time and distance standards for providing access to telehealth services – could be applicable to QHPs.**

Solicitation of Comments – Unintended Impact of Stronger Network Adequacy Standards. Recognizing that network adequacy standards could create an uneven playing field in network negotiations and drive up costs, HHS seeks comment on policies that would promote competition without inadvertently increasing the market power of some providers. HHS describes the

practice of "steering" patients away from high-cost providers by providing incentives for enrollees to use cost-effective providers. However, some providers are imposing contractual steering restrictions on issuers. HHS seeks feedback on the feasibility and parameters of a potential rule to circumscribe such steering restrictions or other solutions that could balance the bargaining power between issuers and providers in a way that protects the interest of consumers.

Network adequacy standards that empower providers to charge higher prices are particularly concerning to HHS when the provider is part of a multi-provider hospital system that contracts on an all-or-nothing basis with issuers. An all-or-nothing contract requires an issuer to contract with all of the facilities in a health system if the issuer wishes to include any of the providers in the system in the network. This can drive up health care costs. HHS is interested in exploring how limiting such contracting provisions in payer contracts could counteract the power imbalance and potentially reduce health care costs.

HHS seeks feedback on how this practice affects enrollees' use of and access to in-network care and how it may contribute to the cost of care; ways that HHS could help stem the use of all-or-nothing contracts; how issuers can use provider networks to drive costs down; and what impact all-or-nothing contracting has on enrollees, plans, providers, and the market.

Solicitation of Comments – Network Adequacy in State Exchanges. HHS is interested in learning more about the network adequacy policies in place in states with State Exchanges. HHS understands that there is a mix of different network adequacy policies and while it is not inclined to propose network adequacy standards for State Exchanges, it is exploring whether there is a need for greater alignment of the standards applicable to issuers in State Exchanges and FFEs.

HHS seeks comment on whether the disparate state standards necessitate a more coordinated, national approach to network adequacy; whether HHS should consider imposing network adequacy rules in FFEs and State Exchanges that would be intended to increase the standardization of network adequacy across Exchanges; specific measures to support such standardization; and whether there are specific gaps in provider accessibility that exist under disparate State Exchange network adequacy standards that might be addressed through greater federal regulation of network adequacy standards across all Exchanges.

11. Essential Community Providers (156.235)

Essential Community Providers (ECPs) serve predominantly low-income and medically underserved individuals and include Federally Qualified Health Centers, Indian Health providers, Ryan White providers and others. QHPs are required to have a sufficient number and geographic distribution of such providers in their networks.

HHS makes the follow proposals for strengthening the ECP policy:

- It would raise the minimum percentage of ECP providers that a QHP network must have from 20 percent to 35 percent of the available ECPs in each plan's service area.

- For plans using tiered networks, only ECPs that are contracted within the network tier with the lowest cost-sharing obligation would count toward the minimum percentage requirement.
- For PY 2023 and beyond, issuers could comply with the existing requirement that a QHP must contract with at least one ECP in the category of "other ECP providers" by offering a contract to a Substance Use Disorder Treatment Center.

HHS also seeks comment on whether additional clarifications are needed to the text of the requirement that QHPs offer contracts to at least one ECP in each of the ECP categories; whether and how QHPs should increase their use of telehealth services as part of their contingency planning to ensure access to adequate care for enrollees who might otherwise be cared for by relevant ECP types that may be missing from the issuer's provider network; and whether Medicare-certified Rural Emergency Hospitals should be added to the Hospitals ECP category.

12. Standards for Downstream and Delegated Entities (§156.340)

Existing §156.340 establishes the duties of a QHP issuer to maintain responsibility for compliance with a series of requirements and to ensure that any downstream and delegated entities that it contracts with meet any requirements that a QHP passes along via a contract.

HHS proposes to add clarity about those requirements based on the type of Exchange model that the issuer participates in. It would add that for

- QHP issuers participating in Exchange models that do not use the Federal platform, including State Exchanges and State Exchange SHOPs must maintain responsibility for ensuring their downstream and delegated entities comply with the Federal standards related to Exchanges and to the small group market; and
- QHP issuers participating in Exchanges that use the Federal platform, including FFEs, FF-SHOPs, SBE-FPs, and SBE-FP-SHOPs must maintain responsibility for ensuring their downstream and delegated entities comply with Federal standards related to Exchanges and to the small group market. They must also comply with standards for maintaining records and compliance reviews as applicable to the Exchange type in which the QHP issuer is participating.

