Patient Protection and Affordable Care Act,
HHS Notice of Benefit and Payment Parameters for 2024
(CMS-9899-F)
Summary of Final Rule

On April 18, 2023, the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services (HHS) placed on public display at the Federal Register the final Notice of Benefit and Payment Parameters (NBPP) for 2024 (hereinafter referred to as the "final 2024 Payment Notice"). The final 2024 Payment Notice includes payment parameters and provisions related to the HHS-operated risk adjustment and risk adjustment data validation programs, as well as proposed 2024 user fee rates for issuers offering qualified health plans (QHPs) through Federally-facilitated Exchanges (FFEs) and State-based Exchanges on the Federal platform (SBE-FPs). The rule also implements requirements related to standardized plan options, re-enrollment hierarchy, plan and plan variation marketing names for QHPs, essential community providers (ECPs) and network adequacy, the failure to file and reconcile process, special enrollment periods (SEPs), annual household income verification, the deadline for QHP issuers to report enrollment and payment inaccuracies, the State Exchange improper payment measurement program, and for agents, brokers, and web-brokers assisting FFE and SBE-FP consumers.

These regulations are effective 60 days from official display in the Federal Register.

I. Background

HHS reviews the statutory and regulatory history related to the implementation of the Exchanges and related topics. Its goals for this rule are to provide quality, affordable coverage to consumers while minimizing administrative burden and ensuring program integrity and to help advance health equity and mitigate health disparities.

Most recently, revisions were finalized in the 2023 Payment Notice issued on May 6, 2022 (87 FR 27208), including the benefit and payment parameters for the 2023 benefit year, risk adjustment model recalibration, and collection and extraction of enrollee-level External Data Gathering Environment (EDGE) data. Also adopted were the interacted HCC count specification for the adult and child models, along with modified enrollment duration factors for the adult models, beginning with the 2023 benefit year. HHS repealed the ability for states, other than prior participants, to request a reduction in risk adjustment state transfers starting with the 2024 benefit year, and it approved a 25 percent reduction to 2023 benefit year transfers in Alabama's individual market and a 10 percent reduction to 2023 benefit year transfers in Alabama's small group market. Further refinements to the HHS risk adjustment data validation (HHS-RADV) error rate calculation methodology beginning with the 2021 benefit year and beyond were finalized.

In that same rule, HHS finalized changes to maintain the Exchange user fee rate for issuers offering plans through the FFEs and the SBE-FPs. Various policies to address certain agent,

broker, and web-broker practices and conduct were finalized, as were updates to the requirement that all Exchanges conduct special enrollment period verifications.

II. Summary of Major Provisions

A. Part 153—Risk Adjustment Program

The permanent risk adjustment program is subject to the fiscal year (FY) 2023 sequestration. The risk adjustment program will be sequestered at a rate of 5.7 percent for payments made from FY2023 resources (i.e., funds collected during FY 2023).

Risk adjustment will be operated by HHS in every state and the District of Columbia for the 2024 benefit year. HHS will recalibrate risk adjustment parameters using enrollee-level EDGE data from 2018, 2019 and 2020, with no exceptions. A market pricing adjustment to the plan liability for Hepatitis C drugs will continue to be applied in the risk adjustment models for the 2024 benefit year.

For the 2025 benefit year and beyond, HHS is repealing the authority for states to request reductions of risk adjustment state transfers under the state payment transfer formula in all state market risk pools. However, HHS is approving Alabama's requests to reduce risk adjustment state transfers in its individual and small group markets by 50 percent for the 2024 benefit year.

Beginning with the 2023 benefit year, a new data element will be collected and extracted from issuers' EDGE servers through issuers' EDGE Server Enrollment Submission (ESES) files and risk adjustment recalibration enrollment files; that new data element is a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) indicator. HHS is also finalizing extracting the plan identifier and rating area data elements from issuers' EDGE servers for certain benefit years prior to the 2021 benefit year. The proposed risk adjustment user fee for the 2024 benefit year of $0.21 per member per month (PMPM) is also finalized.

Starting with the risk adjustment data validation for the 2022 benefit year, the materiality threshold established under 45 CFR §153.630(g)(2)[1] for random and targeted sampling will be changed from $15 million in total annual premiums statewide to 30,000 total billable member months (BMM) statewide. This will be calculated by combining an issuer's enrollment in a state's individual non-catastrophic, catastrophic, small group, and merged markets, as applicable, in the benefit year being audited. Additionally, beginning with the HHS RADV for the 2021 benefit year, HHS finalizes eliminating the exemption for exiting issuers from adjustments to risk scores and risk adjustment transfers when they are negative error rate outliers in the applicable benefit year's HHS-RADV.

Beginning with the 2022 benefit year HHS-RADV, the window to confirm the findings of a second validation audit (SVA) or to file a discrepancy report to dispute the SVA findings will be

[1] Henceforth, all regulatory section references are to Title 45 of the Code of Federal Regulations (CFR), unless noted otherwise.

shortened to within 15 calendar days of the HHS notification. Finally, the materiality threshold to file a discrepancy report is revised so that the amount in dispute must be at least $100,000 or one percent of the total estimated transfer amount in the applicable state market risk pool.

B. Part 155—Exchange Standards

HHS finalizes removing the deadlines for when HHS approves, or conditionally approves, an Exchange Blueprint for states transitioning from either a FFE to an SBE-FP or State-based Exchange (SBE), or from an SBE-FP to an SBE; instead, approval must be provided at some point before the Exchange proposes to begin open enrollment either as an SBE or SBE-FP. The prohibition is removed on Navigators, other assisters, and certified application counselors from going door-to-door or using other unsolicited means of direct contact to help provide consumers with enrollment assistance; this also applies to non-Navigator assistance personnel in FFEs and in State Exchanges if funded with section 1311(a) Exchange Establishment grants.

With respect to the practices of agents, brokers, and web-brokers, HHS finalizes additional time for the agency to review evidence to rebut allegations that led to suspension or termination of their Exchange agreements and to respond to that evidence or requests for reconsideration. Additionally, agents, brokers, and web-brokers assisting consumers with eligibility applications, including for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs), will have to document that the consumer reviewed and confirmed the information. They will also have to document that the consumer gave their consent to get assistance from the agent, broker or web-broker to apply and enroll through FFEs and SBE-FPs, make updates to an existing application, or assist an individual with applying for APTC and CSRs for QHPs. The documentation would have to be maintained for 10 years.

For determining eligibility for the APTC and those consumers that fail to file a tax return (referred to as the failure to file and reconcile process (FTR)), HHS codifies its guidance that the Exchanges on the federal platform will not act on data from the IRS for consumers who have failed to file tax returns and reconcile a previous year's APTC with the PTC allowed for the year. As of the general effective date of this rule, an Exchange may only determine an enrollee to be ineligible for the APTC after a taxpayer or spouse has failed to file a federal income tax return and reconcile their past APTC for two consecutive years. FTR operations will continue to be paused until HHS and the Internal Revenue Service (IRS) are able to implement the new FTR policy.

As finalized, an Exchange must accept an applicant's attestation of projected annual household income in cases where the Exchange seeks tax return data from the IRS to verify attested projected annual household income, but the IRS confirms there is no such tax return data available. HHS must also provide an additional 60 days for enrollees with income inconsistencies, also known as a data matching issue (DMI), to present satisfactory documentary evidence (in addition to the 90 days currently provided).

The re-enrollment rules at §153.335(j) are revised to allow Exchanges to direct re-enrollment for CSR-eligible enrollees from a bronze QHP to a silver QHP with a lower or equivalent net

premium under the same product and QHP issuer, regardless of whether the enrollee's current plan is available. For enrollees whose current QHP will no longer be available, Exchanges are required to incorporate network similarity into auto re-enrollment criteria.

Several changes to the special enrollment period (SEP) rules are finalized. These include a clarification that only one person in a tax household applying for coverage or financial assistance through the Exchange must qualify for an SEP in order for the entire tax household to qualify for the SEP, and permitting Exchanges to offer earlier coverage effective start dates for consumers attesting to a future loss of minimum essential coverage (MEC). HHS also finalizes permitting Exchanges to allow consumers up to 90 days after loss of Medicaid or CHIP coverage to select an Exchange plan. Finally, a new SEP could be triggered for an individual if enrollment in a QHP through the Exchanges on the federal platform was influenced by a material plan display error.

As finalized, issuers participating in Exchanges on the federal platform are explicitly prohibited from terminating coverage for a dependent child prior to the end of the plan year because the dependent child has reached the applicable maximum age; the policy would be optional for State Exchanges.

HHS finalizes implementing a new Improper Payment Pre-Testing and Assessment (IPPTA) program under which SBEs will be required to participate in pre-audit activities that prepare them to comply with audits required under the Payment Integrity Information Act of 2019 (PIIA).

C. Part 156—Health Insurance Issuer Standards

Based on revised projections from newly available data, HHS finalizes the following Exchange user fee rates for the 2024 benefit year: for issuers in FFEs, 2.2 percent of monthly premiums, and for issuers in SBE-FPs, 1.8 percent of monthly premiums.[2]

With respect to standardized QHP options, HHS finalizes minor updates to its approach in the 2023 Payment Notice. Beginning with PY 2024, a standardized plan option will no longer be included for the non-expanded bronze metal level, mainly due to actuarial value (AV) constraints. The following standardized plan options remain: one expanded bronze plan, one standard silver plan, one version of each of the three income-based silver CSR plan variations, one gold plan, and one platinum plan.

HHS also finalizes limits to the number of non-standardized plan options that QHP issuers may offer through the Exchanges using the federal platform:

- For PY 2024, 4 non-standardized plan options per product network type and metal level (excluding catastrophic plans), in any service area; and

[2] Proposed amounts were 2.5 percent of monthly premiums for issuers in FFEs and 2.0 percent of monthly premiums for issuers in SBE-FPs.

- For PY 2025 and subsequent years, 2 non-standardized plan options per product network type and metal level (excluding catastrophic plans), in any service area.

Beginning with PY 2024, issuers of stand-alone dental plans (SADPs) are required, as a condition of QHP certification, to use age on effective date as the only method to calculate an enrollee's age rating and to submit guaranteed rates, whether the plan is sold on or off the Exchange.

As finalized, plan and plan variation marketing names for QHPs offered through Exchanges on the federal platform are required to include correct information, not omit material facts, and not include misleading content.

This rule finalizes network adequacy and Essential Community Provider (ECP) standards, which would apply to all individual market QHPs (including SADPs) and all Small Business Health Options Program (SHOP) QHPs, across all Exchanges. It also removes the exception for plans that do not use a provider network, except for a limited exception for certain SADPs in areas where it is prohibitively difficult to establish a network of dental providers.[3]

HHS finalizes its proposal to establish the following two additional stand-alone ECP categories for PY 2024 and subsequent PYs: Mental Health Facilities and Substance Use Disorder Treatment Centers. Rural Emergency Hospitals (REHs) are added as a provider type in the Other ECP Providers category, reflecting the fact that REHs could begin participating in Medicare beginning January 1, 2023. Moreover, in addition to meeting the current overall 35 percent ECP threshold requirement in the plan's service area, QHP issuers would be required to contract with at least 35 percent of available FQHCs and at least 35 percent of available Family Planning Providers that qualify as an ECP in the plan's service area, beginning with PY 2024.

With respect to requirements for termination of coverage or enrollment for qualified individuals, HHS finalizes a requirement that issuers on the federal platform send notices of payment delinquency promptly and without undue delay (within 10 business days of the date the issuer should have discovered the delinquency).

For data inaccuracies identified in a payment and collections report from HHS for discovered underpayments of APTC to the issuer and user fee overpayments to HHS, beginning with the 2015 plan year coverage, HHS finalizes dropping the alternative deadline (relating to the completion of an audit) and will only apply the current 3-year deadline. Thus, HHS will not pay additional APTC payments or reimburse user fee payments for FFE, SBE-FP, and SBE issuers for data inaccuracies reported after the 3-year deadline. HHS will not accept or take action that results in an outgoing payment on data inaccuracies or payment errors for the 2015 through 2019 plan year coverage that are reported after December 31, 2023.

[3] Based on attestations from state departments of insurance in states with at least 80 percent of their counties classified as Counties with Extreme Access Considerations (CEAC) with at least one of the following: a significant shortage of dental providers, a significant number of dental providers unwilling to contract with Exchange issuers, or significant geographic limitations impacting consumer access to dental providers.

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

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

Standards for the administration of the risk adjustment program created by the Affordable Care Act (ACA)[4] 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 2024 benefit year.

1. Sequestration

The risk adjustment program is subject to the fiscal year 2023 sequestration and will therefore be sequestered at a rate of 5.7 percent for payments made from fiscal year 2023 resources (that is, funds collected during the 2023 fiscal year). Consistent with prior years, however, funds that are sequestered in fiscal year 2023 from the risk adjustment program are available for payment to issuers in fiscal year 2024 without further congressional action. HHS also notes that the Infrastructure Investment and Jobs Act (P.L. 117-58) extended sequestration for the risk adjustment program through fiscal year 2031 at a rate of 5.7 percent per fiscal year. HHS received no comments on this topic.

2. HHS Risk Adjustment (§153.320)

The HHS risk adjustment models predict 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 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.

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.

[4] Henceforth, all statutory references are to the ACA, unless noted otherwise.

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

HHS proposed to use 2018, 2019 and 2020 benefit year enrollee-level External Data Gathering Environment (EDGE) data to recalibrate the 2024 benefit year risk adjustment models with an exception to exclude the 2020 benefit year data from the blending of the age-sex coefficients for the adult models. HHS' proposal included the exception based on the potential impacts in 2020 of the COVID-19 public health emergency (PHE) on costs and utilization.

After considering comments, HHS is not finalizing the proposed recalibration approach with the exception. Rather, HHS is finalizing use of the 2018-2020 EDGE data for recalibration of the 2024 risk adjustment models for all model coefficients, including the adult age-sex coefficients, with no exceptions. This is a continuation of current policy, using the 3 most recent consecutive years of enrollee-level EDGE data, with no exceptions.

Selected Comment/Response: Comments were mixed, with most either supporting the proposal or continuing current policy (i.e., no exceptions). Objections to the proposal included relying on different data years to recalibrate various coefficients for the same benefit year.

HHS says that although there were some anomalous results in the 2020 enrollee-level EDGE data, the relative costs of specific services were largely unaffected. The trends in specific age-sex factors that appeared anomalous were small and did not appear as anomalous when further compared to prior years. Thus, considering comments and to maintain stability, HHS is continuing current policy for the 2024 risk adjustment models, using the 3 most recent consecutive years of data with no exceptions.

b. Pricing Adjustment for Hepatitis C Drugs

HHS proposed to continue incorporating 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 2024 benefit year since the data used to recalibrate the risk adjustment models do not reflect the more recent declines in prices for such drugs. HHS found that the data for the Hepatitis C RXC that would be used for the 2024 benefit year recalibration do not account for the significant pricing changes from the introduction of generic Hepatitis C drugs[5] and thus do not precisely reflect the average cost of Hepatitis C treatments applicable to the 2024 benefit year. Without a pricing adjustment, issuers would be overcompensated and incentivized to encourage overprescribing. HHS will continue to reassess this adjustment in future benefit years' model recalibrations.

Selected Comment/Response: Most commenters supported continuing the pricing adjustment for Hepatitis C drugs. Some commenters expressed concerns about reducing the RXC coefficient more than the expected decrease in cost, which would result in reduced availability of treatment.

[5] Generic Hepatitis C drugs did not become available on the market until 2019.

HHS finalizes its proposal to continue applying the pricing adjustment for Hepatitis C drugs, believing that it accurately captures the costs for 2024 using the latest available data.

One commenter contended that if a pricing adjustment is merited to account for generic Hepatitis C drugs, pricing adjustments may also be merited for other drugs, such as biosimilars for adalimumab (Humira®). HHS notes it did not propose or solicit comments on extending a pricing adjustment to any other drugs. However, its criteria for including or excluding drugs in RXC mapping and recalibration were published in the 2023 Payment Notice (87 FR 27231 through 27235) and, at this time, HHS does not believe there is evidence that the introduction of biosimilar alternatives to adalimumab will create market patterns that meet its three criteria. For example, although costs are expected to be lower for adalimumab biosimilars, the nature of the different production process for biologic drugs means that the price reductions are expected to be much smaller than with the introduction of generic medications such as for Hepatitis C.

c. Request for Information: Payment HCC for Gender Dysphoria

In the proposed rule, HHS sought information on whether it should consider adding a payment HCC for gender dysphoria to the HHS risk adjustment models for future benefit years. In this final rule, HHS provided no summary of comments but said it would consider the comments in future rulemaking.

d. List of Factors for Risk Adjustment Models (§153.320)

Tables 1 through 6 in the final 2024 Payment Notice list the finalized 2024 benefit year risk adjustment model factors incorporating all of the model specification changes and recalibrations described above. The adult, child, and infant models have been truncated to account for the high-cost risk pool payment parameters by removing 60 percent of costs above the $1 million threshold.

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

e. Cost-sharing Reduction Adjustments

HHS proposed**,** consistent with prior years, to include cost-sharing reductions in the risk adjustment models in all 50 states and the District of Columbia to account for increased plan liability due to higher utilization of health care services by individuals receiving cost-sharing reductions (CSRs). HHS proposed continuing to use a cost-sharing reduction factor of 1.12 for

Massachusetts wrap-around plans, since all of Massachusetts' cost-sharing plan variations have actuarial values above 94 percent (81 FR 12228).

Selected Comment/Response: A few commenters supported further evaluation of the CSR adjustment factors, particularly in light of an absence of funding for CSR subsidies and health equity issues associated with lower-than-anticipated utilization levels in the CSR population. One commenter stated that current CSR adjustment factors, specifically for CSR 87 percent and 94 percent variants, do not accurately reflect population risk, and another commenter requested that the risk adjustment formula reflect actual costs incurred by 87 percent and 94 percent AV enrollees.

While HHS agrees that continued study is warranted, it is not planning to publish another technical paper in the near term. Before it would propose any changes in future rulemaking, HHS says it would provide sufficient analysis and justification—for example, reviewing the enrollee-level EDGE data with the plan ID and rating area, which was not previously available. Nevertheless, HHS says the findings from the 2021 RA Technical paper, on which the current CSR adjustment factors are based, are predicting actual plan liability relatively accurately. For example, the nationally approximated risk term predictive ratios for CSR 87 percent and 94 percent variants are both within +/- 5 percent.

A few commenters express concern about the underprediction of certain CSR plan variants for American Indian/Alaska Natives (AI/AN) in the risk term of the state payment transfer formula, as outlined in the 2021 RA Technical Paper—particularly in states with a high percentage of AI/AN enrollment. Concerns include that the underprediction could discourage competition for these enrollees. HHS says that its analysis in the 2021 RA Technical Paper was at the national level, so it could not show trends for particular issuers, states or rating areas having higher percentages of AI/AN enrollment. However, with policies finalized in the 2023 Payment Notice (87 FR 27241 through 27243) and this final rule, HHS will have the ability in the future to extract and use multiple years of enrollee-level EDGE data with plan ID and rating area markers and will be able to further analyze the CSR populations at a more granular level, including in certain states with high proportions of AI/AN populations. In the meantime, HHS finalizes the factors as proposed.