In addition, HHS would require that agreements between issuers offering QHPs through an Exchange and delegated or downstream entities must include language stating that the relevant Exchange authority may demand and receive the delegated or downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP issuer's obligations until 10 years from the final date of the agreement period.

13. Clarification of CSR Payment and Data Collection Processes (§156.430)

HHS proposes a number of amendments related to CSR reporting. It would:

- Clarify when issuers' CSR data submissions are mandatory or voluntary. Under the clarification, submission of CSR Reconciliation Data is mandatory for those issuers receiving CSR payments from HHS for any part of the benefit year. It is voluntary for other issuers.
- Add that HHS will periodically provide a submission window for issuers to submit CSR data documenting CSR payments. HHS will notify QHP issuers that submission of CSR data is mandatory for those issuers receiving such payments and will use the data to reconcile advance CSR payments. Further, when CSR payments are not made, HHS will notify those issuers that did not receive CSR payments that their CSR data submission is voluntary.
- Change the title of §156.430(e) from "Payment of discrepancies" to "Cost-sharing Reductions Payments and Charges."
- Clarify that HHS will collect data regarding the CSRs actually provided by issuers to their enrollees as opposed to collecting data on the value of CSRs HHS provided to the issuer, and that HHS only pays reconciled CSR amounts when there is an appropriation to make CSR payments and to the extent permitted by such appropriation.

14. Quality Standards: Quality Improvement Strategy (QIS) (156.1130)

HHS proposes to update the Quality Improvement Strategy (QIS) standards beginning in 2023 by adopting a new guideline under which QHP issuers would be required to address disparities in health and health care as a specific topic area within their QIS. The requirement to address the disparities topic area would be separate from and in addition to the existing requirement that issuers address at least one of the other topic areas described in section 1311(g)(1) of the ACA (i.e., improving health outcomes of plan enrollees, preventing hospital readmissions, improving patient safety and reducing medical errors, or promoting wellness and health).

The current QIS regulatory text (see §156.1130) allows for the new guideline to be adopted without amending the existing text. The QIS section will continue to apply to QHP issuers participating in an Exchange for 2 or more consecutive years, and the definition of a QIS will not be changed by the proposed new guideline. HHS notes that the new guideline would align with other health equity efforts underway across federal policies and programs and would use the definition of equity established in Executive Order 13985 issued on January 20, 2021.[15] HHS estimates that 60 percent of PY 2020 QIS submissions already addressed health care disparities.

15. Disbursement of Recouped High-Cost Risk Pool Funds – Administrative Appeals of Issuers of Risk Adjustment Covered Plans (§156.1220)

Consistent with provisions described above, HHS proposes that any funds recouped as a result of a successful high-cost risk pool administrative appeal under §156.1220(a)(1)(ii) would be used to

[15] Equity is defined as "the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities who have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; LGBYQI+ persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality".

reduce high cost-risk pool charges for that national high-cost risk pool for the current benefit year, if high-cost risk pool payments have not already been calculated for that benefit year. If high-cost risk pool payments have already been calculated for that benefit year, the funds would be used to reduce high-cost risk pool charges for that national high-cost risk pool for the next benefit year. HHS also proposes to clarify that the issuer that filed the appeal would be responsible for reporting the adjustment to its high-cost risk pool payment in the next MLR reporting cycle.

16. Direct Enrollment with the QHP Issuer in a Manner Considered to be through the Exchange (§156.1230)

Consistent with provisions described above, HHS proposes to add prohibitions against discrimination based on sexual orientation and gender identity to the nondiscrimination standards applicable to QHP issuers using DE options.

17. Solicitation of Comments – Choice Architecture and Plan Choice Overload

HHS describes the sharp increase in recent years of plan offerings through the Exchanges and expresses concern that proliferation of seemingly similar plans creates plan choice overload for consumers. Choice overload can impair consumers' ability to make informed decisions about which plans will best match their health care needs. **HHS, therefore, seeks comment on choice architectural changes that could better enable consumers to compare QHPs and choose wisely among them**. Specifically, HHS asks about the following:

- The utility and impact of limiting the number of plans that FFE and SBE-FP issuers can offer through the Exchanges;
- Effective methods for limiting the number of plans and the advantages and disadvantages of each method, including methods beyond those described by HHS in the preamble; and
- Evidence-based approaches to improving plan architecture, other than limiting plan numbers.

HHS notes that proposals are being made elsewhere in this rule whose effects also would support preventing plan choice overload: 1) requiring issuers to offer plans with standardized cost-sharing parameters at every product network type, metal level, and throughout every service area where they offer non-standardized options; and 2) limiting AV de minimis ranges for most plan types. Other interventions under consideration by HHS include resuming the meaningful differences standard and adopting the active purchaser model in use by several State Exchanges (e.g., require issuers to offer standardized options exclusively).

F. Part 158 – Issuer Use of Premium Revenue: Reporting and Rebate Requirements

1. Reimbursement for Clinical Services Provided to Enrollees (§158.140)

HHS proposes clarifications to the provider incentive and bonus payments that are permitted to be reported as expenses for the purpose of MLR reporting. While many of the bonuses or

rewards appropriately are intended to incentivize providers to deliver higher quality care to consumers to achieve greater value for those consumers, HHS has identified some practices in the payment of incentives and bonus payments that are not consistent with the law and regulations' purpose. HHS has found that some issuers are reporting incentive or bonus payments to providers that are not based on quality or performance metrics, but are rather transfers of excess premium revenues to providers to circumvent MLR rebate requirements. In those cases, rather than a quality or performance metric, the funds are paid based on the issuer's failure to meet the MLR standard.

HHS notes that this practice artificially raises the issuer's MLR and eliminates most if not all of the rebate owed to enrollees. In response, HHS proposes to clarify that only those provider incentives and bonuses made to providers that are tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers may be included in incurred claims for MLR reporting and rebate calculation purposes.

2. Activities that Improve Health Care Quality (§158.150)

HHS proposes to amend MLR reporting requirements to specify that only spending directly related to activities that improve health care quality can be included as expenses for MLR reporting and rebate calculation purposes.

The clarification is intended to address a wide variety of imaginative expenses that issuers are claiming are for activities that improve health care quality for the purpose of MLR reporting. HHS states that this is due to a lack of clarity in existing regulations. The result has been a wide variety of expenses claimed to be included as being for activities that improve health care quality including a portion of overhead, marketing, lobbying, vendor profits, and other fixed costs including office space, human resources, IT cost centers, etc.

Reporting such expenses as part of quality improvement activities costs is described by HHS as inflating an issuer's expenses and undermining the purpose and intent of the MLR statute.

3. Allocation of Expenses (§158.170)

A provision of the regulations that had permitted issuers to report an amount equal to 0.8 percent of earned premium in lieu of their actual spending on activities to improve health care quality was vacated by the City of Columbus, et al. v. Cochran decision. Consistent with that decision, HHS removed the option in Part 2 of the 2022 Payment Notice. HHS inadvertently, however, did not remove a reference to the option in provisions describing certain reporting requirements. HHS proposes a technical amendment to conform the provision with the removal of the 0.8 percent option.

G. Solicitation of Comments on Health Equity, Climate Health, and QHPs

Health Equity

Consistent with efforts across the federal government to advance equity in general and efforts across CMS to advance health equity in particular, **CMS is seeking comment in the following general areas**:

1. Advancing health equity through QHP certification standards;
2. Advancing CMS's understanding of the existing landscape of issuer collection of health equity data; and
3. Assessing data sources that focus on population-level factors made available by governments, quasi-governmental entities, data vendors and other organizations.

CMS poses a long list of specific questions that should be used by stakeholders when formulating their comments including:

- Whether CMS should require QHP issuers to obtain the National Committee for Quality Assurance (NCQA) Health Equity Accreditation in addition to their existing accreditation requirements;
- What demographic and/or social risk factor data do QHP issuers currently collect from enrollees? Should QHP issuers be required to collect demographic and other social risk factor SDOH data? What are some of the challenges and barriers to data collection?
- What datasets related to population factors could CMS leverage to analyze whether QHP networks are providing adequate access to health care services for members within specific geographic areas? What ability do QHP issuers have to tailor provider networks based on the health needs of enrollees in specific geographic areas?
- What are some of the ways that CMS could measure QHP issuers' progress toward advancing health equity? What are the challenges QHP issuers face in promoting and advancing health equity and strategies for overcoming them?