Several commenters objected to HHS considering any method of estimating CSR premium load factors that involves issuers using experience data or issuer pricing models to estimate the CSR load for silver plan variants.[6] These commenters cite a letter from the American Academy of Actuaries referenced by HHS in the proposed rule (footnote 49 at 87 FR 78235) that offered options, including using actual experience data/issuer pricing models. These commenters believe such a methodology is a violation of the ACA's single risk pool requirement (section 1312(c)(1)), which requires issuers to treat all individual market enrollees as part of a single risk pool so that pricing reflects utilization of essential benefits by a standard population.

[6] "CSR load" (or "silver load" when the load is applied only to silver plans) is the premium increase attributed to the estimated value of unfunded CSR subsidies. Beginning in 2018, issuers increased premium rates to account for the liability associated with providing reduced cost-sharing that the federal government stopped funding under section 1402 of the ACA.

HHS reiterated that it is continuing to study these issues for potential updates in the future, with reliance on the more granular data made available through recent policy changes. HHS is aware of the interaction of future changes to the CSR adjustment factors with the ACA's single risk pool requirement and affirms that interested parties will have an opportunity to comment on any potential changes through future notice-and-comment rulemaking.

Without modification, HHS finalizes its proposed CSR adjustment factors in the HHS-operated risk adjustment program. Table 7 in the rule provides the specific adjustment factors for plans at each metal level. The factors range from 1.00 to 1.15.

f. 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. In Table 8, HHS provides the R-squared statistics for each proposed model and enrollee-level EDGE data for each benefit year 2018, 2019 and 2020. HHS notes that the R-squared statistic is in the range of published estimates for concurrent risk adjustment models.

3. Overview of the HHS Risk Adjustment 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 2024 Proposed Payment Notice, HHS did not propose changes to the formulas and did not republish the formulas. Further, it proposed no changes to the high-cost risk pool parameters for the 2024 benefit year, maintaining the $1 million threshold and 60 percent coinsurance rate.

Selected Comment/Response: A few commenters assert that, based on findings from the state of Massachusetts,[7] using a population's history of health care utilization (like the HHS-operated risk adjustment program does) entrenches resource disparities and barriers to health care access, shifting resources from issuers serving lower-income communities to those serving higher-income communities. These commenters state that HHS should include social determinants of health (SDOH) as factors in the HHS risk adjustment models.

In response, HHS did its own analysis of enrollee-level EDGE data and found that the Massachusetts experience is not applicable in other state markets for a number of reasons. HHS continues to review and consider public comments in response to the 2023 Payment Notice on how to incentivize plan designs that improve health equity, as well as potential future collection and extraction of z codes (particularly Z55-Z65) as part of required EDGE submissions. HHS notes that including SDOH in the HHS-operated risk adjustment models would require careful consideration, because doing so could actually increase health disparities rather than reduce them. For example, if individuals with a particular SDOH factor in risk

[7] Massachusetts Attorney General, "Examination of Health Care Cost Trends and Cost Drivers 2022."

adjustment tended to underutilize health care services relative to their health status, including that factor in risk adjustment models could perpetuate and even exacerbate the under compensation of issuers for enrollees that receive that factor in risk adjustment. HHS says it continues to analyze data in this area, especially as new enrollee-level EDGE data elements become available.

4. Repeal of Risk Adjustment State Flexibility to Request a Reduction in Risk Adjustment State Transfers (§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 state 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.

In the 2023 Payment Notice (87 FR 27236), HHS repealed the state flexibility framework for states to request reductions in risk adjustment state transfer payments for the 2024 benefit year and beyond, with an exception for prior participant states. Only Alabama qualifies as a prior participant state. Prior participant states submitting reduction requests must demonstrate that the requested reduction satisfies the de minimis standard—that is, the premium increase necessary to cover the reduced risk adjustment payments of the affected issuer(s) does not exceed 1 percent in that state's risk pool.

Effective for the 2025 benefit year and thereafter, HHS proposed to repeal this flexibility entirely, including for prior participant states that previously requested a reduction. No state, including Alabama, could then request a reduction in risk adjustment transfers calculated by HHS under the state payment transfer formula starting with the 2025 benefit year.

For the 2024 benefit year, the final year for which the state would be able to request a reduction, Alabama submitted requests to reduce risk adjustment state transfers for its individual and small group markets by 50 percent, asserting that the HHS-operated risk adjustment program does not work precisely in the Alabama market. The data submitted by the state suggests premium increases would satisfy the de minimis standard.

Selected Comment/Response: Several commenters supported the proposal to repeal the ability for states to request a reduction in risk adjustment state transfers, due to concerns that it would contribute to adverse selection, increased premiums, and reduced plan options. Commenters also noted that the HHS risk adjustment methodology accounts for differences in state market conditions and that states can run their own risk adjustment programs if they so choose. HHS agrees with these points.

Several opposing commenters stated their support for states making their own decisions about how best to address the unique circumstances of their insurance markets, noting that HHS has the ability to review and reject these requests. One commenter raised concerns regarding the ability of states to run their own risk adjustment programs, particularly due to the costs.

HHS is finalizing its proposal to repeal, beginning with the 2025 benefit year, the exception for prior participant states (Alabama) to request a reduction in risk adjustment state transfers of up to 50 percent. HHS says it is not clear that Alabama has seen market stabilization or improved plan quality since its reduction requests have been approved and provides a detailed discussion of Alabama's market dynamics. Nevertheless, HHS is approving Alabama's requests for the 2024 benefit year to reduce risk adjustment state transfers in its individual and small group markets by 50 percent.

HHS says it is ready to work with any state interested in operating its own risk adjustment program for the individual and small group (including merged) markets.

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 for use in 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. Issuers of risk adjustment covered plans must submit or make accessible all required risk adjustment data in accordance with the data collection approach established by HHS in states where HHS operates the program on behalf of a state.

In the proposed 2024 Payment Notice, HHS proposed to collect and extract one new data element from issuers' EDGE servers, beginning with the 2023 benefit year: a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) indicator. It also proposed to extract plan ID and rating area data elements that issuers have submitted to their EDGE servers from certain benefit years before 2021. HHS finalizes collection of the QSEHRA indicator as proposed.

a. Collection and Extraction of the QSEHRA indicator

The additional data element will allow HHS to better analyze the actuarial characteristics of the Health Reimbursement Arrangement (HRA) population and how or whether HRA enrollment is impacting state individual and small group (including merged) market risk pools. It will also allow HHS to examine whether the risk profile of enrollees in QSEHRAs—which differ from individual coverage Health Reimbursement Arrangements (ICHRAs) with respect to standards related to employer eligibility, employee eligibility, restrictions on allowance amounts, and eligibility for PTCs—differ from enrollees in ICHRAs. HHS will use the QSEHRA indicator to conduct policy analysis, operationalize and calibrate other HHS programs in the individual and small group markets, and to inform policy analysis and improve the integrity of other HHS federal health-related programs.

HHS proposed to begin extracting a QSEHRA indicator from issuers' EDGE data beginning with the 2023 benefit year. It also proposed to include this indicator in the enrollee-level EDGE

limited data set (LDS) made available to qualified researchers upon request, beginning with 2023 benefit year data. It notes that, similar to the ICHRA indicator, the proposed QSEHRA indicator will not be a direct identifier that must be excluded from an LDS under the HIPAA Privacy Rule and thus will not add to the risk of enrollees being identified. HHS will continue to exclude data from the LDS that could lead to identification of certain enrollees.

HHS notes that FFEs and SBE-FPs currently collect information about QSEHRA provision from all applicants to determine eligibility for a special enrollment period (SEP) and that SBEs also collect similar information for the same purpose. Thus, it proposed to allow issuers to populate the required QSEHRA indicator with information from the FFE or SBE-FP enrollees or enrollees through SBEs, or from other sources for collecting this information, and to structure this data element for EDGE data submissions similar to current collections, where possible.

A transitional approach was proposed for the collection and extraction of the QSEHRA indicator. Specifically, for the 2023 and 2024 benefit years, issuers will have to populate the QSEHRA indicator using only data they already collect or have accessible regarding their enrollees. Beginning with the 2025 benefit year, issuers will have to populate the QSEHRA field using available sources (for example, information from Exchanges, and requesting information directly from enrollees) and, if there is no existing source for some enrollees, to make a good faith effort to ensure collection and submission of the QSEHRA indicator for those enrollees. The transitional approach is designed to reduce the burden of collecting the new data element and will be the same approach finalized for the ICHRA indicator in the 2023 Payment Notice.

Selected Comment/Response: While several commenters supported the collection and extraction of a QSEHRA indicator, including the proposed transition for implementation, many opposed, citing significant operational concerns with collecting and reporting a QSEHRA indicator.

HHS finalizes its proposal without modification, acknowledging concerns raised but believing it is important to collect this information to understand the associated risk profile and to inform analyses of whether any refinements to the HHS risk adjustment methodology should be examined or proposed. Additional information collected through the QSEHRA indicator will also be used to inform policy analysis and potential updates to the AV Calculator, other HHS individual or small group (including merged) market programs, the PHS Act requirements enforced by HHS, or other HHS federal health-related programs.

b. Extracting Plan ID and Rating Area

HHS also proposed to extract the plan ID[8] and rating area data elements from the 2017, 2018, 2019 and 2020 benefit year data submissions that issuers already made accessible to HHS.

[8] For details on the plan ID and its components, see p. 42 of the following: CMS. (2013, March 22). CMS Standard Companion Guide Transaction Information: Instructions related to the ASC X12 Benefit Enrollment and

However, those data elements would be excluded from the enrollee-level EDGE LDS made available to qualified researchers upon request. HHS believes that the analysis of risk adjustment data would be more valuable if it could compare historical trends, and access to these data elements for past years would further that analysis and improve the risk adjustment program. Because these data elements have already been collected and made available to HHS for those benefit years, no additional burden would be imposed on issuers.

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

HHS is finalizing its proposal without modification, because these additional data will allow it to better assess actuarial risk in the individual and small group market risk pools, examine historical trends, and consider changes to improve the HHS-operated risk adjustment program. While acknowledging commenters' privacy and security concerns, it disagrees that the extraction of plan ID and rating area data elements for these additional benefit years would increase risk of disclosure of enrollee PII; moreover, those elements do not fall under the category of PHI in the HIPAA Privacy Rule. Nevertheless, to mitigate the risk that entities receiving the LDS file could identify issuers based on these identifiers, HHS will not include these data elements in the LDS files made available to qualified researchers upon request.

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

HHS proposed a risk adjustment user fee for the 2024 benefit year of $0.21 per member per month (PMPM), slightly lower than the amount for the 2023 benefit year ($0.22 PMPM). That amount is based on the same methodology as used for 2023 and reflects a total cost of approximately $60 million to operate the program for the 2024 benefit year. HHS expects enrollment levels to remain steady through the 2025 benefit year. HHS finalizes its proposal without modification.

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

HHS conducts risk adjustment data validation (HHS-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

Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the FFE. https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/companion-guide-for-ffe-enrollment-transaction-v15.pdf.

validation auditor for data validation. The second validation audit (SVA) is conducted by an entity that HHS retains to verify the accuracy of the findings of the initial validation audit (IVA).

a. Materiality Threshold for Risk Adjustment Data Validation

Beginning with the 2022 benefit year's HHS-RADV, HHS proposed to change the HHS-RADV materiality threshold from a dollar threshold ($15 million in total annual premiums statewide) to one based on total billable member months (BMM) statewide (30,000). This would be calculated by combining an issuer's enrollment in a state's individual non-catastrophic, catastrophic, small group, and merged markets, as applicable, in the benefit year being audited. Issuers falling below the new proposed materiality threshold would not be subject to the annual IVA (or SVA) audit requirements; however, they could be selected to participate in a given benefit year of HHS-RADV based on random sampling or targeted sampling due to the identification of any risk-based triggers that warrant more frequent audits.

HHS notes that estimated costs to complete an IVA ($170,000) have increased since the materiality threshold was established. To limit the proportion of an issuer's premiums that would be used to cover IVA costs to 1 percent, that threshold would have to be increased to $17 million in total annual premiums statewide. HHS estimates that 30,000 BMM statewide translates to approximately $17 million in total annual premiums statewide on average across markets. It proposed to use a BMM threshold because it would continue to exempt small issuers that face a disproportionally higher burden, even in situations where PMPM premiums grow over time. The proposal was not expected to change the current burden estimates of the annual HHS-RADV requirements on issuers, nor have more than a minimal impact on data validation activities.

Selected Comment/Response: Most commenters supported changing the HHS-RADV materiality threshold definition to 30,000 total BMM, calculated by combining an issuer's enrollment in a state's individual non-catastrophic, catastrophic, small group, and merged markets, as applicable, in the benefit year being audited. Many asserted that a BMM-based threshold would be more consistent over time and across geographies, as the threshold would be unaffected by premium increases or variation in health care costs.

HHS finalizes its proposal without modification.

b. HHS-RADV Adjustments for Issuers that Have Exited the Market

HHS previously established a prospective approach to adjust risk scores and risk adjustment state transfers based on the results of HHS-RADV; an issuer's HHS-RADV error rate for a given benefit year is applied to the following benefit year's risk scores and risk adjustment state transfers. However, an issuer that exits all market risk pools in the state during a benefit year being audited would not have risk scores and state transfers to adjust in the next applicable benefit year. To qualify as an exiting issuer, the issuer must exit all of the market risk pools in the state (that is, not selling or offering any new plans in the state). The 2019

Payment Notice (83 FR 16965 through 16966) created an exception to the prospective approach for exiting issuers; it provides for the concurrent application of HHS-RADV results for exiting issuers identified as outliers.

The HHS-RADV error rate of an outlier exiting issuer is used to adjust the exiting issuer's prior year risk scores and state transfers for the applicable state market risk pool(s), which could also impact other issuers in the applicable state market risk pool(s). To address that concern, a policy was finalized to only make risk score and risk adjustment state transfer adjustments reflect an exiting issuer's HHS-RADV results if that issuer is a positive error rate outlier in the benefit year being audited. No adjustment was made for negative error rate outliers.

The 2020 HHS-RADV Amendments Rule (85 FR 76979) finalized a transition to the concurrent application of HHS-RADV results for all issuers, including non-exiting issuers, beginning with the 2020 benefit year HHS-RADV. Because of the concurrent application of HHS-RADV adjustments for all issuers, HHS does not believe there is any reason to treat exiting issuers differently than non-exiting issuers.

Beginning with the 2021 benefit year's HHS-RADV, HHS proposed to strike its current policy of only applying an exiting issuer's HHS-RADV results in the adjustments to risk scores and risk adjustment transfers if the issuer is a positive rate outlier. HHS would apply HHS-RADV results to adjust the plan liability risk scores and state transfers for all positive and negative error rate outliers. No other changes were proposed for HHS-RADV audit for exiting issuers; thus, the existing framework for determining whether an issuer is an exiting issuer would be maintained.

All commenters supported this policy change. HHS is finalizing its proposal without modification.

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

The Lifelong Permanent Conditions (LLPC) list was developed for HHS-RADV medical record abstraction purposes beginning with the 2016 benefit year, when issuers were first learning the HHS-RADV protocols and gaining experience with EDGE data submissions. It was intended to balance the burden and costs of HHS-RADV with validation of actuarial risk of enrollees. The LLPC list was designed to reduce the burden of medical record retrieval for lifelong conditions by simplifying and standardizing coding abstraction for IVA and SVA entities that may have different interpretations of standard coding guidelines. While the LLPC list was developed for HHS-RADV medical record abstraction purposes, the EDGE Server Business Rules for risk adjustment EDGE data submissions direct that EDGE server data submissions are claim-based and follow standard coding principles and guidelines. Concerns were raised that the LLPC list may incentivize issuers to submit EDGE supplemental diagnosis files containing LLPC diagnoses even though those diagnoses may not have been addressed in the claim submitted to the EDGE server for that encounter.

HHS sought comments on discontinuing the use of the LLPC list and the use of Non-EDGE Claims in HHS-RADV, beginning with the 2022 benefit year HHS-RADV. It believes the change would better align HHS-RADV guidance with the EDGE Server Business Rules and would eliminate some situations where an issuer may receive risk score credit for conditions that did not require treatment during an active enrollment period. Additionally, HHS believes that issuers have enough experience with the EDGE data submission process and HHS-RADV protocols that it may not be necessary to continue use of the LLPC list. Comment was specifically requested for the date of discontinuance and the extent to which issuers and their IVA entities have relied on the LLPC list to document diagnoses.

Comment was also requested on discontinuing the ability of issuers to use non-EDGE claims in HHS-RADV beginning with the 2022 HHS-RADV benefit year. This policy was also adopted during the early years of HHS-RADV when issuers were gaining experience with HHS-RADV protocols, and some may have experienced challenges submitting claims to the EDGE server. HHS notes that issuers have consistently met data integrity criteria for their EDGE data submissions for multiple consecutive benefit years, which would obviate the need for the non-EDGE claims protocol.

Selected Comment/Response: Several commenters supported discontinuing use of the LLPC list, and a few commenters supported discontinuing the use of non-EDGE claims, primarily raising data integrity concerns. Some commenters assert there is misalignment between EDGE Server Business Rules and HHS-RADV that creates opportunities for issuers to submit data to the EDGE server without following EDGE Server Business Rules and then receive credit for this data in HHS-RADV. Discontinuing the use of the LLPC list and non-EDGE claims in HHS-RADV would support consistency between the EDGE Server Business Rules and what is allowable in HHS-RADV. One commenter suggested that, under a concurrent risk adjustment model, issuers should get credit for diagnoses that are treated during the benefit year being risk adjusted and should not be allowed to rely on historic data or documentation from before the applicable coverage period.

HHS agrees with the support expressed and reviews how the LLPC list was created in the early years of HHS-RADV to ease the burden of medical record retrieval for lifelong conditions in HHS-RADV. It believes that continuing the policy to permit use of the LLPC list is no longer necessary and its removal will better align HHS-RADV guidance with the EDGE Server Business Rules, as well as ensure that audit entities follow the same standard coding principles and guidelines for HHS-RADV that issuers must follow when submitting data to EDGE. Issuers have now gained sufficient experience with the HHS-RADV protocols and consistently met data integrity criteria for their EDGE data submissions.

Several commenters opposed discontinuing the use of the LLPC list and non-EDGE claims, because it would hinder issuers' ability to accurately capture health care costs and be appropriately compensated for enrollee risk. A few stated that the LLPC list helps capture diagnoses that might otherwise only be reflected in pharmacy costs. While acknowledging some benefits to these policies, HHS restates its reasons for the proposed changes and that it

will give issuers a stronger incentive to encourage enrollees to access care within the benefit year so the risk can be captured on a risk adjustment-eligible claim.

HHS disagrees with concerns of upcoding with HCCs in the HHS-operated risk adjustment program, given the population risk profile,[9] HHS' specifications to mitigate the potential for upcoding, and the presence of the HHS-RADV program itself.

Some opponents cited concerns with provider coding practices. LLPC diagnoses are taken into consideration by providers during medical decision-making and are sometimes treated, regardless of whether they separately appear on a claim. One commenter shared an ongoing issue where providers are not consistently capturing the care provided for conditions diagnosed in prior-year claims. HHS says that if an issuer is aware of incorrect or incomplete coding practices by a provider, the issuer should work to resolve those practices with the provider and should not rely on the use of the LLPC list or non-EDGE claims to address provider coding concerns.