Climate Health

In response to the growing harm to Americans from climate change, **HHS seeks input on how Qualified Health Plans can more effectively:** (1) determine likely climate impacts on their enrollees, especially those most vulnerable; (2) determine potential costs of climate impacts; (3) develop plans to mitigate catastrophic and chronic impacts for their enrollees, including those most vulnerable (i.e., plans for resilience); and (4) take responsibility for greenhouse gas mission reduction across the networks of organizations that make up their exchanges. Specifically, HHS asks:

- Do Exchanges and issuers have a plan to assess, reduce or mitigate its emissions in its operations or organizations?
- What data do Exchanges and issuers currently collect with respect to the climate threats faced by their enrollees and particularly their most vulnerable enrollees? Do they complete risk assessments or surveys that have a geographic or population focus?

- What types of utilization reviews could issuers perform of medical or prescription data to better understand the impact of climate change events on their enrollees?
- Do NCQA health equity requirements include reviews of climate resilience?
- What would incentivize Exchanges and issuers participating in those Exchanges to more fully prepare for climate change's impacts on vulnerable populations? What would incentivize them to take action on decarbonization? How can issuers strengthen the overall health of their enrollees to be more resilient to harmful climate change events?
- Do issuers currently use, or could they use, apps and/or AI to alert enrollees of severe climate events and steps to mitigate related harmful effects (for example, extreme heat or wildfire events)?
- What measures would be appropriate for assessing QHP performance on climate change and health equity?

IV. Collection of Information Requirements

Tables 22 and 23 show new burden (Table 22) and the reduction in burden (Table 23) annually that would result from the proposed rule. (The tables are reproduced from the rule at the end of this summary section). Preceding these tables, sections IV.B through IV.M of the rule provide the applicable regulatory provisions along with short descriptions of the proposed changes.

§ 153.320: This section generally repeals the ability of states to request a reduction in risk adjustment state transfers in any state market risk pool starting with the 2024 benefit year with exceptions for states that previously participated in risk adjustment state flexibility. The estimated burden related to submission of these requests would be reduced as a result of these proposed changes, since only one state, Alabama, previously participated and would still be able to request this flexibility.

§§ 153.610 and 153.710: HHS is proposing to collect five new data elements from states that do not operate their risk adjustment program and HHS operates it on their behalf. There would be increased burden on those states associated with this proposal.

§ 155.220. HHS expects that a small number of web-brokers that use non-Exchange websites would be affected by its proposed revisions to the standard disclaimer that enrollment support is available on the Exchange website. The revisions to the disclaimer are minor. The proposal to require web-broker websites to prominently display a clear explanation of the rationale for explicit QHP recommendations and the methodology for the default display of QHPs on their websites (for

example, alphabetically based on plan name, from lowest to highest premium, etc.) would also have minor impacts since text-based changes are relatively easy to implement.

§ 155.420 (but appears to be listed in Table 23 as §155.1510). HHS' proposal limits pre-enrollment eligibility verification to one type, loss of minimum essential coverage. This proposal would reduce burden by limiting pre-enrollment eligibility verification to fewer types.

§ 155.1200. This proposal would allow a State Exchange to complete an audit under the SEIPM process resulting in less burden as states operating their own exchanges would no longer be required to dedicate resources to procure and reimburse auditing entities for services rendered to complete the annual independent external programmatic audits.

§ 155.1510. HHS proposes that it will provide State Exchanges with a pre-sampling data request and a sampled unit data request for completion and return to HHS. Costs are not expected to vary substantially since the data being collected are largely in a digitized format and states would be providing information for approximately 100 sampled units.

§ 156.111. The proposals in this section would be burden reducing as HHS would no longer require states to notify HHS of any state-required benefits applicable to QHPs.

§§ 155.220 and 156.265. HHS is considering resuming the differential display of standardized options and enforcing those requirements for approved web-brokers and QHP issuers using a direct enrollment pathway to facilitate enrollment through an FFE or SBE-FP. There would be increased burden costs associated with making changes to implement the different display requirements ($18,804) and requests to deviate from the display on Healthcare.gov ($3,998.50).

§§ 156.230 and 156.235. To ensure QHP enrollees have reasonable and timely access to providers that serve predominantly low-income, medically underserved individuals, HHS has standards related to time and distance and appointment wait time to assess QHP issuers' fulfillment of the reasonable access network adequacy standard. HHS is proposing to raise the ECP threshold from 20 percent to 35 percent and estimates an increase in burden because some issuers have previously only included enough contracted ECPs on the template in order to meet the current threshold for that year's certification process.

§§ 156.430 (not in Table 22 or 23). HHS is proposing several clarifications that CSR data submission is mandatory for those issuers that received CSR payments from HHS for any part of the benefit year, and voluntary for other issuers. Burden savings are expected with these proposals. The existing OMB ICR has been revised to reflect the reduced burden.

§ 156.1130 (not in Table 22 or 23). HHS is proposing that beginning in 2023, a QHP issuer would be required to address reducing health and health care disparities as one of their QIS topic areas in

addition to at least one other topic area outlined in section 1311(g)(1) of the ACA. Any burden associated with this proposal is accounted for in the existing ICR.

§§ 158.140, 158.150 and 158.170 (not in Table 22 or 23). HHS is proposing to amend these regulations to clarify that only those provider incentives tied to clearly defined, objectively measurable and well-documented improvement standards may be included in MLR reporting and rebates. These changes are not expected to significantly change reporting burden.

TABLE 22: Proposed Annual Recordkeeping and Reporting Requirements (New Burden)

Regulation Section(s)	OMB Control Number	Number of Respondents	Number of Responses	Burden/ Response (hours)	Annual Burden (hours)	Labor Cost of Reporting ($)	Total Cost ($)
§§ 153.610 and 153.710	0938-1155	600	600	4	2,400	$225,168	$225,168
§ 155.220	0938-1349	20	40	5	200	$16,440	$16,440
§ 155.1510	0938-NEW	18	18	719	12,942	$1,339,523	$1,339,523
§ 155.1535	0938-NEW	18	18	1,000	18,000	$1,688,760	$1,688,760
§§ 156.230 and 156.235	0938-NEW	485	485	20	5,380	$391,126	$391,126
§§ 155.220 and 156.265	0938-1329	55	55	1	55	$3,998.50	$3,998.50
§§ 155.220 and 156.265	0938-1329	110	110	2	220	$18,804	$18,804
Total				1,751	39,197	$3,683,819	$3,683,819

TABLE 23: Proposed Annual Recordkeeping and Reporting Requirements (Reduction)

Regulation Section(s)	OMB Control Number	Original Number of Respondents	Number of Respondents (if reduced)	Burden per Response (hours)	Reduced Total Annual Burden (hours)	Labor Cost Reporting ($)	Total Cost ($)
§ 153.320	0938-1155	25	1	60	-1,440	-$130,339.20	-$130,339.20
§ 155.1510*	0938-1207	n>10		.2	-38,800	-$1,790,232	-$1,790,232
§ 155.1200	0938-1244	18	0	6	-108	-$11,243.16	-$11,243.16
§ 156.111	0938-1174	41	0	13	-533	-$45,817	-$45,817
Total				79.2	-40,881	-$1,977,631	-1,977,931

V. Regulatory Impact Analysis

HHS does not expect the provisions of this proposed rule to significantly alter CBO's estimates of the budget impact of the premium stabilization programs in Table 25. The effects of the provisions proposed in this rule are consistent with previous estimates in the 2022 Payment Notice for the impacts associated with the APTCs, the premium stabilization programs, and FFE (including SBE-FP) user fee requirements.

TABLE 25: Estimated Federal Government Outlays and Receipts for the Risk Adjustment and Reinsurance Programs from Fiscal Year 2023-2027, in billions of dollars

Year	2023	2024	2025	2026	2027	2023-2027
Risk Adjustment and Reinsurance Program Payments	6	6	6	7	7	32
Risk Adjustment and Reinsurance Program Collections	6	6	7	7	7	33

Note: Risk adjustment program payments and receipts lag by one quarter. Receipt will fully offset payments over time. Source: Congressional Budget Office. Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2020 to 2030 Table A-2. September 29, 2020. Available at https://www.cbo.gov/system/files/2020-09/56571-federal-health-subsidies.pdf.

Risk adjustment user fee costs for the 2023 benefit year are expected to remain steady from the prior 2022 benefit year estimates. The total cost for HHS to operate the risk adjustment program on behalf of states for 2023 will be approximately $60 million, and the proposed risk adjustment user fee would be $0.22 PMPM.