Other commenters note that many LLPCs are captured in medical history or surgical history notes but may not be included in any notes on current treatment. HHS notes that these policies were specific to HHS-RADV and do not supplement or replace the data submission requirements or EDGE Server Business Rules that issuers must follow in submitting claims to their EDGE servers; this includes the rules governing the necessary medical record documentation to support each condition, diagnosis or treatment on each claim.

HHS finalizes discontinuing use of the LLPC list and the use of non-EDGE claims beginning with the 2022 benefit year of HHS-RADV and will update the applicable HHS-RADV protocols accordingly.

d. HHS-RADV Discrepancy and Administrative Appeals Process

HHS proposed shortening the current 30-calendar-day attestation and discrepancy reporting window for SVA findings (if applicable) to within 15 calendar days of the issuance of the SVA findings report, beginning with the 2022 benefit year HHS-RADV.

Issuers have had 30 calendar days to confirm the findings of the SVA or file a discrepancy report to dispute those SVA findings.[10] The shorter time period would improve HHS' ability to finalize SVA findings results before the release of the applicable benefit year HHS-RADV Results Memo and the Summary Report of Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers for the applicable benefit year; these are time-sensitive publications because information on HHS-RADV adjustments is used by issuers for medical loss ratio (MLR) reporting. The Department believes that issuers have sufficient experience with HHS-

[9] As of the 2021 benefit year, more than 75 percent of enrollees of risk adjustment covered plans in the individual non-catastrophic risk pool did not have a single HCC.

[10] In the proposed 2024 Rate Notice, HHS noted that it did not propose to shorten the 30-calendar-day window to confirm or file a discrepancy for the risk score error rate, as the same timing considerations do not apply to the risk score error rate attestation and discrepancy reporting window.

RADV, including several non-pilot years, to act within 15 days. Further, a 15-calendar-day attestation and discrepancy reporting window is consistent with the IVA sample and EDGE attestation and discrepancy reporting windows.

Selected Comment/Response: Supportive comments echoed HHS' rationale for the policy change. Those who opposed believe that the proposed 15-day timeline would not provide adequate time for issuers to complete a thorough review of the SVA findings and that it would create internal challenges and operational burden in cases that require data extraction or information from clinical staff.

HHS finalizes its proposal. While appreciating the concerns expressed by some commenters—especially the potential internal challenges, operational burden, and potential downstream impacts on members—it believes the positive effects to reporting, combined with experience suggesting the 15-day window is feasible, provide sufficient countervailing support to shortening the window.

8. EDGE Discrepancy Materiality Threshold (§153.710)

As noted above, an issuer of a risk adjustment covered plan must provide to HHS, through their EDGE server, access to enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data as specified by HHS for a benefit year by April 30 of the year following the applicable benefit year, in order to be considered for risk adjustment payments and charges. HHS issues final EDGE server reports, reflecting the successful submission of the issuer's data, and the issuer must confirm the findings of the report or file a discrepancy report within 15 days.

In the 2022 Payment Notice (86 FR 24194 through 24195), HHS codified at §153.710(e) a materiality threshold for the reporting of EDGE discrepancies; the amount in dispute must be at least the lesser of $100,000 or one percent of the applicable payment or charge payable to or due from the issuer for the benefit year. However, the preamble to that Payment Notice expressed the second test differently, as "one percent of the total estimated transfer amount in the applicable state market risk pool." HHS proposed to change the language in its regulations for the second test to conform to the language used in the preamble; thus, the materiality threshold under that section would be the lesser of $100,000 or one percent of the total estimated transfer amount in the applicable state market risk pool.

The only comment was in support. HHS finalizes its proposal.

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

1. Exchange Blueprint Approval Timelines (§155.106)

A state seeking to transition to an SBE must submit its Exchange Blueprint[11] to HHS 15 months before when the SBE would begin open enrollment. Under current regulations, the state must then have an approved or conditionally approved Exchange Blueprint 14 months prior to open enrollment, which gives one month for HHS approval. However, the process to approve an Exchange Blueprint is iterative, taking place over several months.

Under current regulations, a state transitioning from an FFE to an SBE-FP must have an approved or conditionally approved Exchange Blueprint 3 months prior to open enrollment.

HHS proposed to require Exchange Blueprint approval or conditional approval prior to an Exchange's first open enrollment period to provide states additional time and flexibility.

Selected Comment/Response: Multiple commenters expressed support for the proposal. A few commenters opposed the proposal, stating that without assurance of HHS' approval, impacted interested parties (such as issuers and brokers) in states transitioning to State Exchanges or SBE-FPs could face implementation risks. HHS responds by emphasizing that HHS will continue to provide technical assistance to states to aid in transitions and coordination between HHS and states will remain in place to assist in the transitions, including with respect to developing plans and an information technology infrastructure.

HHS is finalizing, as proposed, its proposal to require, in the case of a state transitioning from FFE or SBE-FP to SBE or of a state transitioning from FFE to SBE-FP, Exchange Blueprint approval or conditional approval prior to that Exchange's open enrollment period.

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

Assisters[12] are currently prohibited from going door-to-door or using other unsolicited means of direct contact to provide enrollment assistance. HHS reviews statutory and regulatory provisions regarding Navigators, Exchanges, and related consumer service functions and personnel requirements. Under current regulations, assisters may not call a consumer to provide application or enrollment assistance without the consumer initiating the contact, unless the individual has a pre-existing relationship with the individual Assister or designated organization. However, door-to-door and other unsolicited contacts are permitted to conduct general consumer education and outreach, including to let the community know that the Assister's organization is available to provide application and enrollment assistance services.

Assisters now have more name recognition in their communities, and HHS believes its previous concerns related to consumers' privacy and security interests have been sufficiently mitigated

[11] The Exchange Blueprint is the vehicle for the state to document its progress toward implementing its intended Exchange operational model. HHS' review and approval of the Blueprint involves providing substantial technical assistance to states as they design, finalize, and implement their Exchange operations.
[12] That is, Navigators, certified application counselors (CACs), non-Navigator assistance personnel in FFEs, and non-Navigator assistance personnel in certain state Exchanges funded with section 1311(a) Exchange Establishment grants.

through other HHS measures that a blanket prohibition on unsolicited direct contact of consumers by Assisters for application or enrollment assistance is no longer necessary. In fact, the prohibition on door-to-door enrollment places additional burden on consumers and Assisters to make subsequent appointments to facilitate enrollment, which creates access barriers for consumers to receive timely enrollment assistance.

HHS proposed to repeal the general prohibition on door-to-door and other direct outreach by Assisters, believing such contact would be a positive step enabling Assisters to reach a broader consumer base in a timely fashion—helping reduce uninsured rates and health disparities by increasing access to health coverage.

Selected Comment/Response: The vast majority of comments were in support of the proposal. Some commenters opposing the proposal raised concerns about privacy and unwanted solicitations. HHS responded by describing mechanisms in place to ensure privacy of consumers' information.

HHS is finalizing the proposal to repeal the prohibition as proposed.

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)

The ACA directs the Secretary to establish procedures for states permitting agents and brokers to enroll individuals and employers in QHPs and financial assistance. The Secretary must also provide for the efficient and non-discriminatory administration of Exchange activities and implement any measure the Secretary determines appropriate to reduce fraud and abuse. The regulations in §155.220 implement procedures to support states' ability to permit agents, brokers, and web-brokers to assist in Exchange enrollment. These include processes for suspending or terminating the Exchange agreement of agents, brokers, or web-brokers in circumstances that involve fraud or abusive conduct, or where there are sufficiently severe findings of non-compliance. Agents, brokers, and web-brokers that assist with or facilitate enrollment in states with SBE-FPs must comply with all applicable FFE standards.

a. Extension of time to review suspension rebuttal evidence and termination reconsideration requests

If HHS reasonably suspects that an agent, broker, or web-broker may have engaged in fraud or abusive conduct using personally identifiable information of Exchange applicants or enrollees (or in connection with an Exchange enrollment or application), HHS may temporarily suspend the Exchange agreement(s) of the agent, broker, or web-broker for up to 90 calendar days, with the suspension effective as of the date of the notice to the agent, broker, or web-broker. The agent, broker, or web-broker can submit evidence to HHS to rebut the allegations. If HHS determines that the agent, broker, or web-broker satisfactorily addresses the concerns, HHS will lift the temporary suspension and notify the agent, broker, or web-broker. If the rebuttal evidence does not persuade HHS to lift the suspension, HHS may terminate the Exchange agreement(s) of the agent, broker, or web-broker for cause.

HHS may also terminate the agreement for cause in cases of sufficiently severe violations or patterns of violations. In these situations, an advance 30-day notice and an opportunity to address the non-compliance finding(s) are provided. If the noncompliance is not satisfactorily addressed, the Exchange agreement(s) of the agent, broker, or web-broker may be terminated for cause, losing registration with the FFE and the ability to assist or facilitate Exchange enrollment.

Under current regulations, HHS has 30 days to review evidence submitted by agents, brokers, or web-brokers to:

- Rebut allegations that led to suspension of their Exchange agreement, or
- Request reconsideration of termination of their Exchange agreement.

HHS proposed to provide more time for the agency to review evidence submitted by agents, brokers, or web-brokers:

- An additional 15 days (45 days total) regarding allegations that led to suspension of their Exchange agreement, and
- An additional 30 days (60 days total) requesting reconsideration of termination of their Exchange agreement.

HHS has found that the process of reviewing the evidence, especially in more complex situations, often requires significant resources and time. HHS is aware this could delay the ability of agents, brokers, and web-brokers to conduct business, but expects that not all reviews are so complex that they would require the use of this additional time.

The justification provided for the proposal to allow HHS up to 45 calendar days to review rebuttal evidence is that agents, brokers, and web-brokers have up to 90 days to submit rebuttal evidence, while HHS currently only has 30 days to review, consider, and make determinations based on that evidence. Thus, HHS does not consider it unreasonable to increase this combined maximum 120-day time period to 135 days, particularly where HHS has a reasonable suspicion of fraud or abusive conduct that may cause imminent or ongoing consumer harm using personally identifiable information of an Exchange enrollee or applicant.

The proposal to allow HHS up to 60 calendar days to review a request for reconsideration of termination includes, for example, repeated violations of the Exchange privacy and security standards. Combined with HHS' 30-day notice and opportunity to respond, the maximum timeframe would be 90 days. Additional time was proposed for HHS because this review is part of the appeal process in §155.220(h)(2), under which the agent, broker, or web-broker had additional time at an earlier stage to rebut the allegations or findings and to take remedial actions to address the concerns that led to suspension or termination.

Selected Comment/Response: Multiple commenters supported the proposal as necessary to allow for proper review of complex cases but encourage HHS to limit the use of the extra review time to only those cases in which it is necessary and to conduct reviews as quickly as possible.

HHS is finalizing its proposal as proposed.

b. Providing Correct Information to the FFEs

While agents, brokers, and web-brokers can assist consumers with completing the Exchange application, the consumer is the individual with the knowledge to confirm the accuracy of the information provided on the application. Agents, brokers, or web-brokers must provide FFEs and SBE-FPs with correct information, but current regulations do not require them to confirm with the consumers they are assisting that the information entered on the application is accurate. HHS continues to find applications containing incorrect consumer information and to receive complaints from consumers that information submitted by agents, brokers, or web-brokers on their behalf was incorrect. Incorrect consumer information on eligibility applications may result in consumers receiving inaccurate eligibility determinations and could affect their tax liability.

HHS proposed to require agents, brokers, or web-brokers assisting with enrollment through FFEs and SBE-FPs or assisting individuals applying for APTC and CSRs to document that eligibility application information has been reviewed and confirmed to be accurate by the consumer (or their authorized representative) prior to application submission. Such documentation would be created by the assisting agent, broker, or web-broker and would require the consumer (or their authorized representative) to take an action, such as providing a signature or a recorded verbal confirmation, that produces a record that can be maintained by the agent, broker, or web-broker and produced to confirm the submitted eligibility application information was reviewed and confirmed to be accurate by the consumer (or their authorized representative).

The documentation would need to include the date the information was reviewed, the name of the consumer (or their authorized representative), an explanation of the attestations at the end of the eligibility application, and the name of the agent, broker, or web-broker providing assistance. The documentation would be maintained by the agent, broker, or web-broker for a minimum of 10 years and produced upon request in response to monitoring, audit, and enforcement activities. HHS also proposed that the eligibility application information documentation include an explanation of the attestations at the end of the eligibility documentation to remind the consumer they are responsible for the accuracy of the information within the application.

HHS did not propose any specific method for documenting that eligibility application information has been reviewed and confirmed, but proposed to include in §155.220(j)(2)(ii)(A) a non-exhaustive list of examples of acceptable methods such as a signature (electronic or otherwise), verbal confirmation captured in an audio recording, or a written response (electronic or otherwise) to a communication sent by the agent, broker, or web-broker. HHS invited comment on whether there may be other acceptable methods of documentation that HHS should consider specifying, particularly any current best practices or approaches.

The consumer would be able to review and confirm the accuracy of application information on behalf of other applicants (for example, dependents or other household members). This would allow agents, brokers, and web-brokers to continue assisting consumers as they currently do—for example, by working with an individual representing a household when submitting an application for a family.

Selected Comment/Response: Many commenters supported the proposals as protective to consumers. A number of commenters expressed concerns that the proposals would impose heavy burdens on agents, brokers, and web-brokers, especially during the Open Enrollment Period and especially on smaller agencies and independent agents, brokers, and web-brokers. Some commenters expressed concern the extra time needed to comply with the requirements may discourage consumers from enrolling. HHS acknowledged the concerns but responds that agents, brokers, and web-brokers will be provided flexibility to establish methods that meet their needs and that the benefits of the requirements would outweigh any potential burden. HHS states it will monitor to see if there is any noticeable negative impact.

HHS is finalizing these proposals as proposed.

c. Documenting Receipt of Consumer Consent

HHS proposed to require agents, brokers, or web-brokers assisting with enrollment through FFEs and SBE-FPs, or assisting individuals with applying for APTC and CSRs, to document the receipt of consent from the consumer, the consumer's authorized representative, qualified employers, or qualified employees. As with the attestation of accuracy, the documentation of consumer consent would require an action by the consumer (or representative) that produces a record that can be maintained by the agent, broker, or web-broker for 10 years and produced upon HHS request. The record must contain not only the date consent was given, name of the consumer or their authorized representative, and the name of the agent, broker, web-broker, or agency being granted consent, but also a description of the scope, purpose, and duration of the consent provided by the consumer (or their authorized representative) as well as the process by which the consumer or their authorized representative may rescind such consent.

This proposal rises not only out of disputes between agents, brokers, or web-brokers and the individuals they are assisting, but also between multiple agents, brokers, or web-brokers who claim to be authorized to act on behalf of the consumer. HHS has received complaints from consumers where enrollments occurred without the consumer's consent, and where agents, brokers, or web-brokers attest they obtained consent and acted in good faith but cannot produce reliable records of such consent.

As with the attestation of accuracy, HHS does not specify the method to document consumer consent, as long as it meets the foregoing requirements. Possible methods to document individual consent include requiring individuals to create user accounts on an agency's website where they indicate the agents, brokers, or web-brokers to whom they have provided consent. If agents, brokers, and web-brokers have already adopted such consent documentation processes, no changes would be required from this proposed standard.

Selected Comment/Response: Multiple commenters expressed support of the proposals as helping to eliminate unauthorized enrollment and protect consumers. Some commenters expressed concern relating to burden resulting from the additional requirements, especially during the Open Enrollment Period and especially on smaller agencies and independent agents, brokers, and web-

brokers, and relating to potentially discouraging consumers from enrolling in coverage because of the additional time associated with complying with the new requirements. HHS responds that it does not believe documenting consent, which must already be provided, will result in significant burden, and that having a reliable record of consent will assist with resolution of disputes. HHS also responds that agents, brokers, and web-brokers will be provided flexibility to establish methods that meet their needs and that it believes the benefits of the requirements would outweigh any potential burden.

HHS is finalizing these proposals as proposed with a technical update.

4. Eligibility Standards (§155.305)

Currently, an Exchange cannot determine a taxpayer eligible for APTC if the taxpayer (or spouse) failed to file a federal income tax return and reconcile their past APTC for a year in which tax data would be used to verify household income and family size. This is referred to as having failed to file and reconcile (FTR). HHS has taken steps to increase taxpayer compliance with filing and reconciliation requirements but believes the costs of the current policy outweigh the benefits for a number of reasons. For example, Exchanges sometimes have to determine an enrollee ineligible for APTC without having up-to-date information while federal income tax returns are still being processed by the IRS.

Since 2015, consumers with an FTR status have been permitted to attest during Open Enrollment on the single, streamlined application that they have filed and reconciled their APTC and thus retain their APTC, even if this is not reflected in IRS data. This prevents enrollees from losing APTC erroneously. After Open Enrollment, FFEs and SBE-FPs conduct a second look at FTR data to verify the attestation early in the coverage year, known as the FTR Recheck.[13]

HHS proposed a new process for Exchanges to conduct FTR while also ensuring that Exchanges preserve program integrity by paying APTC only to eligible consumers and avoiding situations where enrollees become uninsured when their APTC is terminated. Changes to the policies are proposed for multiple reasons—for example, that Exchange enrollees often do not understand the requirement that they must file a federal income tax return and reconcile their APTC or that they must also submit IRS Form 8962 to properly reconcile their APTC (notwithstanding the attestations required of consumers).

Under current regulations, if an enrollee has 1 year with an FTR status, the Exchange must determine them ineligible for APTC. HHS considers this overly punitive. Some consumers may have their APTC ended due to delayed data, so that their only remedy is to appeal. Consumers may also be confused or have received inadequate education on the requirement to file and reconcile; in this case, they must actually file, reconcile, and appeal to get their APTC reinstated.

HHS proposed that Exchanges can determine an enrollee ineligible for APTC only after having an FTR status for two consecutive tax years—that is, years for which tax data would be utilized

[13] SBEs have implemented similar processes.

for verification of household income and family size. This gives Exchanges more time to conduct outreach to consumers whose data indicates a failure to file and reconcile, to prevent erroneous terminations of APTC and to provide access to APTC for an additional year even when APTC would have been correctly terminated under the original FTR process.

FFEs and SBE-FPs would still send notices to consumers for the year in which they have failed to reconcile, as an initial warning that they risk being determined ineligible for APTC if they fail to file and reconcile for a second consecutive tax year. This change would also alleviate burden on HHS hearing officers by reducing the number of appeals related to denial of APTC due to FTR, and prevent consumers who did reconcile but for whom IRS data was not updated quickly enough from having to go through an appeal process to have their APTC rightfully reinstated. This will prevent coverage gaps, as FFE and SBE-FP enrollees who lose APTC often cannot afford unsubsidized coverage.

Although this proposed regulatory policy would begin January 1, 2024, CMS had already paused ending APTC for enrollees with an FTR status for 2021 and 2022, due to IRS processing delays of 2019 federal tax returns related to the COVID-19 PHE.[14] CMS extended this pause for 2023.[15] CMS proposed to continue to pause FTR until HHS and IRS can implement the new FTR policy, if finalized—that is, until the IRS can update its systems to implement the new FTR policy, and HHS can notify the Exchange of an enrollee's consecutive 2-year FTR status. HHS believes these proposed changes will allow Exchanges to maintain program integrity by denying APTC to consumers who have, over the course of two years, been given ample notification of their obligation to file and reconcile but have failed to do so.

HHS sought comment on this proposal, especially from states and other interested parties regarding tax burdens on consumers to inform its decision on this proposal.

Selected Comment/Response: Many commenters agreed with the proposal for an applicant's FTR status to result in an Exchange determination that the applicant is ineligible for APTC only after having an FTR status for two consecutive tax years, agreeing that it better protects vulnerable enrollees, promotes continuity of coverage, and would allow for more consumer education on the requirement to file and reconcile past APTC and the process for doing so. HHS agrees with these comments and believes the proposal strikes a balance between protecting consumers from large tax liabilities, while also ensuring program integrity.

A few comments from State Exchanges supported the proposal, but asked HHS to provide clear and early information about the technical specifications and processes that will be required to

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

[15] CMS, "Failure to File and Reconcile (FTR) Operations Flexibilities for Plan Year 2023," July 18, 2022, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/FTR-flexibilities-2023.pdf. The CMS guidance also said, "This flexibility also extends to State-Based Exchanges. As with last year's announcement, today's announcement does not change the general requirement for taxpayers for whom APTC was paid in 2021 to file their taxes and reconcile the APTC with the PTC allowed for the year."

implement the FTR proposal within State Exchange's systems and requested clarification on the timeline. HHS responded the department will work with all parties to make sure the technical specifications and process are explained clearly before and during implementation. HHS details that the department intends to continue pausing implementation of the FTR requirement on Exchanges on the federal platform until data from IRS about APTC reconciliation is available to HHS, which is expected to be available for eligibility determinations for PY 2025. Since HHS expects to resume timely notification to Exchanges of FTR status by September 2024, it believes there will be sufficient time for Medicaid unwinding and to ensure alignment with IRS systems. In response to concerns regarding adequate notice, HHS responds it will provide at least 3 months' notice before Exchanges are required to deny APTC to consumers who the IRS reports to have failed to reconcile APTC for 2 consecutive years.

A few comments raised concerns about consumers being put at risk for higher tax liability if they are unable to reconcile their APTC after two years rather than one year. HHS agrees with this observation. To address this, HHS intends to continue issuing FTR warning notices for enrollees in Exchanges on the federal platform who have not filed and reconciled for one tax year, and encourage State Exchanges to do so as well. HHS believes, though, that the policy balances providing for consumer protections while supporting program integrity, and provides that the department will monitor the implementation of the policy to see if further guidance or any changes are needed.

HHS is finalizing the policy as proposed except that the final rule will become effective on the general effective date of the final rule, instead of January 1, 2024, to provide flexibility for HHS and IRS to resume FTR operations as soon as HHS and IRS are ready to begin. HHS will provide at least three months' notice to consumers and other interested parties prior to resuming FTR operations. HHS is not finalizing a technical correction it had proposed to clarify that HHS receives data from the IRS for consumers who have failed to file tax returns and reconcile a previous year's APTC because HHS believes the correction is not needed and the original wording of the rule more accurately reflects how information is passed through the Federal Data Services Hub. HHS clarifies that until the department and the IRS are able to implement the FTR policy, Exchanges must continue to pause APTC denials based on a failure to reconcile.

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

Current regulations outline a multistep process to verify household income for those seeking financial assistance for Exchange coverage. Applicants and enrollees must attest to their projected annual household income, after which the Exchange must request their tax return data from the IRS. If that data indicates that attested projected annual household income represents an accurate projection of household income for the benefit year for which coverage is requested, the Exchange must determine eligibility for APTC and CSR based on the IRS tax data.

If the IRS data indicates the attested projected annual income is *not* an accurate projection, or if IRS data is unavailable, the applicant or enrollee is considered to have experienced a change in circumstances, which triggers procedures using information other than IRS tax return data—an

alternative verification process (§155.320(c)(3)(iii)-(vi)). HHS notes that tax data is usually unavailable when an applicant or enrollee has experienced a change in family size, other household circumstances (such as a birth or death), filing status changes (such as a marriage or divorce), or the applicant or enrollee was not required to file a tax return.

If the individual qualifies for an alternate verification process and the attested projected annual household income is *greater* than the income amount returned by the IRS, the Exchange accepts the applicant's attestation without further verification.[16] If the attested projected income is significantly lower than the income amount returned by the IRS (or if there is no IRS data available), the Exchange generates an income inconsistency, also known as a data matching issue (DMI), which triggers another set of procedures (for example, §155.315(f)(1)-(4)). This typically requires documentary evidence from the individual.

HHS notes the current process is overly punitive to consumers and burdensome to Exchanges, since reasons for a DMI can be attributed to birth, marriage, divorce, name changes, or other reasons. Receiving an income DMI and not providing sufficient documentation to verify projected household income results in consumers being determined ineligible for financial assistance (§155.320(c)(3)(vi)(G)). HHS believes this negative consequence on consumers outweighs the intended programmatic benefits. HHS provides findings that income DMIs have a negative impact on access, health equity, and the risk pool. With respect to burden on Exchanges, DMI verification by the Exchange requires an outlay of administrative hours to monitor and facilitate the resolution of income inconsistencies. Within the federal platform, this administrative task accounts for approximately 300,000 hours of labor annually, which is likely proportionally mirrored by state Exchanges.

HHS proposed that Exchanges would be required to accept an attestation of projected income when the IRS confirms tax return data is not available. HHS cites statutory authority in the ACA for the change (sections 1412(b)(2) and 1411(c)(4)(B)). The Exchange would continue to generate income DMIs when IRS data is available and the attested projected income is more than a reasonable threshold below the amount returned by the IRS, and other sources cannot provide income data within the reasonable threshold. Additionally, the Exchange would continue to generate income DMIs when IRS tax data cannot be requested because an applicant or enrollee did not provide sufficient information (namely, a Social Security number), and other sources cannot provide income data within the reasonable threshold.

Lastly, applicants would receive an automatic 60-day extension, in addition to the 90 days currently provided, to allow them time to provide documentation verifying income. This extension would be granted automatically when consumers exceed the allotted 90 days without resolving any income DMI. This aligns with current regulations that provide applicants

[16] HPA notes a related story by Kaiser Health News, "How Optimism Can Close the Medicaid Coverage Gap." Particularly relevant for individuals in states that have not expanded Medicaid, if individuals report projected income that makes them eligible for subsidized exchange coverage (for example, above 100 percent of the federal poverty level, even if it is higher than what the IRS previously found) and if their income ultimately falls short of the projection, they will not face a financial penalty or have to pay back money to the government as long as the prediction was not made "with an intentional or reckless disregard for the facts," said a spokesperson for the IRS.

extensions beyond 90 days if the applicant demonstrates a good faith effort to obtain documentation. HHS has found that 90 days is often insufficient for many applicants to provide this documentation, since it can require multiple documents from various household members along with an explanation of seasonal employment or self-employment, including multiple jobs. Between 2018 and 2021, more than a third of consumers who resolved their income DMIs on the Exchange did so in more than 90 days. HHS believes Exchanges should utilize the additional time to work with consumers to submit this documentation.

Selected Comment/Response: Multiple commenters requested clarification on the usage of state data sources to resolve income inconsistencies. HHS agrees that State Exchanges may continue to use income data from other electronic data sources to verify income if income is not already verified by the IRS or if IRS data is inconsistent with the projected annual household income, unless flexibility is granted and approved by HHS. Multiple commenters expressed program integrity concerns and concerns about consumer tax liability. HHS acknowledges the concerns and responds that it will continue to engage with interested parties on how to increase the accuracy of consumer income attestation and subsequent APTC determination.

Some commenters expressed concern that the 60-day extension was not necessary for all consumers and may slow the process, suggesting that the extension be offered on a case-by-case basis. HHS responds that when afforded additional time (beyond the 90-day current period), many consumers can resolve their DMIs, and that if the additional time facilitates more DMI resolutions there would potentially be fewer resulting appeals, and therefore states the policy would not result in additional administrative burden.

One commenter asked for flexibility in the implementation timeline for State Exchanges. HHS responded that it believes the provision must be implemented in all Exchanges to account for the difficult process of submitting documentation and therefore would not provide flexibility on the implementation timeline, but would be available to provide technical assistance to State Exchanges.

CMS is finalizing as proposed the policies to accept a household income attestation when the IRS confirms tax return data is not available and to provide an automatic 60-day extension for income DMIs.

6. 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 enrollees remain eligible for enrollment in a QHP through the Exchange upon annual redetermination, and the product in which they were enrolled remains available for renewal, their enrollment in that product will be 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.

Because enrollees who are eligible for CSRs may only receive those CSRs if they enroll in a silver-level QHP, HHS proposed that Exchanges could modify their re-enrollment hierarchies to ensure certain enrollees obtain those CSRs. Enrollees who are eligible for CSRs and would otherwise be automatically re-enrolled in a bronze-level QHP without CSRs could instead be automatically re-enrolled into a silver-level QHP with CSRs, in the same product with a lower or equivalent premium (after APTC) (referred to as the "bronze-to-silver crosswalk policy").

In addition, HHS proposed to amend the re-enrollment hierarchy to allow Exchanges to ensure enrollees whose QHPs are no longer available and those who would be re-enrolled into a silver-level QHP to receive CSRs are re-enrolled into plans with the most similar network, provided that certain conditions are met. To honor other criteria the enrollee may have used to make the original selection, HHS proposed to limit re-enrollment of such enrollees into plans offered by the same issuer and of the same product if the enrollee's plan and product remains available.

Exchanges (including Exchanges on the federal platform and SBEs) would implement this option beginning with the open enrollment period for plan year 2024 coverage, if operationally feasible. If not, then this option must be available beginning with the open enrollment period for 2025 coverage.

This policy is based on comments in response to the 2023 Payment Notice (87 FR 27208, 27273), in which HHS announced it would consider proposing amendments to the Exchange re-enrollment hierarchy in future rulemaking and would take into account comments received. HHS solicited comments on incorporating the net premium, maximum out-of-pocket (MOOP), deductible, and total out-of-pocket cost of a plan into the Exchange re-enrollment hierarchy. HHS had specifically sought comment on re-enrolling current bronze QHP enrollees into an available silver QHP with a lower net premium and higher plan generosity offered by the same issuer, which is an example that HHS proposed to codify as to how Exchanges may modify their re-enrollment hierarchies.

HHS is considering whether, for future years, it would be appropriate to modify the re-enrollment process to incorporate both net premium costs (that is, premium minus the APTC) and out-of-pocket costs attributable to cost sharing (referred to collectively as total out-of-pocket cost) when both directing re-enrollment to a plan at the same metal level as the enrollee's current QHP and directing re-enrollment to a plan at a higher metal level than the enrollee's current QHP. For now, HHS believes limiting the scope of this policy to only income-based CSR-eligible enrollees who are currently in a bronze QHP and have a lower cost silver CSR QHP available would allow issuers and Exchanges to incrementally update their processes, as opposed to incorporating net premium and out-of-pocket cost (OOPC) throughout the hierarchy for PY 2024.

HHS believes that enrollees are best able to make plan selections themselves, and outreach from the Exchanges on the federal platform always encourages enrollees to actively return, provide their latest eligibility information, and shop and compare Exchange plans. Income-based CSR-eligible enrollees in Exchanges on the federal platform who are subject to the proposed policy would receive a notice from the Exchange advising them that they will be re-enrolled into a silver plan if they do not make an active selection by December 15. They would also see the silver plan highlighted in the online shopping experience if they return on or before December 15 to review their options. The notice would inform enrollees that if they prefer to keep their bronze plan, they can actively select it through December 15, for an effective date of January 1.

Selected Comment/Response: Many commenters supported the proposed bronze-to-silver crosswalk policy, agreeing that it would help limit CSR forfeiture and would encourage more individuals to be enrolled in more generous coverage without additional costs. Some commenters cited similar auto re-enrollment policies used in State Exchanges (including under Massachusetts Health Connector and Covered California). Commenters generally agreed with the prioritization of network and benefit continuity for enrollees auto re-enrolled in a QHP that is different from the current QHP. In response to a comment requesting clarity on the auto re-enrollment hierarchy for enrollees who are auto re-enrolled in a silver plan with CSRs but become ineligible for CSRs the following year, HHS clarifies that a CSR-eligible individual who is enrolled in a silver plan for a plan year in accordance with the bronze-to-silver crosswalk policy and who does not select a plan for the next plan year will be auto re-enrolled without consideration of the prior re-enrollment under the crosswalk policy.

Some opposing commenters expressed concern about interpreting an individual's inaction for enrolling as indifference, that plan selection is made on more factors than just premiums, and that auto enrollment into a silver plan could increase tax liability for an individual in case of household income increases that are not reported. HHS acknowledges these concerns and expresses the intent for outreach and education (including existing tools such as notices though HealthCare.gov) and continued work on decision-making tools. HHS also notes that changes in household income mid-year that may result in ineligibility for CSRs or APTC could enable an individual to qualify for an SEP.

Some commenters raised concern about timely notification being provided to enrollees auto re-enrolled from a bronze to a silver plan and multiple commenters requested an SEP be provided to allow enrollees so auto re-enrolled into a silver plan to change plans after the coverage starts if they choose. HHS responds that information is provided before and after auto re-enrollment to affected enrollees and describes that messaging will be provided to affected income-based CSR eligible enrollees through Exchanges on the federal platform informing them that they will be auto re-enrolled into a silver plan if action is not taken before December 15 and that further notification would be provided after December 15 to those auto re-enrolled from a bronze to silver plan that their new coverage begins January 1 and of the availability to change enrollment by January 15 which would become effective February 1. HHS reiterates that no changes were proposed (and therefore none are being finalized) to SEP eligibility or duration. HHS believes that a SEP is not necessary because enrollees who are auto re-enrolled into a silver plan will have the same network as if they had instead been auto re-enrolled into a bronze plan absent the crosswalk policy.

HHS is finalizing these proposals, with modifications to help distinguish between the enrollment procedures under the bronze-to-silver crosswalk policy and the procedures for when an enrollee's current QHP is no longer available.

To ensure that Exchanges will make auto re-enrollment determinations based on comparable premium information, HHS is modifying the proposed policy to clarify that Exchanges implementing the bronze-to-silver crosswalk policy will compare net monthly silver plan premiums for the future year with net monthly bronze plan premiums for that future year, instead of to net monthly bronze plan premiums for the current year (where net monthly premium is the enrollee's responsible amount after applying APTC).

In response to comments, HHS is modifying its proposed amendments to §155.335(j) to clarify that the bronze-to-silver crosswalk policy will not result in enrollment into a plan for any enrollee that is in a different product or that has a different provider network from the one the enrollee would have had absent the policy. HHS is therefore finalizing the policy to require Exchanges to take into account network similarity to the current year plan when re-enrolling enrollees whose current year plans are no longer available, and to permit Exchanges to re-enroll enrollees under the bronze-to-silver crosswalk policy only if the future year silver plan has the same network that the future year bronze plan would have absent the policy.

For PY 2024, HHS will implement the policies in Exchanges on the federal platform by incorporating plan network ID into the auto re-enrollment process and will permit issuers to submit justifications to HHS for review if they believe a different network ID in the following plan year has the most similar network to the enrollee's current QHP.

HHS notes it will take into account in future rulemaking feedback it received to the request for information in the HHS Notice of Benefit and Payment Parameters for 2024 proposed rule on additional potential future changes to the auto re-enrollment hierarchy.

7. Special Enrollment Periods (§155.420)

a. Use of Special Enrollment Periods by Enrollees

HHS proposed technical corrections to clarify that only one person in a household (including a dependent) would need to qualify for a special enrollment period (SEP) in order for the entire family to qualify. This change was previously proposed and codified elsewhere, but was neglected for §155.420(a)(4)(ii)(A) and (B), which are the regulation sections addressed in this rule.

Select Comment/Response: All commenters strongly supported the proposed technical corrections, agreeing that they support different types of household compositions and reduce burden and confusion.

HHS is finalizing the technical corrections as proposed with a modification to use gender neutral language and a correction that any member of a household, rather than any member of a tax household, can trigger the SEP for the household.

b. Effective Dates for Qualified Individuals Losing Other Minimum Essential Coverage

The earliest start date for Exchange coverage is the first day of the month *following* the loss of minimum essential coverage (MEC). Some states regularly terminate Medicaid or CHIP mid-month. Consumers may face gaps in coverage because current Exchange rules do not permit retroactive or mid-month coverage effective dates for consumers whose other coverage ends mid-month. HHS notes that because of the Medicaid unwinding it expects to see a higher than usual volume of individuals transitioning from Medicaid and CHIP coverage to the Exchange from April 1, 2023, through May 31, 2024.

HHS proposed, for consumers attesting to a future loss of MEC, to permit Exchanges the option of offering earlier coverage start dates—that is, at the beginning of the month in which the loss of MEC will occur. At the option of the Exchange, if the plan selection is made on or before the last day of the month preceding the triggering event, the Exchange would have to ensure that coverage is effective on the first day of the month in which the triggering event occurs. HHS solicited input on whether the proposed change would help consumers, especially those impacted by Medicaid/CHIP unwinding, to seamlessly transition to Exchange coverage.

HHS acknowledges that this proposed change may have a limited impact because many types of coverage do not typically have end dates in the middle of the month. HHS sought comment on the frequency of mid-month coverage end dates, potential program integrity issues associated with earlier effective dates, and on instances when the expedited effective date would (or would not) mitigate coverage gaps or introduce coordination of benefits issues.

Generally, individuals eligible for other MEC are not eligible for APTC. Individuals affected by this proposal would have a short period of dual enrollment. HHS says this would not bar an enrollee from APTC or CSR benefits given IRS rules that a consumer may qualify when not eligible for MEC for the *full calendar month*, based on the definition of "coverage month" (26 CFR §1.36B-3(c)(1)(iii)). HHS considered and sought comment on whether a conforming change should be made in Exchange regulations at 45 CFR §155.305(f), to align with the IRS definition of coverage month.

The proposed changes to the effective date for future loss of MEC would be effective for individual market coverage offered off-Exchange as well as through an Exchange, except that for coverage offered off an Exchange the proposed option of the Exchange to specify the effective date would refer to an option of the applicable state authority.

HHS considered other options, such as retroactive coverage for consumers reporting past loss of MEC, but decided against that to avoid adverse selection. HHS sought comment on additional regulatory changes that would improve transitions to Exchange coverage and minimize periods of uninsurance for consumers who report a loss of MEC to the Exchange.

Selected Comment/Response: The majority of commenters supported the proposal, agreeing that it would help ensure access to treatment and noting that it is especially needed given the timing of the Medicaid unwinding. Some commenters supported the proposal but raised concerns about adverse selection and offered suggestions to make the proposal mandatory on Exchanges rather than optional or to allow enrollees to have the choice of effective date. HHS acknowledged the concerns but stated the need to allow flexibility for the Exchanges and that allowing enrollees the choice would be too operationally complex to implement.