Because overall risk adjustment costs estimated for the 2023 benefit year are similar to 2022 costs, the proposed risk adjustment user fee for the 2023 benefit year is not expected to materially impact the transfer amounts collected or paid by issuers of risk adjustment covered plans. Although the proposed changes are expected to have a small impact on issuers' HHS-RADV risk adjustment transfer adjustments, risk adjustment is a budget neutral program.

Also, HHS proposed to collect five new RADV data elements beginning with the 2023 benefit year with an estimated cost of $225,168 for 600 issuers or $375.28 per issuer.

For all of the sections presented below, CMS explicitly requested comments on its assumptions, estimates and conclusions.

1. Guaranteed Availability of Coverage. This proposed rule would reverse the policy allowing an issuer to attribute a premium payment made for new coverage to any past-due premiums owed for coverage. CMS lacks information on the frequency with which consumers miss payments or the frequency with which binder payments are currently being made, and seeks data or information related to past-due premiums.

The proposal would increase access to health insurance coverage for individuals who stop paying premiums due to reasons such as financial hardship or affordability and who are currently unable to enroll in coverage because of past-due premiums. This policy could result in transfers from issuers who would have been able to recoup unpaid premiums from enrollees to those enrollees who would now be able to enroll in coverage from the same issuer or another issuer in the same controlled group without having to pay past due premiums. CMS anticipates that these transfers would be minimal as issuers are not permitted to waive past-due premiums and would be expected to pursue other means of collecting them.

2. Nondiscrimination Based on Sexual Orientation and Gender Identity. CMS does not anticipate coming into compliance with these proposed changes would substantially impose administrative costs on any regulated entities that did not subsequently revise nondiscrimination policies based

on the removal of these requirements in 2020. The nondiscrimination policy proposals in this rulemaking will most likely impact the vast majority of state EHB benchmark plans, but the actions necessary to come into compliance will likely minimally increase premiums.

3. Risk Adjustment. HHS estimates that the proposed risk adjustment user fee would be $0.22 PMPM. Because overall risk adjustment costs estimated for the 2023 benefit year are similar to 2022 costs, HHS does not expect the proposed risk adjustment user fee for the 2023 benefit year to materially impact the transfer amounts collected or paid by issuers of risk adjustment covered plans.

4. Risk Adjustment Data Validation. HHS proposed updates to the HHS-RADV error rate calculation methodology beginning with the 2021 benefit year. Impact details are provided above.

5. Agents, Brokers, and Web-brokers.

a. *Required QHP Comparative Information on Web-broker Websites and Related Disclaimer*. Discussed in the ICR section.

b. *Prohibition of QHP Advertising on Web-broker Websites*. Proposals on these issues should impose no new costs on web-brokers so long as they are not displaying QHP advertisements on their websites as HHS believes is the case for most web-brokers. For those few web-brokers that are displaying QHP advertisements on their websites, they would be required to update their websites to remove those advertisements and would lose any advertising revenue associated with such placements. Since advertisements on websites are inherently subject to change, costs may be very limited. Brokers may seek to recoup the lost revenue from other sources resulting in a transfer of costs.

c. *Explanation of Rationale for QHP Recommendations on Web-broker Websites*. Discussed in the ICR section.

d. *Providing Correct Information to the FFEs and Prohibited Business Practices*. None of the proposals in this area impose new requirements. Rather, the proposals are intended to address common problems that HHS has observed, and provide clear, enforceable standards intended to protect consumers and support the efficient operation of Exchanges by substantially reducing the occurrence of problems.

6. Verification Process Related to Eligibility for Insurance Affordability Programs. HHS proposed to remove the requirement to conduct random sampling in favor of a verification process that is based on risk for inappropriate APTC/CSRs. Four of 15 State Exchanges have already incurred one-time costs of approximately $4.5 million per Exchange and will only experience recurring costs savings. One-time savings for Exchanges using the Federal platform and the remaining State Exchanges that operate their own eligibility and enrollment platform will be approximately $49.5 million.

Annual costs to conduct sampling for the Exchanges using the Federal platform and the 15 State Exchanges that operate their own eligibility and enrollment platform would have been $113 million in 2022 and onward. Eliminating these estimated costs would be offset by the costs of designing and implementing an appropriate verification process.

7. Proration of Advance Premium Tax Credit (APTC) and Premium. HHS anticipates that there will be 10 affected State Based Exchanges that will incur an estimated $1 million one-time burden to account for the IT build to support new calculation and reporting systems.

8. Special Enrollment Periods[16] – This section largely repeats information from the ICR section but further indicates a $5,150,700 decrease in annual ongoing costs to the federal government in addition to these cost burden reductions described earlier. Additionally, the rule indicates that SEP documentation deters younger, likely healthier individuals from enrolling, but there could be an increase in claims costs to QHP issuers since the Exchanges on the Federal platform will be requiring document submission prior to enrollment for fewer special enrollment period types.

9. General Program Integrity and Oversight Requirements. This section was described earlier in the ICR section. However, here the rule states that cost savings in contracting and reporting would result in an average annual reduction of approximately $90,624.62 for each State Exchange beginning in benefit year 2024. The total annual cost reduction across 18 State Exchanges would be approximately $1,631,243. It is unclear what accounts for the difference between the amounts in this section and those listed for §155.1200 in Table 23.

10. State Exchange Improper Payment Measurement (SEIPM) Program. Recordkeeping costs of $3.0 million annually will begin in 2023 from proposals related to the SEIPM.

11. FFE and SBE-FP User Fees. HHS proposes no change to the FFE user fee rate of 2.75 percent of monthly premiums or the SBE-FP user fee rate of 2.25 percent of monthly premiums for the 2023 benefit year.

12. State Selection of EHB-Benchmark Plan for Plan Years Beginning on or After January 1, 2020. Discussed in the ICR section.

13. Levels of Coverage (Actuarial Value). For PYs beginning in 2023, there are proposals to change the de minimis range for levels of coverage to a variation of:

- +2/-2 percentage points for all standard bronze plans, gold plans, platinum plans, individual market off-Exchange silver plans, and all small group market silver plans (on and off-Exchange),
- +5/-2 for expanded bronze plans that are required to comply with AV standards for PYs beginning in 2023,
- +2/0 percentage points for individual market silver QHPs, and
- +2/0 percentage points for the income-based silver CSR plan.

[16] In the proposed rule, this section is labeled out of order as "10" and subsequent sections follow this renumbering.

Changing the de minimis ranges for standard metal level plans would generate a transfer of costs from the government and issuers to consumers in the form of increased APTC and decreased premiums, because narrowing the de minimis range for silver plans can affect the generosity of the second lowest cost silver plan (SLCSP) and, in turn, the individual's premium tax credit (PTC). A subsidized enrollee in any county that has a SLCSP that is currently below 70 percent AV would see the generosity of their current SLCSP increase, resulting in an increase in PTC.

In states using HealthCare.gov, approximately 87 percent of counties across 23 states have a SLCSP that is below 70 percent AV. For this proposal, the Office of the Actuary (OACT) estimates a nationwide increase in PTCs through PY 2032, as shown in Table 26:

TABLE 26: PTC Impact of +2/0 Silver, +1/0 CSR De Minimis Plan AVs, 2023-2032
($ in Billions)

CY	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**
Impact	0.73	0.77	0.77	0.76	0.77	0.78	0.82	0.83	0.87	0.92
FY	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Impact	0.55	0.76	0.77	0.76	0.77	0.78	0.81	0.83	0.86	0.91

Of the plans on HealthCare.gov, OACT estimates that there are approximately 150,000 enrollees in gold plans below 78 percent AV, and 3,500 enrollees in platinum plans below 88 percent AV. Additionally, there are approximately 248,000 enrollees in HealthCare.gov silver QHPs below 70 percent AV, with approximately 4.2 million enrollees in corresponding income-based CSR plan variations. Under these proposals, those enrollees would need to select a different plan for PY 2023 if the issuer chooses to discontinue the plan rather than revise the plan's cost sharing. Additionally, these proposals would similarly affect enrollees in such plans that are not available on HealthCare.gov, such as plans sold on state Exchanges, for which OACT does not have data to make an informed estimate.

Premiums for these plans are estimated to increase approximately 2 percent on average because of benefit changes required for plans to meet a +2/0 de minimis threshold. However, for Exchange enrollees, this premium increase is expected to be substantially offset by the corresponding increase in PTC because of the proposal's impact on the SLCSP. Similarly, the proposal to change the de minimis range for CSR variants to +1/0 would lead to improved cost-sharing due to the higher relative AV compared to the current +1/-1 range, along with increased gross premiums that would be substantially offset by increased PTC payments.