One commenter requested HHS maintain the current special enrollment flexibilities permitted pursuant to the COVID-19 PHE. HHS clarifies that the COVID national emergency ended on April 10, 2023, and therefore the current SEP flexibilities due to the COVID-19 FEMA national emergency will end June 9, 2023.

One commenter opposed the policy stating that it could further complicate the Medicaid unwinding process. HHS responded that it believes the policy still has value given that it would facilitate timely coverage transitions, including during the Medicaid unwinding.

HHS is finalizing this provision as proposed, with a modification to section §155.305(f)(1)(ii)(B) to clarify that a tax filer must be determined eligible for APTC if the tax filer (or a member of their tax household) is not eligible for a full calendar month of MEC (and other criteria are met). This change is being made in response to a clarification requested by a commenter that an

enrollee who is not eligible for or enrolled in non-Exchange MEC for a full month, and who is enrolled in a QHP on the first day of such month, may be eligible for APTC or CSR.

c. Special Rule for Loss of Medicaid or CHIP Coverage

Currently, individuals who lose MEC qualify for an SEP under §155.420(d)(1)(i) and may report a loss of MEC to Exchanges up to 60 days before and up to 60 days after their loss of MEC. When individuals are disenrolled from Medicaid or CHIP based on modified adjusted gross income (MAGI) following an eligibility redetermination, states must provide a 90-day reconsideration window for former beneficiaries to provide information to re-establish their eligibility. Because the SEP for loss of MEC lasts only 60 days, by the time a consumer exhausts their attempt to regain coverage through Medicaid or CHIP, they may have missed their window to enroll in Exchange coverage through the SEP.

HHS proposed that, effective January 1, 2024, Exchanges will have the option to implement a new special rule that consumers eligible for an SEP due to loss of Medicaid or CHIP MEC will have up to 90 days after their loss of Medicaid or CHIP coverage to enroll in an Exchange QHP, aligning with the reconsideration window in Medicaid. Sixty days remains the default unless the Exchange exercises the proposed option.

Selected Comment/Response: Multiple commenters supported the proposed special rule, specifically that it will encourage continuity of coverage and support flexibility for SBEs to choose whether or not to apply it.

A few commenters opposed the proposed special rule—one stating that it is not necessary given the Medicaid unwinding SEP, and another stating that HHS is introducing too many SEPs, which could increase burden and confusion. HHS responds that the Medicaid unwinding SEP is only temporary and would not address the misalignment of the loss of MEC SEP eligibility period and Medicaid and CHIP reconsideration periods outside of the exceptional circumstances of Medicaid unwinding. HHS acknowledges concern raised about confusion with many SEPs, but responds that it is at the option (and not required) of an Exchange to apply the special rule.

HHS is finalizing the proposal as proposed, with two modifications to provide SBEs additional flexibilities in response to comments received. First, SBEs are permitted, if the State Medicaid Agency allows or provides a longer Medicaid or CHIP reconsideration period, to provide that a qualified individual (or their dependent) who is losing Medicaid or CHIP coverage may have more time to select a QHP up to the number of days provided for the applicable Medicaid or CHIP reconsideration period. Second, SBEs may implement this special rule as soon as the final rule takes effect, instead of on January 1, 2024.

d. Plan Display Error Special Enrollment Periods

Under current regulations, an SEP may be triggered when individuals adequately demonstrate to the Exchange that a material error related to plan benefits, service area, or premium (a "plan display error") influenced their decision to purchase an Exchange QHP. This generally allowed

consumers who enrolled in a plan for which HealthCare.gov displayed incorrect information and who could demonstrate that such incorrect information influenced their decision to purchase a QHP through the Exchange, to select a new plan that better suited their needs. For this SEP, the consumer must have already completed their Exchange application, been determined eligible for QHP coverage, and viewed the material error while making a final selection to enroll in the QHP.

In the majority of the plan display errors, the issuer or state regulator has identified the display error. Consumers may not be aware that an incorrect premium payment was due to a plan display error. The issuer is the only party that can identify and notify the Exchange that the error was caused by incorrect premium amounts between the issuer's records and data submitted to HealthCare.gov Therefore, the issuer can notify CMS of the plan display error, and CMS can then work with the issuer to implement its established data correction processes to make the necessary corrections to HealthCare.gov. CMS is likely to determine that the plan display error impacted the consumer's purchasing decision because the consumer was presented erroneous information when purchasing the plan and likely made an enrollment decision based on the premium and cost sharing amounts. Issuers submitting a data change request that adversely impacts the consumers' enrollment on HealthCare.gov are required to notify consumers of the plan display error and the remediation.

HHS proposed revising the regulation to remove the burden solely from the qualified individual, enrollee, and their dependents. HHS also proposed adding cost sharing to the list of plan display errors. HHS expects this change to have minimal operational impact.

HHS notes if an error is not material, it does not trigger an SEP. Generally, the most straightforward and consumer-friendly resolution of a plan display error is for issuers to honor the benefit as it was displayed, if permitted by the applicable state regulatory authority; in this case, CMS would not provide an SEP.

All comments supported the proposed policy. HHS is finalizing the proposal, as proposed.

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

HHS guidance requires issuers that cover dependent children to provide coverage to them until the end of the plan year in which they turn 26 (or the higher maximum age under state law).[17] HHS proposed to codify that requirement in federal regulations, adding §155.430(b)(3), applicable in FFEs and SBE-FPs. This proposal would codify the current implementation of the federal platform. HHS proposed to make implementation optional for SBEs that wish to establish a similar prohibition against issuers terminating coverage before the end of the plan year because the dependent child reached age 26 (or the maximum age under state law).

[17] Similarly, the dependent child can receive a portion of the family's APTC for the entire plan year. Exchange eligibility determinations for enrollment through the Exchange and for APTC are based on the tax household, and the determination is made for the entire plan year unless it is replaced by a new determination of eligibility. The IRS has no maximum age cap for tax dependents.

Selected Comment/Response: Multiple commenters supported the proposal and none opposed it. One commenter suggested encouraging state Exchanges to also adopt the proposed policy. HHS responded that the policy is applied to Exchanges on the federal platform based on Exchange operations and the fact that APTC determinations are made for the entire plan year based on household income. Since state Exchanges may establish their own operational practices regarding the maximum age for dependent enrollees that are different from those of Exchanges on the federal platform, HHS believes it is appropriate to allow state Exchanges the option to adopt the proposal.

HHS is finalizing this codification proposal as proposed, with the additional clarification that issuers who have adopted a higher maximum age than required by state or federal law must maintain coverage for dependent children until the end of the plan year in which they reach that maximum age.

9. General Eligibility Appeals Requirements (§155.505)

Under the current appeals process regarding applicants' and enrollees' eligibility determinations in an Exchange, appellants may seek judicial review of an Exchange eligibility appeal decision made by the HHS appeals entity and state Exchange appeals entities. Currently, the regulation specifies no other administrative opportunities for appellants to appeal these decisions made by the HHS appeals entity.

HHS proposed a revision to acknowledge the ability of the CMS Administrator to review Exchange eligibility appeals decisions prior to judicial review. This would ensure that accountability for the decisions of the HHS appeals entity is vested in a principal officer, as well as to bring §155.505(g) of the appeals process in line with other CMS appeals entities that provide Administrator review.

Select Comment/Response: One commenter requested clarification regarding the interaction between the administrative review process and the timeliness standards. HHS clarifies that the administrative review process will not affect the requirement that the HHS appeals entity must issue written notice of the appeal decision to the appellant within 90 days of the date an appeal request is received.

HHS is finalizing the proposal as proposed, with technical corrections to improve understanding of the review process, and with a modified effective date for the new process to be available for eligibility appeal decisions issued on or after January 1, 2024, instead of the proposed date of 60 days after the final rule is displayed in the Federal Register.

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

In 2019, HHS developed a voluntary initiative for state Exchanges to engage with HHS to prepare for future measurement of improper APTC payments. Ten of 18 state Exchanges have participated in some form. In the 2023 Payment Notice proposed rule (87 FR 654 through 655),

HHS said it was in the planning phase of establishing an improper payment measurement program regarding APTC in state Exchanges—the State Exchange Improper Payment Measurement (SEIPM) program. Implementation of SEIPM was intended to begin in 2023 but was delayed in response to several comments from state Exchanges indicating concerns with the implementation timeline, proposed data collection processes, and other burdens.

In the 2024 Payment Notice proposed rule (87 FR 78206, 78270), HHS proposed the IPPTA to provide state Exchanges with more time to prepare for the planned measurement of improper payments of APTC. IPPTA would replace the current, voluntary state engagement initiative. Activities already completed by state Exchanges would satisfy elements of the proposed IPPTA. Participation from all state Exchanges would be required in order to test processes and procedures that would prepare the state Exchanges for the planned measurement of improper payments of APTC.

IPPTA requirements would be codified in a new subpart P under 45 CFR part 155 (containing §§155.1500 through 155.1515).

Selected Comment/Response: Some commenters expressed that IPPTA would duplicate existing federal reporting requirements, and a few suggested HHS build on existing audit requirements rather than build the new IPPTA requirement. HHS responds that:

- IPPTA is not an audit program but is to test processes and procedures that support HHS' review of determinations of APTC made by state Exchanges to measure improper payments,
- The independent external programmatic audits ensure oversight of more than only APTC payments, and
- Existing federal reporting requirements do not provide HHS with the information needed (nor information at the level of specificity needed) to review APTC determinations and improper payments (such as information that verifies citizenship, social security number, and residency).

Some commenters stated that IPPTA would create financial, administrative, and staffing burdens for the State Exchanges.

HHS is finalizing the proposal, with modifications to address concerns raised in comments regarding the additional burden on state Exchanges by extending the pre-testing and assessment period from 1 year to 2 years to give state Exchanges more time to complete the IPPTA requirements and spread costs over that extended period. The modifications make the codified requirements applicable beginning in 2024 with a change to the definition in §155.1505 that extends the pre-testing and assessment period from one calendar year to 2 calendar years, and similarly clarify that each State Exchange will be selected to participate in the IPPTA for a pre-testing and assessment period of 2 calendar years, which will begin in either 2024 or 2025.

a. Purpose and Scope

The new §155.1500 would convey the purpose and scope of the IPPTA as an initiative between HHS and state Exchanges. The proposed requirements are intended to prepare state Exchanges for the planned measurement of improper APTC payments, to test processes and procedures that support HHS' review of determinations of APTC made by state Exchanges, and provide a mechanism for HHS and state Exchanges to share information that would aid in developing an efficient measurement process.

HHS is finalizing the purpose and scope of IPPTA provision as proposed.

b. Definitions

Several terms were proposed to be defined as follows:

- *Business rules*: The state Exchange's internal directives defining, guiding, or constraining the state Exchange's actions when making eligibility determinations and related APTC calculations.
- *Entity relationship diagram*: A graphical representation illustrating the organization and relationship of the data elements that are pertinent to applications for QHP and associated APTC payments.
- *Pre-testing and assessment*: The process that uses the procedures specified in §155.1515 to prepare state Exchanges for the planned measurement of improper payments of APTC.
- *Pre-testing and assessment checklist*: The document that contains criteria that HHS will use to review a state Exchange's completion of the requirements of the IPPTA.
- *Pre-testing and assessment data request form*: The document that specifies the structure for the data elements that HHS would require each State Exchange to submit.
- *Pre-testing and assessment period*: The timespan during which HHS will engage in the pre-testing and assessment procedures with a state Exchange, which will cover one calendar year.
- *Pre-testing and assessment plan*: The template developed by HHS in collaboration with each state Exchange enumerating the procedures, sequence, and schedule to accomplish the pre-testing and assessment.
- *Pre-testing and assessment report*: The summary report provided by HHS to each state Exchange at the end of the pretesting and assessment period that will include the state Exchange's status regarding completion of each of the pre-testing and assessment procedures specified in proposed §155.1515, as well as observations and recommendations from processing and testing the data submitted by the state Exchange to HHS. The pre-testing and assessment report is intended to be used internally by HHS and each state Exchange as a reference document for performance improvement and would not be released to the public by HHS unless otherwise required by law.

HHS is finalizing the definitions as proposed, with the modification described above changing the proposed definition of "Pre-testing and assessment period" to extend the pre-testing and

assessment period from a one calendar year to 2 calendar years, to address concern raised in comments regarding burden and resource strain on state Exchanges.

c. Data Submission

HHS proposed that each state Exchange submit to HHS a sample of no fewer than 10 tax identification numbers of households determined eligible to receive APTC. By the deadline in the pre-testing and assessment plan, states would be required to provide the following documentation for their data:

- The state Exchange's data dictionary, including attribute name, data type, allowable values, and description;
- An entity relationship diagram (defined above), including the data tables and the residing data elements that identify the relationships between the data tables; and
- Business rules and related calculations.

The state Exchange must use the pre-testing and assessment data request form, or other method specified by HHS, to submit the application data associated with no fewer than 10 tax household identification numbers and the associated policy identification numbers that address scenarios specified by HHS to allow HHS to test all of the pre-testing and assessment processes and procedures. The scenarios would include a variety of characteristics—household composition, data matching inconsistencies (for example, SSN, citizenship, annual income), SEP application types (for example, relocation, marriage), periodic data matching (for example, Medicaid/CHIP, Medicare, death), application status (for example, policy terminated), and application types (for example, initial application). While no single tax household could address all of these characteristics, the entirety of the households provided should address all of the characteristics in all of the scenarios specified. If not, HHS would coordinate with the state Exchange to select additional tax households.

Selected Comment/Response: A few commenters suggested that HHS not require state Exchanges to produce information about their business rules, software, or systems, or to require new data documentation. Concern was also raised about proprietary information. HHS responded that it is requiring state Exchanges to provide existing or available data documentation (not new data documentation) and that the information is necessary for it to test its processes for review of APTC determinations made by state Exchanges. HHS also responds that state Exchanges will be able to submit their data documentation in the format they currently use. HHS specifies that it will coordinate with State Exchanges to resolve any issues that may arise related to the potential proprietary nature of the data documentation.

HHS is finalizing the data submission provisions as proposed.

d. Pre-testing and Assessment Procedures

HHS proposed the state Exchange must participate in the IPPTA for a period of one calendar year that would occur in either 2024 or 2025. In response to comments regarding additional burden and resource cost, as described above, HHS is finalizing this proposal with the

modification that participation in the pre-testing and assessment period would be extended from one calendar year to 2 calendar years (beginning in 2024 or 2025), without increasing or changing any of the IPPTA requirements.

HHS also proposed the following:

- The state Exchange and HHS would work together to execute the IPPTA procedures in accordance with timelines in the pre-testing and assessment plan.
- As part of the orientation process:
    - HHS would provide state Exchanges with an overview of the pre-testing and assessment procedures.
    - HHS would identify the documentation that a state Exchange must provide to HHS for pre-testing and assessment (for example, data use agreements).
    - HHS, in collaboration with each state Exchange, would rely on a template to develop a pre-testing and assessment plan that enumerates the procedures, sequence, and schedule to accomplish pre-testing and assessment. The pre-testing and assessment plan would take into consideration relevant activities that were completed during a prior, voluntary state engagement, and would include the pre-testing and assessment checklist.
    - HHS would issue a pre-testing and assessment plan specific to that state Exchange at the conclusion of the pre-testing and assessment planning process, which would be for HHS and state Exchange internal use only and would not be made available to the public by HHS unless otherwise required by law.
- HHS would be required to provide state Exchanges with certain notices.
- State Exchanges must provide HHS with information regarding any operational, policy, business rules, information technology, or other changes that may impact the ability of the state Exchange to satisfy the requirements of the IPPTA during the pre-testing and assessment period.
- State exchanges must also submit required data and documentation, with HHS' responsibility to coordinate with each state Exchange, based on which HHS would execute the pre-testing and assessment procedures and checklist.

Very few comments were received regarding these proposals. HHS is finalizing these policies as proposed.

C. Part 156—Health Insurance Issuer Standards, Standards Related to Exchanges

1. FFE and SBE-FP User Fee Rates for the 2024 Benefit Year (§156.50)

HHS proposed user fee rates for the 2024 plan year for all participating FFE issuers of 2.5 percent of premiums, reflecting the costs of certifying plans as QHPs and selling coverage through the 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.

HHS noted that the extension of premium tax credit (PTC) subsidies through the 2025 benefit year in the Inflation Reduction Act (IRA) significantly influenced the development of the 2024 enrollment and premium projections. Those subsidies are expected to result in continued higher enrollment levels since the 2021 benefit year, when the enhanced subsidies originally enacted in the American Rescue Plan Act of 2021 (ARP) took effect.

The proposed FFE user fee rates for 2024 are slightly lower than the 2.75 percent rate established for the 2023 benefit year, which assumed the expiration of the PTC subsidies. After accounting for the impact of the lower user fee rate (that is, additional enrollment), HHS estimates that sufficient funding would be available to fully fund user-fee eligible Exchange activities.

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 proposed user fees of 2.0 percent of premiums for 2024. This amount reflects the proportion of FFE costs associated with FFE information technology infrastructure, the consumer call center, and eligibility and enrollment services. This is slightly lower than the 2023 rate of 2.25 percent.

Based on revised projections from newly available data, HHS finalizes the Exchange user fee rates for the 2024 benefit year of 2.2 percent of monthly premiums for issuers in FFEs and 1.8 percent for issuers in SBE-FPs. HHS points to 2 major events that changed its estimated enrollment for benefit year 2024: record 2023 Exchange Open Enrollment and congressional action in the Consolidated Appropriations Act, 2023, signed into law on December 29, 2022, which included provisions that provided certainty that Medicaid redeterminations would take place beginning in 2023.

In response to comments, HHS said that although it is reducing the user fee rates, it is not reducing the budget, which accounts for the additional cost of Medicaid redeterminations, including providing consumer outreach and education related to unwinding. Because of anticipated increased enrollment due to Medicaid redeterminations, HHS is able to reduce the user fee rate without reducing the budget.

2. Publication of 2024 Payment Parameters in Guidance (§156.130)

As finalized in the 2022 Payment Notice, beginning with the 2023 benefit year, HHS will publish the following payment parameters in guidance: the premium adjustment percentage, the required contribution percentage, maximum annual limitations on cost sharing, and reduced maximum annual limitation on cost sharing. These parameters are not included in this rulemaking, as HHS is not proposing changes to the methodology for these parameters for 2024. HHS must publish these parameters no later than January 2023.

On December 12, 2022, CMS published "Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2024 Benefit Year," available at https://www.cms.gov/files/document/2024-papi-parameters-guidance-2022-12-12.pdf.

3. Standardized Plan Options (§156.201)

In the 2017 Payment Notice, HHS first introduced standardized options, which issuers were not required to offer. To facilitate plan shopping and to educate consumers about the distinctive cost sharing features of standardized plan options, these plans were differentially displayed on HealthCare.gov. The 2019 Payment Notice discontinued standardized plan options, which was subsequently challenged in court. 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 finalized the reinstatement of standardized benefit options for issuers of QHPs in FFEs and SBE-FPs beginning in PY 2023. Since SBE-FPs use the same platform as the FFEs, these standardized plan option requirements apply equally and are generally the same on FFEs and SBE-FPs (with a couple exceptions described below). Issuers in FFEs and SBE-FPs are required to offer a standardized option at each metal level, for each network type, and throughout every service area for which they offer a non-standardized option. This requirement applies to the individual market, not the small group market. In the individual market, issuers may continue to offer non-standardized options, and the federal standardized option requirements do not apply to plans offered through state Exchanges. Issuers subject to state laws in place on or before January 1, 2020, that mandate standardized plans (that is, Oregon) would be exempt from the requirements, to reduce duplicative efforts.

After publishing the 2023 Payment Notice, HHS conducted extensive engagement with a range of participants, including issuers, agents, brokers, web-brokers, states, state Exchanges, researchers, disease advocacy groups, and consumer support groups. In these sessions, HHS discussed a range of topics related to standardized plan options, including plan designs, cost sharing, pre-deductible coverage of particular benefits, formulary tiering, choice architecture, plan display on HealthCare.gov, the risk of plan choice overload, and health equity.

For PY 2024 and subsequent PYs, only minor updates were proposed compared to the standardized options in the 2023 Payment Notice. HHS proposed to drop a standardized plan option for the non-expanded bronze metal level. (Thus, standardized options would be required at every metal level *except* the non-expanded bronze level.) HHS' stated rationale was that (1) it is not feasible to design a non-expanded bronze plan that includes any pre-deductible coverage while maintaining an AV within the permissible AV de minimis range, and (2) few issuers chose to offer non-expanded bronze standardized plan options in PY 2023. If an issuer offers a non-standardized plan option at the bronze metal level, whether expanded or non-expanded, it would also need to offer an expanded bronze standardized plan option.

As in the 2023 Payment Notice, the standardized plan options are designed to resemble the most popular QHP offerings that millions are already enrolled in. HHS selected the most popular cost sharing type for each benefit category, using enrollee-weighted median values for each of these benefit categories based on refreshed PY 2022 cost sharing and enrollment data, modifying these plans to be able to accommodate state cost sharing laws, and decreasing the AVs for these plan designs to be at the floor of each AV de minimis range (primarily by increasing deductibles).

HHS will continue to differentially display standardized plan options on HealthCare.gov (including in Oregon, which operates an SBE-FP). HHS will also continue enforcement of standardized option display requirements for approved web-brokers and QHP issuers using direct enrollment. These entities only need to display those standardized options that they cover.

HHS proposed to continue using the four tiers of prescription drug cost sharing in the standardized plan options—generic drugs, preferred brand drugs, non-preferred brand drugs, and specialty drugs. However, there are concerns that issuers may not be including specific drugs at appropriate cost sharing tiers for the standardized plan options. For example, some issuers may be placing brand name drugs in the generic drug cost sharing tier, while others include generic drugs in various brand drug cost sharing tiers. In a new §156.201(c), HHS proposed (but did not finalize) requiring issuers of standardized plan options to do the following:

- Place all covered generic drugs in the standardized plan options' generic drug cost sharing tier (or the specialty drug tier if there is an appropriate and non-discriminatory basis[18] for doing so), and
- Place brand name drugs in either the standardized plan options' preferred brand or non-preferred brand tiers (or the specialty drug tier if there is an appropriate and non-discriminatory basis for doing so).

Selected Comment/Response: Many commenters expressed support for continuing to require FFE and SBE-FP issuers to offer standardized plan options and lauded several distinctive features, such as enhanced pre-deductible coverage for a wide range of benefit categories, as shown with asterisks in Tables 9 and 10 below. These commenters also expressed support for including copayments instead of coinsurance rates as the form of cost sharing for as many benefit categories as possible, to enhance the predictability of costs for consumers and reduce the risk of unexpected financial harm.

Several commenters opposed continuing to require standardized plan options, since QHPs are sufficiently standardized due to requirements pertaining to EHB, annual limitations on cost sharing, metal tiers, and the recently narrowed AV de minimis ranges for each metal tier. They contend that it inhibits issuer innovation in plan design and reduces the degree of consumer choice, and that in PY 2023 it contributed to the sharp increase in plans offered during this past Open Enrollment, which further increased the risk of plan choice overload.

HHS acknowledges that requiring issuers to offer these standardized plan options contributed to the increase in the total number of plans offered through the Exchanges. However, HHS encouraged (87 FR 27318) and continues to encourage issuers to modify their existing non-standardized plan offerings, in accordance with uniform modification requirements at §147.106(e), to conform with the cost-sharing parameters of the standardized plan options finalized in the 2023 Payment Notice in order to significantly reduce the number of total new plan offerings on the Exchanges. HHS believes limiting the number of non-standardized plan

[18] For this proposal, "non-discriminatory basis" means there must be a clinical basis for placing a prescription drug in the specialty drug tier in accordance with §156.125.

options that issuers can offer will offset this increase in the number of total plan offerings (see the next section, III.C.4.).

HHS disagrees that requiring standardized plan options inhibits innovation in plan design and reduces consumer choice, given that issuers will still be permitted to offer two non-standardized plan options per product network type, metal level, inclusion of dental or vision benefit coverage, and service area. HHS also cites research that a choice among too many plans results in declines in enrollment rates and poor enrollment decisions.

The finalized standardized options for 2024 appear in Tables 9 and 10 of the 2024 Payment Notice, duplicated below. The first set of standardized plan options (Table 9) is applicable to issuers in all FFE and SBE-FP states except for Delaware, Louisiana and Oregon. The second set (Table 10) is applicable to Delaware and Louisiana, to accommodate those states' specialty tier prescription drug cost sharing laws. The only changes from the proposed versions were that, in both tables for standard silver plans, the finalized deductible was reduced by $100 from $6,000 to $5,900, which increases the AV for these plans from 70.00 percent to 70.01 percent. This was done to correct a rounding discrepancy that caused the proposed deductible to produce an AV (69.998) outside of the de minimis range validation within the Plans and Benefits Template, meaning that issuers would not have been able to successfully submit these plans during QHP certification.

TABLE 9: 2024 Standardized Options Set One (For All FFE and SBE-FP States, Excluding Delaware, Louisiana and Oregon)

	Expanded Bronze	**Standard Silver**	**Silver 73 CSR**	**Silver 87 CSR**	**Silver 94 CSR**	**Gold**	**Platinum**
Actuarial Value	64.39%	70.01%	73.00%	87.03%	94.06%	78.02%	88.10%
Deductible	$7,500	$5,900	$5,700	$700	$0	$1,500	$0
Annual Limitation on Cost Sharing	$9,400	$9,100	$7,200	$3,000	$1,800	$8,700	$3,200
Emergency Room Services	50%	40%	40%	30%	25%*	25%	$100*
Inpatient Hospital Services (Including Mental Health & Substance Use Disorder**)**	50%	40%	40%	30%	25%*	25%	$350*
Primary Care Visit	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Urgent Care	$75*	$60*	$60*	$30*	$5*	$45*	$15*
Specialist Visit	$100*	$80*	$80*	$40*	$10*	$60*	$20*
Mental Health & Substance Use Disorder **Outpatient *Office Visit***	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Imaging (CT/PET Scans, MRIs)	50%	40%	40%	30%	25%*	25%	$100*
Speech Therapy	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Occupational, Physical Therapy	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Laboratory Services	50%	40%	40%	30%	25%*	25%	$30*
X-rays/Diagnostic Imaging	50%	40%	40%	30%	25%*	25%	$30*
Skilled Nursing Facility	50%	40%	40%	30%	25%*	25%	$150*

	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Outpatient Facility Fee (Ambulatory Surgery Center)	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Surgery Physician & Services	50%	40%	40%	30%	25%*	25%	$150*
Generic Drugs	$25*	$20*	$20*	$10*	$0*	$15*	$5*
Preferred Brand Drugs	$50	$40*	$40*	$20*	$15*	$30*	$10*
Non-Preferred Brand Drugs	$100	$80	$80	$60	$50*	$60*	$50*
Specialty Drugs	$500	$350	$350	$250	$150*	$250*	$150*

*Benefit category not subject to the deductible

TABLE 10: 2024 Standardized Options Set Two (For Delaware and Louisiana)

	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Actuarial Value	64.39%	70.01%	73.00%	87.04%	94.08%	78.04%	88.11%
Deductible	$7,500	$5,900	$5,700	$700	$0	$1,500	$0
Annual Limitation on Cost Sharing	$9,400	$9,100	$7,200	$3,000	$1,900	$8,700	$3,200
Emergency Room Services	50%	40%	40%	30%	25%*	25%	$100*
Inpatient Hospital Services (Including Mental Health & Substance Use Disorder**)**	50%	40%	40%	30%	25%*	25%	$350*
Primary Care Visit	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Urgent Care	$75*	$60*	$60*	$30*	$5*	$45*	$15*
Specialist Visit	$100*	$80*	$80*	$40*	$10*	$60*	$20*
Mental Health & Substance Use Disorder **Outpatient *Office Visit***	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Imaging (CT/PET Scans, MRIs)	50%	40%	40%	30%	25%*	25%	$100*
Speech Therapy	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Occupational, Physical Therapy	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Laboratory Services	50%	40%	40%	30%	25%*	25%	$30*
X-rays/Diagnostic Imaging	50%	40%	40%	30%	25%*	25%	$30*
Skilled Nursing Facility	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Facility Fee (Ambulatory Surgery Center)	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Surgery Physician & Services	50%	40%	40%	30%	25%*	25%	$150*
Generic Drugs	$25*	$20*	$20*	$10*	$0*	$15*	$5*
Preferred Brand Drugs	$50	$40*	$40*	$20*	$5*	$30*	$10*
Non-Preferred Brand Drugs	$100	$80	$80	$60	$10*	$60*	$50*
Specialty Drugs	$150	$125	$125	$100	$20*	$100*	$75*

*Benefit category not subject to the deductible

Many commenters express concerns about several aspects of these plans designs, particularly their high deductibles. However, HHS states that to ensure these plans have design attributes that reflect the most popular plan offerings, to maintain reasonable cost sharing amounts, to continue exempting benefit categories that contain some of the most frequently utilized health care services from the deductible, and to ensure these plans have competitive premiums, while maintaining an AV within the permissible AV de minimis range, it is unable to materially lower the deductibles or exempt additional benefit categories from the deductibles.

Regarding prescription drugs, several commenters supported continuing only four tiers in the formularies of the standardized options, while others supported including more than four tiers as is common in the commercial market. While acknowledging that five or six tiers is common practice in the commercial market, HHS believes the advantages of maintaining four tiers outweigh the advantages of permitting additional tiers at this time.

Several commenters supported the proposal to require issuers to place all covered generic drugs in the generic drug cost sharing tier and all covered brand drugs in either the preferred brand or non-preferred brand drug cost sharing tiers—or the specialty tier, with an appropriate and non-discriminatory basis—in the standardized plan options. They explained that it would enhance predictability for consumers, allowing them to anticipate the expected costs for prescription drugs and further decrease the risk of unexpected financial harm. It would also act as an important step in ensuring that patients are not forced to overpay for low-cost generic prescription drugs. Commenters provided numbers demonstrating a decline in the percentage of generic drugs covered on generic tiers—for example, 65 percent of generic drugs in 2016 were covered on generic tiers, but by 2022 the number had fallen to 43 percent.

On the other hand, several opposed the proposal, stating that there are numerous examples of high-cost generic prescription drugs that have lower-cost, clinically similar brand-name prescription alternatives. In addition, there are brand-name prescription drugs that may offer clinical and financial value that supports tiering lower than the preferred brand tier. Commenters further stated that it is commonplace in all market segments to shift generics to lower tiers only at the point where they become the most cost-effective option. Commenters also explained that the purpose of tiered formularies is to encourage the use of high value drugs, not to encourage the use of generic drugs, per se, especially since generic prescription drugs are no longer consistently inexpensive or high value. Several commenters expressed concern that this requirement would limit flexibility for pharmacy benefit managers (PBMs) to effectively manage formularies and enrollee drug spending, as well as PBM and issuer position in negotiations with manufacturers.

HHS was persuaded by comments regarding the changing nature of the costs of brand name drugs and generics, flexibility in designing formularies, and decreased medication adherence. HHS is not finalizing the proposed formulary tiering placement regulations that would have required issuers to place all covered generic drugs in the generic cost-sharing tier and all brand drugs in either the preferred or non-preferred brand cost-sharing tier (or the specialty cost-sharing tier, with an appropriate and non-discriminatory basis). According to HHS, this will continue to facilitate competition among manufacturers for favorable formulary placement.

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

For PY 2024 and beyond, as a condition of QHP certification, HHS proposed, in a new 45 CFR §156.202, to limit the number of non-standardized plan options that QHP issuers can offer through FFEs and SBE-FPs to two per product network type and metal level (excluding catastrophic plans) in any service area. HHS described multiple ACA statutory provisions that provide it with this authority.

HHS provided the following examples: An issuer would be limited to offering two gold HMO and two gold PPO non-standardized plan options in any service area in PY 2024 or any subsequent PY. If an issuer wanted to offer two statewide bronze HMO non-standardized plan options as well as two additional bronze HMO non-standardized plan options in one particular service area that covers less than the entire state, in the service areas that all four plans would cover, the issuer could choose to offer through the Exchange either the two bronze HMO non-standardized plan options offered statewide or the two bronze HMO non-standardized plan options offered in that particular service area (or any combination thereof), so long as the total number of non-standardized plan options does not exceed the limit of two per issuer, product network type, and metal level in the service area.

This proposal would not apply to state Exchanges, with multiple reasons. However, since SBE-FPs use the same platform as FFEs, HHS proposed to apply this requirement equally on FFEs and SBE-FPs. This proposed requirement would not apply to plans offered through the SHOPs or to SADPs.

CMS would utilize the existing discontinuation notices and process as well as the re-enrollment hierarchy to ensure a seamless transition and continuity of coverage. In addition, CMS would ensure that necessary consumer assistance would be available as part of the expanded funding for Navigator programs.

Selected Comment/Response: Many commenters agreed that the number of plan choices available through the Exchanges has increased to be beyond productive for consumers and that additional action should be taken to reduce the risk of plan choice overload. Several pointed to the fact that numerous SBEs have successfully limited the number of non-standardized plan options as evidence that adopting such a policy would benefit consumers. However, many support a more gradual approach, to phase in a reduction in the number of non-standardized plan options instead of directly adopting a limit of two for PY 2024.

Several commenters opposed the proposal, explaining that limiting the number of non-standardized plans would impose a significant burden on issuers as they develop product portfolios for PY 2024, because issuers have already made strategic decisions about plan offerings and participation; finalizing these changes for PY 2024 would result in significant operational challenges. It would also be extremely disruptive to consumers, as 2.72 million enrollees on the FFE and SBE-FPs (26.6 percent of total enrollees) would have to change plans due to plan discontinuations in PY 2024, based on HHS' own estimates (87 FR 78280), and would be particularly poor timing as issuers prepare for and process a deluge of Medicaid

redeterminations with the unwinding of the Public Health Emergency. In addition, commenters expressed concern regarding the simultaneous implementation of other substantive changes (e.g., to the re-enrollment hierarchy and to standardized plan option formulary tiering) that would be extremely disruptive if all finalized.

HHS disagrees that issuers will have insufficient time to operationalize these changes, since it regularly issues new requirements for the following plan year in that plan year's Payment Notice. Although HHS acknowledges that the termination of numerous non-standardized plan options would entail burden for issuers, the advantages of enacting these changes outweigh the disadvantages. With plan proliferation continuing unabated for several years, consumers have had to select from among record numbers of available plan options, which makes it increasingly difficult for consumers, especially those with lower rates of healthcare literacy. HHS lists additional reasons and analyses in support of its proposal.

While acknowledging that many consumers would have their current plan discontinued, HHS says a significant number will be auto-reenrolled into another non-standardized or standardized plan option offered by the same issuer. Consumers auto-reenrolled in a standardized plan option would benefit from several important distinctive features, such as enhanced pre-deductible coverage and copayments instead of coinsurance rates for a broad range of benefit categories.

HHS is finalizing adding the new 45 CFR §156.202, with some modifications from the proposal. For PY 2024, the number of non-standardized plan options that issuers of QHPs can offer through Exchanges on the Federal platform (including SBE-FPs) is four (rather than two) per product network type, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage, in any service area. For PY 2025 and subsequent plan years, the number is limited to 2.

The addition of "inclusion of dental and/or vision benefit coverage" is also a modification. This means that, for example in PY 2024, an issuer could be permitted to offer four non-standardized gold HMOs with no additional dental or vision benefit coverage and four non-standardized gold HMOs with additional dental or vision benefit coverage. To provide further clarification, HHS is adding §156.202(c), which defines the "inclusion of dental and/or vision benefit coverage" as coverage of any or all of the following:

- Adult dental coverage in the "Benefits" column in the Plans and Benefits Template:
    - Routine Dental Services (Adult),
    - Basic Dental Care—Adult, or
    - Major Dental Care—Adult.
- Pediatric dental benefit coverage in the "Benefits" column in the Plans and Benefits Template:
    - Dental Check-Up for Children,
    - Basic Dental Care—Child, or
    - Major Dental Care—Child.
- Adult vision benefit coverage in the "Benefits" column in the Plans and Benefits Template must include Routine Eye Exam (Adult).

Based on PY 2023 data, HHS estimates the following results from the finalized policy in PY 2024:

- Approximately 0.81 million of the 12.2 million enrollees on the FFEs and SBE-FPs (6.6 percent) will be affected by these discontinuations.
- Approximately 17,532 of the total 101,453 non-standardized plan option plan-county combinations (17.3 percent) will be discontinued.
- The weighted average number of non-standardized plan options available to each consumer will be reduced from approximately 89.5 in PY 2023 to 66.3 in PY 2024.
- The weighted average total number of plans (including both standardized and non-standardized plan options) available to each consumer will be reduced from approximately 113.7 in PY 2023 to 90.5 in PY 2024.

HHS says at this time it is unable to provide meaningful estimates of the effects for PY 2025. One reason is that such estimates could not take into account the exceptions process HHS intends to propose that would allow issuers to offer non-standardized plan options above the limit of two for PY 2025 and subsequent plan years. HHS says it intends to propose the exceptions process, as well as the specific criteria and thresholds to be included, in the 2025 Payment Notice proposed rule. It does anticipate that reducing the limit on non-standardized plan options from four in PY 2024 to two in PY 2025 and subsequent plan years will result in additional plan-county discontinuations and affected enrollees in PY 2025.

5. QHP Rate and Benefit Information (§156.210)

a. Age on Effective Date for SADPs

Since PY 2014, QHP certification in FFEs and SBE-FPs allows SADP issuers to use one of 4 options to determine an enrollee's age for rating and eligibility purposes. This differs from the policy for medical QHP issuers, which requires using age as of the coverage effective date (that is, the enrollee's age at the time of policy issuance or renewal). Since PY 2014, the vast majority of individual market SADP issuers have used the age on effective date.

HHS believes that allowing Exchange-certified SADPs to rate by other age-calculation methods imposes unnecessary complexity not only on CMS, but also to enrollment partners and consumers in the Exchanges on the federal platform. Thus, HHS proposed to require SADP issuers to use the enrollee's age as of the effective date as the sole method to calculate an enrollee's age for rating and eligibility purposes. This policy would apply beginning PY 2024 for all Exchange-certified SADPs, whether sold on-Exchange or off-Exchange.

Selected Comment/Response: All commenters supported the proposal because it would reduce or eliminate confusion among consumers and improve consumer understanding of SADPs. It also promotes consistency between issuers, as well as between medical QHPs and QHPs that are SADPs.