After implementation of the ARP enhanced financial subsidies, subsidized enrollees make up the majority of HealthCare.gov silver QHP enrollees–only 91,000 of approximately 248,000 individual market silver QHP enrollees in plans with AV between 66.00 and 69.99 percent plan AV remain unsubsidized. By comparison, enrollment within the corresponding income-based silver CSR variations of the above silver QHPs has increased to approximately 4.2 million.

The increased PTC payments due to the premium are expected to incent healthier subsidy eligible enrollees to participate in the Marketplace, and the improved risk pool as a result of increased healthier enrollees are expected to mitigate the net cost burden of covering a

decreasing population of unsubsidized enrollees. In addition, changing the de minimis range for standard silver plans would impact ICHRAs; an employer would have to contribute more to an ICHRA to have it be considered affordable. However, the rule presents an estimated 2 percent premium increase for silver plans with an AV below 70 percent due to more generous benefits, but the increase is not expected to have a significant impact on the number of employers willing to offer ICHRAs or whether an ICHRA is considered affordable to most employees.

14. Standardized options. The proposed rule would require QHP issuers to offer standardized QHP options. However, the burden would be minimal because these new plans' benefits, networks, and formularies would not differ substantially from those issuers currently offer and because the HHS will specify the cost sharing parameters, MOOPs, and deductibles for these new plans. For these and other reasons, HHS does not expect the total number of plans issuers will offer to change substantially.

15. Network Adequacy. In this proposed rule, HHS proposes for PY 2023 and future PYs that all QHPs or QHP candidates that use a provider network must comply with network adequacy standards. HHS proposes to conduct prospective quantitative network adequacy reviews for all FFEs in all FFE states except in states performing plan management functions that adhere to a standard as stringent as the federal standard, conduct reviews prospectively, and choose to conduct their own reviews. For issuers that do not already collect the data necessary to demonstrate compliance, this proposal may increase administrative costs and premiums for some consumers. HHS believes that these additional costs would be mitigated by the expected benefits of the policy.

16. Essential Community Providers (ECP). For PY 2023 and future PYs, HHS proposes to raise the ECP threshold applicable to QHPs and QHP candidates from 20 percent to 35 percent. HHS anticipates that costs may not increase since HHS' data analysis shows most issuers could easily meet this standard or use the justification process.

17. Standards for Delegated and Downstream Entities. HHS is proposing to hold QHP issuers in all Exchange models responsible for their downstream and delegated entities' compliance with applicable Exchange standards, and to make their oversight obligations, and the obligations of their downstream and delegated entities, explicit. HHS expects some QHP issuers may need to make changes to existing record retention policies and their agreements with delegated and downstream entities.

18. Payment for Cost-Sharing Reductions. The proposed rule clarifies that the CSR data submission process is mandatory only for those issuers that received CSR payments from HHS for any part of the benefit year as a result of a valid appropriation to make CSR payments, and voluntary for other issuers. This proposal would codify existing practices.

19. Quality Improvement Strategy. Discussed in the ICR section.

20. Medical Loss Ratio. Also discussed in the ICR section. The rule clarifies that only those provider incentives tied to clearly defined, objectively measurable and well-documented

improvement standards may be included in MLR reporting and rebates. Estimates of the proposed clarification assumed that provider incentive and bonus payments of 1.06 percent or more of paid claims (the top 5 percent of such observations) may represent incentives based on MLR or similar metrics. Based on this assumption and the MLR data for 2019, the proposed clarification would increase rebates paid by issuers to consumers or reduce premiums collected by issuers from consumers by approximately $12 million per year.

In addition, the proposal states only expenditures directly related to activities that improve health care quality may be included in quality improvement activity expenses for MLR reporting and rebate calculation purposes. This proposed change would result in transfers from issuers that currently include indirect expenses in quality improvement activities to enrollees in the form of higher rebates or lower premiums. The proposed clarification is estimated to increase rebates paid by issuers to consumers or reduce premiums collected by issuers from consumers by approximately $49.8 million per year.

D. Regulatory Alternatives Considered

This section describes regulatory alternatives considered to the HHS risk adjustment models. These are all discussed in a risk adjustment technical paper that may be found at: https://www.cms.gov/files/document/2021-ra-technical-paper.pdf.