HHS finalizes this provision at new §156.210(d)(1) as proposed, on the FFEs as well as the SBE-FPs and SBEs.

b. Guaranteed Rates for SADPs

SADPs are excepted benefits and are not subject to the insurance market reform provisions that generally apply to non-grandfathered health plans in the individual and small group markets inside and outside the Exchange. Thus, CMS has historically allowed SADP issuers to offer guaranteed or estimated rates. By indicating the rate is a guaranteed rate, the SADP issuer will charge the approved premium rate that has been calculated using consumers' geographic location, age, and other permissible rating factors. Estimated rates require enrollees to contact the issuer to determine a final rate.

According to HHS, this flexibility was originally needed because the relevant certification template was designed for medical QHPs. The templates now allow SADPs to set the maximum age for dependents to 18 and to rate all such dependents; thus, the FFEs and SBE-FPs can now accommodate dental rating rules.

HHS proposed to require issuers of SADPs to submit only guaranteed rates for Exchange certification, beginning with PY 2024. This policy would apply for all Exchange-certified SADPs, whether sold on-Exchange (FFEs, SBE-FPs and SBEs) or off-Exchange. HHS believes this proposed policy would significantly benefit enrollees by ensuring they receive the correct APTC calculation for the pediatric dental EHB portion of premiums.

Selected Comment/Response: All commenters supported the proposal. One commenter stated that requiring SADPs to submit guaranteed rates helps ensure that consumers and those who assist them will better understand their coverage and the actual premium costs they will incur. It will also eliminate complexity by doing away with estimated rates, which typically requires the enrollee to contact the insurance issuer directly to determine a final rate. Because the portion of APTC attributable to pediatric dental coverage can be applied to SADPs, after-purchase rate information changes could affect APTC calculation, resulting in unnecessary financial burden and uncertainty for enrollees selecting SADPs based on estimated rates.

HHS finalizes this policy as proposed. The guaranteed rates policy does not apply to SADPs that are *not* Exchange-certified, in either an individual market Exchange or SHOP. State Exchanges will be required to certify only SADPs that comply with the requirement. The vast majority of issuers offering on-Exchange and off-Exchange Exchange-certified SADPs already elect to submit guaranteed rates, so most are unlikely to be impacted by this policy.

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

In PY 2022, Exchanges on the federal platform saw a significant increase in the number of plan and plan variation marketing names that included cost sharing information and other benefit details. Following Open Enrollment for PY 2022, CMS received complaints from consumers in multiple states who misunderstood cost sharing information in their QHP's marketing name. CMS and state regulators determined this language was often incorrect or could be misleading.

CMS' review of QHP data for PY 2023 indicates continued use of cost sharing information in these names. Among the examples provided:

- Dollar amounts in the plan name that do not specify:
    - What they refer to (for example, deductible, maximum out-of-pocket, or something else);
    - Whether they apply only to medical, drug, or another type of benefit; or
    - Whether, in cases of deductible or maximum out-of-pocket amounts, they apply to an individual or a family; and
- Reference to health savings accounts (HSAs) in marketing names of plans or plan variations that do not permit enrollees to set up an HSA.

HHS proposed to require QHP plan and plan variation marketing names to include correct information, without omission of material fact, and not include content that is misleading. CMS would review plan and plan variation marketing names during the annual QHP certification process in close collaboration with state regulators in states with Exchanges on the federal platform. Information included in the plan names would need to match information in the Plans & Benefits Template and other materials submitted as part of the QHP certification process.

Selected Comment/Response: Almost all commenters supported the proposal. Some added that, like HHS and states, they also heard concerns and complaints from consumers applying for Exchange coverage about inaccurate or misleading marketing names, or marketing names that included extensive detail that was confusing.

A few opposed the proposal, stating that they generally supported the intent but disagreed that additional regulation was necessary to achieve its purpose. Some shared concerns about examples provided by HHS in the proposed rule and recommended that issuers not be required to include the term "deductible" in marketing names that include a deductible dollar amount; some issuers have long included these dollar amounts in marketing names, and adding verbiage could create confusion.

Commenters raised a variety of concerns about marketing names, including their length, which prompted recommendations such as dropping the company name that is already displayed elsewhere or limiting marketing names to only one cost-sharing feature. Some expressed concern about using terms like "choice" or "star" to refer to narrow networks. Others observed that marketing names for CSR variants of silver plans often keep in the marketing names the dollar amount of the deductible or copay of the non-CSR variant, which can be confusing; a recommendation was provided that HHS require plan and plan variation marketing names to match the plan name in the corresponding Summary of Benefits and Coverage (SBC) at the level of individual CSR variations.

HHS confirms that under this policy, at minimum, it will generally flag for revision marketing names that include the issues listed in the proposed rule (87 FR 78285). However, based on comments that cited the importance of allowing issuers to continue using longstanding marketing names and that encouraged not requiring issuers to include the term "deductible" in marketing names that include a deductible dollar amount, HHS says it will not require issuers to include

cost-sharing terms such as deductible in marketing names that list numbers or dollar amounts. Nevertheless, it strongly encourages issuers to carefully consider the information that numbers and dollar amounts are meant to convey.

HHS has also observed cases of incorrect information in marketing names for CSR variations because the marketing name retains cost-sharing information from the non-CSR variation. Moving forward, as part of its review of marketing names, HHS will make sure that this does not happen. It strongly encourages issuers to proactively update cost-sharing information in marketing names to accurately reflect information for CSR plan variations.

As proposed, §156.225(c) is finalized to require that QHP plan and plan variation marketing names include correct information, without omission of material fact, and not include content that is misleading. CMS will review plan and plan variation marketing names during the annual QHP certification process in close collaboration with state regulators in states with Exchanges on the federal platform. It will also take into account existing state requirements when overseeing marketing names, to prevent contradictory requirements and ensure an efficient review process.

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

When Exchanges were established, HHS established minimum network adequacy criteria that health and dental plans must meet to be certified as QHPs. In the 2016 Payment Notice, this was modified so that network adequacy requirements (and ECP criteria) apply only to QHPs that use a provider network and that a provider network includes only providers that are contracted as in-network.

Since 2016, only a single issuer has sought a certification for a plan that does not use a network. Despite what HHS calls lengthy negotiations with this issuer, the experience convinced the department that commenters who raised concerns about the burden that plans without networks place on enrollees appear to have been correct.

HHS proposed to revise network adequacy and ECP standards so that all individual market QHPs and SADPs and all SHOP QHPs across all Exchanges must use a network of providers that complies with the standards described in §§156.230 and 156.235, and to remove the exception for plans that do not use a provider network.

HHS revisited its prior statement that "nothing in [the ACA] requires a QHP issuer to use a provider network" (86 FR 6154[19]). While it is true that the ACA includes no stand-alone network requirement, HHS now doubts that a plan without a network can comply with the statutory requirement at section 1311(c)(1)(C) that "a plan shall, at a minimum…include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals." HHS also believes that requiring QHPs to use a provider network would be in the interests of qualified individuals

[19] The reference in the proposed rule, 84 FR 6154, is incorrect.

(citing HHS authority in section 1311(e)(1)(B) and §155.1000(c)(2)) and would better protect consumers from potential harms that could arise in cases where QHPs do not use provider networks.

In PY 2022, only 8 of the 672 SADPs certified as QHPs on the FFEs were plans without a provider network, in 2 FFE states (Alaska and Montana). HHS assumes that the few SADP issuers without a provider network in Alaska and Montana only do so because of difficulty in maintaining a sufficient provider network. HHS believes it is reasonable to assume that consumers increasingly gravitate toward SADPs with a network, given the overall decrease in the availability of SADPs without a provider network (as shown in Table 11 of the rule, not reproduced here).[20]

HHS believes it would be appropriate to require all SADPs to use a provider network that complies with the regulatory standards beginning with PY 2024. However, it is also cognizant of challenges to SADP issuers in states like Alaska and Montana, reviewing various statutory and previous regulatory provisions pertaining to SADPs and potential tradeoffs regarding a regulatory requirement to have a network. The department solicited comment on the extent to which it should finalize a limited exception only for SADPs in areas where it is prohibitively difficult for the issuer to establish a network of dental providers.

Selected Comment/Response: A majority of commenters supported the proposal and agreed it is consistent with statutory requirements at section 1311(c)(1)(B) and (C). Some commenters stated that plans without a provider network have historically presented a barrier to consumers' ability to access care and control their health care costs, unnecessarily expose enrollees to medical debt, and are not in the interests of consumers shopping for QHPs.

A minority of commenters, including one health insurance issuer, opposed the proposal, asserting that the proposal to require QHPs to utilize a provider network contravenes section 1311(e)(1)(B)(i) of the ACA, which states that an "Exchange may not exclude a health plan…on the basis that such plan is a fee-for-service plan"; they state that "fee-for-service plans" are understood to be "a type of non-network plan." Commenters also asserted that HHS impermissibly justifies the requirement that QHPs must use a network of providers because only plans with networks can satisfy section 1311(c)(1)(C) regarding the ECP requirement for certification.

HHS disagrees with the opposing commenters, citing section 1311(e)(1)(B)(i) of the ACA—that an Exchange may certify a health plan as a QHP if such plan meets the requirements for certification as promulgated by the Secretary under section 1311(c)(1) and if the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in that state, except that the Exchange may not exclude a health plan, among other reasons, on the basis that such plan is a fee-for-service (FFS)

[20] In the proposed rule (87 FR 78288) and this final rule, the table shows that, for PY 2023, there were 15 QHP-certified SADPs on the FFEs without a provider network, all in Alaska and Montana, which is higher than the 8 for PY 2022; however, there is no discussion of this in the preamble.

plan. In requiring all plans to use a network, HHS cites the authority granted at section 1311(c)(1)(A) to establish requirements for the certification of health plans as QHPs, as well as the requirement for certification at section 1311(e), which states that an Exchange must determine that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the state. In doing so, HHS says it is not excluding plans on the basis of being FFS but because plans without a provider network are inherently unable to comply with the ECP requirements of 1311(c)(1)(C). In addition, HHS believes that section 1311(c)(1)(B)'s requirement that plans must provide a "sufficient choice of providers" in fact provides additional legal support for our regulation.

Some commenters, including two state departments of insurance (Alaska and Montana), favored the limited exception to this requirement for SADPs that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers. Without such an exception, consumer access to any SADP would be in jeopardy. HHS provides additional detail from the comment letters from Alaska and Montana.

HHS is finalizing the proposal to revise the network adequacy and ECP standards §§156.230 and 156.235 to require all individual market QHPs (including individual market SADPs) and all SHOP QHPs (including SHOP SADPs) across all Exchanges to use a provider network that complies with the standards described in those sections. Also as proposed, HHS is also removing the exception at §156.230(f) that these sections do not apply to plans that do not use a provider network. However, a limited exception (not in the proposal) is finalized at §156.230(a)(4) for certain SADP issuers that sell plans in areas where it is "prohibitively difficult" for the issuer to establish a network of dental providers—based on attestations from state departments of insurance in states with at least 80 percent of their counties classified as Counties with Extreme Access Considerations (CEAC)[21] where at least one of the following factors exists in the area of concern:

- A significant shortage of dental providers,
- A significant number of dental providers unwilling to contract with Exchange issuers, or
- Significant geographic limitations impacting consumer access to dental providers.

HHS will operationalize this limited exception beginning with PY 2024 and anticipates that states will apply for this exception and include a justification for requiring an exception, as described in the rule's preamble.

Compliance With Appointment Wait Time Standards. In the proposed rule (87 FR 78289), HHS noted how the 2023 Payment Notice required issuers to demonstrate compliance with appointment wait time standards via attestation, beginning in PY 2024. It said that issuers must work with their network providers to collect the necessary data to assess appointment wait times detailed in the 2023 Letter to Issuers, since CMS will begin conducting reviews of issuer attestations for PY 2024.

[21] The CEAC county type designation is based on a U.S. Census Bureau population density estimate of fewer than 10 people per square mile. Four states have at least 80 percent of their counties classified as CEAC: Alaska, Montana, North Dakota, and Wyoming.

Selected Comment/Response: Numerous commenters responded, with most raising concerns about the finalized policy, requesting delayed implementation to PY 2025. Several highlighted the need for HHS to issue additional guidance, noting the lack of specificity, and to allow industry time to comment. Specific concerns raised include the following: the burden on providers to report data to issuers; the operational challenges in monitoring contracted providers; the difficulty in receiving accurate wait time data from providers; and fluctuations in appointment wait times during the PY.

A few commenters supported implementing the policy on the finalized schedule so that consumers have access to timely necessary care. Others supported the standard but requested that the methodology for assessing compliance include methodologies besides issuer attestation.

In response to the many comments that implementation should be delayed, HHS is amending §156.230(a)(2)(i)(B) to delay applicability of appointment wait standards by one year—until PY 2025.

8. Essential Community Providers (§156.235)

Essential Community Providers (ECPs) serve predominantly low-income and medically underserved individuals and include Federally Qualified Health Centers (FQHCs), 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 proposed to establish two additional stand-alone ECP categories—Mental Health Facilities and Substance Use Disorder (SUD) Treatment Centers. Community Mental Health Centers and SUD Treatment Centers would no longer be categorized as "Other ECP Providers" but would be crosswalked to their new standalone designations. HHS noted that the proposal to require QHPs to offer a contract to at least one available SUD Treatment Center and one available Mental Health Facility in every county in the plan's service area does not unduly penalize issuers facing a lack of certain types of ECPs; if there are no provider types that map to a specified ECP category available within the respective county, the issuer is not penalized.

In addition, Rural Emergency Hospitals (REHs) would be a provider type in the Other ECP Providers category, reflecting the fact that REHs began participating in Medicare beginning January 1, 2023.

These changes would be effective beginning with PY 2024, making eight stand-alone ECP categories: (1) FQHCs, (2) Ryan White Program Providers, (3) Family Planning Providers, (4) Indian Health Care Providers, (5) Inpatient Hospitals, (6) Mental Health Facilities, (7) SUD Treatment Centers, and (8) Other ECP Providers, including Rural Health Clinics, Black Lung Clinics, Hemophilia Treatment Centers, Sexually Transmitted Disease Clinics, and Tuberculosis Clinics. Table 12 in the final rule provides additional detail of the ECP provider types under these 8 major ECP categories.

Under current regulations, a QHP network must have 35 percent of the available ECPs in each plan's service area. HHS proposed to also require, beginning in PY 2024, that a QHP network have 35 percent of the available FQHCs and 35 percent of the available Family Planning Providers that qualify as ECPs in each plan's service area. These two categories were selected, in part, because they represent the two largest ECP categories (combined, roughly 62 percent of all facilities on the ECP list). These thresholds will apply to all issuers regardless of whether they are subject to the General ECP standards in §156.235(a) or the Alternate ECP Standards in §156.235(b).

Using PY 2023 data as if this proposal had been in effect, HHS found it is likely that a majority of issuers would be able to meet these proposed thresholds without needing to contract with additional providers:

- Out of 137 QHP issuers on the FFEs,
    - 76 percent would have been able to meet or exceed the 35 percent FQHC threshold,
    - 61 percent would have been able to meet or exceed the 35 percent Family Planning Provider threshold.
- For SADP issuers, 84 percent would have been able to meet the 35 percent threshold requirement for FQHCs offering dental services.

HHS anticipated that QHP issuers falling short of the 35 percent threshold for PY 2024 and beyond could satisfy the standard by using ECP write-ins and justifications. If an issuer's application does not satisfy the ECP standard, the issuer would be required to submit as part of its application a satisfactory justification.[22]

Selected Comment/Response: Most commenters supported creating the standalone ECP categories for SUD Treatment Centers and Mental Health Facilities, noting that the new categories will expand access to SUD treatment and mental health services.

Two commenters opposed, with one urging delay until PY 2025. Others cited difficulties issuers may have meeting the requirements due to inadequate provider supply.

In response, HHS notes that the standard does not penalize issuers that lack certain types of ECPs within a service area. Section 1311(c)(1)(C) requires that a QHP's network include those ECPs, *where available,* that serve predominantly low income and medically-underserved populations. Thus, the proposal to require QHPs to offer a contract to at least one available SUD Treatment Center and one available Mental Health Facility in every county in the plan's service area does not unduly penalize issuers facing a lack of certain types of ECPs within a service area. HHS also prepares the applicable PY HHS ECP list to help potential QHPs identify eligible ECP facilities.[23] In addition, as in prior years, mechanisms will be in place to assist issuers who encounter difficulty meeting any element of the ECP standard during certification, including the ECP Justification Form and the ECP Write-in Worksheet.

[22] For example, see §156.235(a)(3).
[23] For example, see Final PY 2024 ECP List.

Several commenters supported the proposal to add REHs to the Other ECP Providers category. Two opposed, recommending delay until PY 2025 to allow more time to issuers to prepare and because states, hospitals, providers, and other interested parties are in the process of implementing new REH standards. In response, HHS notes that issuers will often have the option to satisfy the ECP requirement by contracting with another provider type; if no REHs are available in a service area, the issuer will not be penalized.

Many commenters supported applying the 35 percent threshold to FQHCs and Family Planning Providers. Some opposed, stating that they do not account for regional variations in provider availability, enrollee needs, and geographic features, and may lead to inflexibility in contracting with high-quality providers and increased administrative costs. HHS responds that there is already a robust number of these two types of facilities on the ECP list, so it does not anticipate it will be unduly burdensome. Moreover, if issuers encounter difficulty meeting the 35 percent thresholds due to insufficient time, provider availability, or flexibility to carry out contracting activities, the ECP Justification Form, the ECP Write-in Worksheet, and the ECP/NA Post-certification Compliance Monitoring (PCM) program are available as tools to assist issuers.

HHS finalizes its proposal.

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

HHS has long required issuers to send notices of non-payment of premiums, so that enrollees who become delinquent are aware and have a chance to avoid termination of coverage. Enrollees receiving APTC who fail to pay their premiums are entitled to a 3-month grace period, during which they may return to good standing by paying all outstanding premiums before the end of the 3 months. (Enrollees not receiving APTC may also be entitled to a grace period under state law.)

No timeliness requirements are currently set for issuers. However, in conducting oversight of issuers, HHS became aware that some issuers have delayed notifying enrollees of delinquency, thus limiting the amount of time they have available to address the delinquency and avoid termination. An enrollee may not become aware that they have become delinquent until termination has already occurred. HHS provides this example: If an enrollee (who was not receiving APTC) failed to pay August's premium but was not informed by the issuer they had become delinquent until September, they would have already lost coverage and would not have an opportunity to restore it.

HHS proposed in §156.270(f) to explicitly require issuers to send the notice of payment delinquency promptly and without undue delay.

HHS also stated it would be important to specify the number of days the issuer has to send the notice from the time an enrollee becomes delinquent on payment. However, HHS also recognizes that issuers have a variety of practices for sending delinquency notices and thus requested comment on what a reasonable timeframe would be for sending delinquency notices.

Selected Comment/Response: Most commenters supported adding a timeliness standard for sending notices.

One commenter opposed, stating such rules are already included and enforced at the state level. HHS reiterated that it observed instances of significantly delayed delinquency notices, showing the importance of establishing a minimum standard (although states may establish a more protective timeliness standard).

Twenty commenters recommended a variety of timeframes. HHS agrees with the two commenters who suggested that 10 business days would be reasonable, but specifying 10 business days from when the issuer "should have" discovered the delinquency. Thus, there is an expectation that issuers will promptly send notices of delinquency once they discover the delinquency. HHS believes this appropriately balances the need to ensure enrollees receive timely notice of delinquency, while providing issuers with adequate time to send the notices.

HHS finalizes policies in §156.270(f) to require QHP issuers in Exchanges on the federal platform to send notices of payment delinquency promptly and without undue delay. In addition, these notices must be sent within 10 business days of the date the issuer should have discovered the delinquency. This timeliness requirement only applies to QHP issuers operating in Exchanges on the federal platform, not in SBEs.

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

HHS provides issuers with monthly payment and collection reports for Exchange coverage, including APTC payments by the federal government, amounts owed by the issuer for FFE and SBE-FP user fees, and any adjustments from previous payments under those programs. Issuers are generally required to review these reports against the payments they expect. The issuer must notify HHS or the state Exchange (as applicable) within certain timeframes if an inaccuracy is identified. This protects enrollees from unanticipated tax liability for incorrect APTC payments and supports the efficient operation of Exchanges.

Under current regulations, the deadline for reporting underpayments (that is, money is owed to the issuer) is the later of:

(1) The end of the 3-year period beginning at the end of the plan year to which the inaccuracy relates, or
(2) The date by which HHS notifies issuers that the HHS audit process for the plan year has been completed—known as the alternate deadline, at §156.1210(c)(2).

Regarding overpayments (that is, money is owed from the issuer), the department reiterates the ACA's statutory provision (section 1313(a)(6)) that "payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729, et seq.) if those payments include any Federal funds." Thus, any issuer that has an obligation to pay back APTC or pay additional user fees could be liable under the False Claims Act for knowingly and

improperly avoiding the obligation to pay. There is effectively no time limit for issuers' obligation to notify HHS and a state Exchange and to repay any overpayment.

HHS proposed to remove the alternate deadline at §156.1210(c)(2) for issuers to report an underpayment. This proposed change would affect adjustments to APTC and user fee payments and collections beginning for 2015 plan year coverage. This policy would ensure HHS and Exchange processes for handling payment and enrollment disputes related to discovered underpayments are completed before the existing IRS limitation on filing corrected tax returns. This would provide greater consistency and predictability for enrollees and reduce potential confusion caused by the receipt of Forms 1095-A outside of the allowable re-filing window with the IRS.[24]

Removing the alternate deadline means that all issuers in all Exchanges would have to adhere to the final 3-year deadline for identifying and reporting discovered underpayments. Thus, beginning with the 2020 plan year coverage for inaccuracies reported after December 31, 2023, HHS would not pay additional APTC payments or reimburse user fee payments for FFE, SBE-FP, and SBE issuers.

HHS also proposed not to accept or take action that results in an outgoing payment on data inaccuracies or payment errors for 2015 through 2019 plan year coverage reported *after December 31, 2023*. Thus, an issuer must describe all inaccuracies identified in a payment and collections report for PYs 2015 through 2019 before January 1, 2024. This gives issuers some additional time after this rule is finalized to submit any inaccuracies for underpayments for the 2015 through 2019 plan year coverage, which would not be permitted if this proposal was effective upon finalization.

HHS is finalizing these proposals without modification.

11. Administrative Appeals (§156.1220)

HHS proposed that when the last day of the period to request an informal hearing does not fall on a business day, the deadline to request an informal hearing would be extended to the next applicable business day. HHS finalizes this change as proposed.

IV. Collection of Information Requirements

Table 14 summarizes the annual burden estimates resulting from the rule (reproduced below). Preceding these tables, sections IV.B through IV.L of the rule provide the applicable regulatory

[24] IRS Form 1095-A contains dates of coverage, total amount of monthly premiums for one's insurance plan, the second lowest cost silver plan premium used to determine the amount of the premium tax credit, and APTC amounts.

provisions along with short descriptions of the proposed changes with some comments and HHS responses.

§153.320(d): This section repeals the flexibility for any state, including prior participant states, to request a reduction in risk adjustment state transfers in all state market risk pools beginning with the 2025 benefit year. A single prior participating state remained (Alabama) to request this flexibility, with the associated information collection and burden eliminated, beginning with the 2025 benefit year. HHS estimates $5,264.40 in annual reduction in burden to the state.

§§153.610, 153.700 and 153.710: Issuers must collect and make available for HHS' extraction from issuers' EDGE servers a new data element, a QSEHRA indicator from states that do not operate their risk adjustment program and HHS operates it on their behalf, beginning with the 2023 benefit year. There will be increased burden on those states, similar to that of the collection of ICHRA indicator finalized in the 2023 Payment Notice.

HHS also finalizes amending the applicability date for the extraction of the plan ID and rating area data elements to extend the extraction of these two data elements to the 2017, 2018, 2019 and 2020 benefit year data sets. This is not estimated to pose additional operational burden to the majority of issuers, since the creation and storage of the extract (which issuers do not receive) is mainly handled by HHS. However, some issuers may not have the required data readily available for extraction from their EDGE servers, and there may be some burden in restoring past years' data to their EDGE servers. HHS estimates $62,829 in total annual labor costs for 650 issuers (650 total hours per year for all issuers).

§153.630: Issuers below a materiality threshold, as defined by HHS, are exempt from the annual HHS-RADV audit requirements. HHS changes the materiality threshold from $15 million in total annual premiums statewide in the benefit year being audited to 30,000 BMM. HHS does not believe its proposal will significantly impact issuer burden relative to previous estimates for HHS-RADV and the current materiality threshold.

§§155.210 and 155.225: HHS does not anticipate the proposed changes to permit enrollment assistance on initial door-to-door outreach by Navigators, non-Navigator assistance personnel, or certified application counselors will impact information collection burden.

§§155.220(j): Per amendments to §155.220(j)(2)(ii), HHS finalizes that agents, brokers, and web-brokers must document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or their authorized representative prior to application submission. HHS will not mandate any method or prescribe a template for that documentation, which will have to be maintained for 10 years. HHS estimates an annual cost of $27,493,989 associated with the extra time commitment; this is based on an estimate of 5 minutes extra time at a rate of $66.68 per hour for 4,947,909 policies submitted by agents in PY 2022.

Per amendments to §155.220(j)(2)(iii), HHS also finalizes requiring agents, brokers, and web-brokers to document receipt of consumer consent prior to facilitating enrollment in coverage

through the FFEs or SBE-FPs or assisting an individual in applying for APTC and CSRs for QHPs. The consumer or their authorized representative must take an action that produces a record that they provided consent. Agents, brokers, and web-brokers must also maintain this documentation for a minimum of 10 years and produce it upon request in response to monitoring, audit, and enforcement activities. HHS estimates these annual costs at $27,493,989, using the same numbers above.

The annual costs associated with producing records for HHS for monitoring, audit and enforcement activities is estimated at $16,002. This is based on an average annual investigation of 120 agents, brokers or web-brokers requiring on average 2 hours to gather documentation. HHS says that the $16,002 cost for this information collection requirement is captured a single time for both requiring the correct information and obtaining consumer consent. Consistent with that and the proposed rule, $16,002 is listed only a single time in Table 14, unlike the $27,493,989.

§§155.305(f): HHS does not anticipate the changes to the failure to file and reconcile process will impact information collection burden.

§§155.315 and 155.320: HHS finalizes requiring Exchanges to accept an applicant's attestation when the Exchange requests tax return data from the IRS to verify attested projected annual household income but the IRS confirms there is no such tax return data available. It estimates this will decrease the annual burden for the federal government by 240,000 hours, resulting in savings of $11,208,000.

§§155.1500 through 155.1515: HHS finalizes replacing the existing voluntary state engagement initiative with mandatory participation in an Improper Payment Pre-Testing and Assessment program. HHS will provide State Exchanges with pre-testing and assessment data request forms for their completion and return, which will be in an electronic format. Respondent costs will not substantially vary since the data being collected is largely in a digitized format and each State Exchange will be providing the application data and consumer submitted documents for roughly 10 tax households. It estimates 265 hours per state respondent (about half the amount estimated in the proposed rule) at an estimated cost of $28,493.24 each; for all 18 states, the total annual burden would be $512,878.

§156.210: HHS does not anticipate the requirement for SADPs to determine enrollees' age as of effective date and to use guaranteed rates for Exchange certification will impact information collection burden.

§156.270: HHS does not anticipate that adding a timeliness standard to the requirement for QHP issuers to send enrollees notice of payment delinquency will impact information collection burden.

TABLE 14: Final Annual Recordkeeping and Reporting Requirements

Regulation Section(s)	OMB Control Number	Number of Respondents	Number of Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting ($)	Total Cost ($)
§153.320(d)	0938-1155	-1	-1	-60	-60	-$5,264.40	-$5,264.40
§§153.610, 153.700, and 153.710	0938-1155	650	650	1	650	$62,829	$62,829
§155.220(j)(2)(ii) and (iii)	0938-NEW	120	120	2	240	$16,002	$16,002
§155.220(j)(2)(ii)	0938-NEW	4,947,909	4,947,909	0.08	412,326	$27,493,898	$27,493,898
§155.220(j)(2)(iii)	0938-NEW	4,947,909	4,947,909	0.08	412,326	$27,493,898	$27,493,898
§155.320	0938-1207	-1,200,000	-1,200,000	-0.2	-240,000	-$11,208,000	-$11,208,000
§155.1510	0938-1439	18	18	265	4,770	$512,878	$512,878
TOTAL		8,696,605	8,696,605		590,252	$44,366,240.60	$44,366,240.60

V. Regulatory Impact Analysis

HHS is unable to quantify all benefits and costs of this rule. However, Table 15 (not reproduced here) shows the effects of qualitative assessment of impacts and estimated direct monetary costs and transfers resulting from the provisions of the final rule for health insurance issuers and consumers.

Risk Adjustment and Exchange User Fees. HHS finalizes the 2024 benefit year risk adjustment user fee of $0.21 PMPM, to cover the total cost for HHS to operate the risk adjustment program on behalf of states, with its cost of approximately $60 million. The finalized FFE and SBE-FP user fee rates of 2.2 and 1.8 percent of premiums, respectively, are lower than the 2023 rates of 2.75 and 2.25 percent of premiums, respectively. Because enrollment projections have increased for the 2023 and 2024 benefit year due to the IRA and the proposed 2024 risk adjustment user fee is $0.01 PMPM lower than the 2023 user fee, the proposed risk adjustment user fee for the 2024 benefit year is expected to reduce the transfer amounts collected or paid by issuers of risk adjustment covered plans. HHS estimates that FFE and SBE-FP user fee transfers from issuers to the federal government will be $170 million lower compared to those estimated for the prior benefit year, which it hopes will result in lower premiums.

Other changes, such as changes to the materiality thresholds for HHS-RADV exemptions and EDGE discrepancies, are not expected to significantly increase burden.

Navigators. Permitting enrollment assistance on initial door-to-door outreach would not impose new or additional opportunity costs on Navigators, non-Navigator assistance personnel, or CACs since they may currently go door-to-door to engage in outreach and education activities.

Agents, Brokers, and Web-brokers. Extending the time for HHS to review suspension rebuttal evidence and termination reconsideration requests is not expected to impose significant burdens as it would only impact a small number of enrolling agents, brokers and web-brokers, though it could lead to longer times during which they could not enroll consumers through the FFEs and SBE-FPs.

The requirement for agents, brokers, and web-brokers to document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or their authorized representative prior to application submission, and to maintain that documentation, would increase the time to process and submit each application. That additional time could mean fewer applications processed each day, which may result in lower revenues from commissions assuming they were constantly enrolling consumers and running out of time each day. HHS posits that there could be 6 fewer applications completed each by an agent each day during the open enrollment period, which could represent a loss of roughly $5,500 in commissions during that period.

Failure to File and Reconcile (FTR) Process. HHS finalizes requiring that Exchanges determine an enrollee as ineligible for APTC if their taxpayer did not file a federal income tax return and reconcile their APTC for two consecutive tax years, rather than one tax year. This would increase APTC expenditures by promoting continuous enrollment of consumers with APTC, which is estimated to increase APTC expenditures by approximately $373 million per year beginning in benefit year 2025.

HHS notes that five states have only recently transitioned to operating their own State Exchange and have not yet fully implemented the infrastructure to run FTR operations for plan years through 2023. It estimates one-time costs for these five states to fully implement the functionality and infrastructure to conduct FTR operations to be approximately $6.6 million and estimates that the annual costs to maintain FTR operations to be approximately $10 million.

Income Inconsistencies. The finalized policy to provide an additional 60 days for enrollees with income inconsistencies to appeal any eligibility determination notice would result in a minimal regulatory and cost burden on Exchanges—a $500,000 one-time cost to Exchanges on the federal platform and to each of the State Exchanges using their own platform. The change to accept the income attestation for households for which the Exchange requests tax return data from the IRS to verify attested projected annual household income but for whom the IRS confirms there is no such tax return data available is estimated to also result in a minimal regulatory and cost burden on Exchanges—a $500,000 one-time cost to the federal government and a one-time cost of $500,000 to each of the State Exchanges using their own platform.

HHS also anticipates $175 million in increased APTC costs annually as a result of this proposal, due to applicants remaining enrolled through the end of the plan year, instead of losing eligibility for APTC due to not providing sufficient documentation to verify their projected household income. However, annual administrative cost savings of $66 million to the federal government and of $37 million to State Exchanges are also estimated because the requirement to generate income data matching issues (DMIs) would be eliminated.

Annual Eligibility Redeterminations. While HHS anticipates an increase in the costs and burdens for issuers and Exchanges for its modifications for re-enrollment of enrollees, it is unable to quantify them. It believes initially limiting the scope to only CSR-eligible enrollees who are currently in a bronze QHP and have a lower cost silver CSR QHP available would allow issuers

and Exchanges to incrementally update their processes. It also believes allowing the Exchange to direct re-enrollment for CSR-eligible enrollees from bronze plans to silver CSR plans with lower or equivalent premium after APTC would facilitate enrollment into silver CSR plans and help reduce CSR forfeiture.

Special Enrollment Periods. The finalized proposal to provide earlier SEP coverage effective dates for qualifying individuals who attest to a future loss of minimum essential coverage (MEC)—such as coverage offered through an employer, Medicaid, CHIP, or Medicare—within 60 days before such loss of MEC is estimated to increase APTC expenditures by $161 million per coverage year.

The policy to provide qualifying individuals who lose Medicaid or CHIP and who qualify for a SEP with up to 60 days before and up to 90 days after their loss of coverage to enroll in a QHP is estimated to increase APTC expenditures by $98 million per year.

The finalized proposal to grant SEPs to persons who are adversely affected by a plan display error would have minimal operational impact and would not impose additional regulatory burden or costs.

Termination of Exchange Enrollment or Coverage. The finalized proposal to expressly prohibit issuers from terminating coverage for policy dependent children because they reached the maximum allowable age mid-plan year is not expected to have a financial impact on the Exchanges on the federal platform because this prohibition is already in place. State Exchanges that elect to implement this policy could incur some costs, which HHS describes as minor.

State Exchange Improper Payment Pre-testing and Assessment. HHS finalizes implementing the Payment Integrity Information Act of 2019 (PIIA) requirements for State Exchanges, testing State Exchanges' readiness to provide the information necessary to measure the rate of improper payments. The IPPTA incurs approximately $28,500 in costs per respondent, totaling $512,878 for all 18 State Exchanges. HHS notes that even slight decreases in the improper payment rate would produce large taxpayer savings.

Non-Standardized Plans. It is estimated that the finalized limits on the number of non-standardized plan options that issuers of individual market medical QHPs can offer through the FFEs and SBE-FPs will reduce the weighted average number of non-standardized plan options available to each consumer from approximately 89.5 in PY 2023 to 66.3 in PY 2024, along with numbers presented earlier in section III.C.4. HHS reiterates it is unable to provide meaningful estimates for PY 2025 and subsequent plan years. This is because, for these estimates to be meaningful, HHS would need plan offering and enrollment data for PY 2024, which will not be available until the end of the current QHP certification cycle for PY 2024 and the end of the 2024.

SADPs. HHS' finalized proposal modifies the rate submission process to require issuers of Exchange-certified SADPs, whether they are sold on- or off-Exchange, to use age on effective date as the sole method to calculate an enrollee's age for rating and eligibility purposes

beginning with Exchange certification in PY 2024. HHS characterizes this as a small operational change, which should not have any negative financial impact nor create any additional information submission burden.

Plan and Plan Variation Marketing Name Requirements for QHPs. HHS finalizes the requirement that QHP plan and plan variation marketing names include correct information, without omission of material fact, and do not include content that is misleading. HHS does not believe the proposal would create any new information submission burden, because it would apply to information that Exchange issuers already submit as part of the QHP certification process, and it believes it would decrease issuer and state effort after QHP certification.

Network Adequacy. HHS finalizes its proposal that all QHP issuers, including SADP issuers, must use a contracted provider network and comply with network adequacy standards. HHS expects any initial increased issuer costs to differ from the costs experienced once such provider contractual relationships have been established or pre-existing networks associated with their other plans have been leveraged.

HHS acknowledges that some SADPs may withdraw from the Exchange, which could create burdens for enrollees and QHPs, but HHS believes any such burden would affect a small number of consumers. It notes this can be mitigated because the finalized policy provides for a limited exception to the provider network requirements in areas where it is prohibitively difficult for the SADP issuer to establish a network of dental providers consistent with those requirements. HHS anticipates approximately 2,200 enrollees will be affected by this policy.

Essential Community Providers (ECP). HHS finalizes requiring QHPs to contract with at least 35 percent of available FQHCs and at least 35 percent of available Family Planning Providers that qualify as ECPs in the plan's service area. While it acknowledges that issuers whose provider networks do not currently include such a percentage of these provider types that qualify as ECPs may face increased costs associated with complying with the proposed policies, it does not expect the increase to be prohibitive.

HHS also finalizes establishing two additional stand-alone ECP categories to include SUD Treatment Centers and Mental Health Facilities, which it notes will present challenges due to the general shortage and uneven distribution of these provider types. However, HHS clarifies that the requirement for QHPs is to offer a contract to at least one available SUD Treatment Center and one available Mental Health Facility in every county in the plan's service area; if there are no provider types in the county, the issuer is not penalized. HHS did not receive any comments in response to the burden estimates for these policies.

Termination of Coverage or Enrollment for Qualified Individuals. HHS proposed adding a timeliness standard (i.e., promptly and without undue delay, within 10 business days of the date the issuer should have discovered the delinquency) to the requirement for QHP issuers to send enrollees notice of payment delinquency. It anticipates minimal costs to issuers for updates to their internal processes, but it has no data to quantify those costs.

Final Deadline for Reporting Enrollment and Payment Inaccuracies Discovered After the Initial 90-Day Reporting Window. HHS finalizes removing the alternate deadline at §156.1210(c)(2), as described above in III.C.10. It believes the change would result in a less operationally burdensome process to identify and resolve these data inaccuracies for issuers, State Exchanges, and HHS, and a slight reduction in associated burdens, such as resolution of data inaccuracies for discovered underpayments. However, it believes any impact would be minimal and result in no significant financial impact.