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DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 146, 147, 153, 154, 155, 156, and 158

[CMS-9937-P]

RIN 0938-AS57

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment

Parameters for 2017

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule sets forth payment parameters and provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges. It also provides additional standards for the annual open enrollment period for the individual market for the 2017 benefit year; essential health benefits; cost-sharing requirements; qualified health plans; updated standards for Exchange consumer assistance programs; network adequacy; patient safety standards; the Small Business Health Options Program; stand-alone dental plans; acceptance of third-party payments by qualified health plans; the definitions of large employer and small employer; fair health insurance premiums; guaranteed availability; student health insurance coverage; the rate review program; the medical loss ratio program; eligibility and enrollment; exemptions and appeals; and other related topics.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on **December 21, 2015**.

ADDRESSES: In commenting, please refer to file code CMS-9937-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

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

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-9937-P,
P.O. Box 8016,
Baltimore, MD 21244-8016.

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

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-9937-P,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

4. By hand or courier. Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, SW.,
Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

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

FOR FURTHER INFORMATION CONTACT:

Jeff Wu, (301) 492-4305, Krutika Amin, (301) 492-5153, or Lindsey Murtagh (301) 492-4106, for general information.

David Mlawsky, (410) 786-6851, for matters related to fair health insurance premiums, the single risk pool, guaranteed availability, guaranteed renewability, and student health insurance coverage.

Kelly Drury, (410) 786-0558, for matters related to risk adjustment.

Adrianne Glasgow, (410) 786-0686, for matters related to reinsurance, distributed data collection, and administrative appeals of financial transfers.

Melissa Jaffe, (301) 492-4129, for matters related to risk corridors.

Lisa Cuzzo, (410)-786-1746, for matters related to rate review.

Jennifer Stolbach, (301) 492-4350, for matters related to establishing a State Exchange, and State-based Exchanges on the Federal Platform.

Emily Ames, (301) 492-4246, and Michelle Koltov, (301) 492-4225, for matters related to Navigators and non-Navigator assistance personnel under part 155.

Joan Matlack, (301) 492-4223, for matters related to certified application counselors under part 155.

Briana Levine, (301) 492-4247, for matters related to agents and brokers.

Dana Krohn, (301) 492-4412, for matters related to employer notification and verification.

Rachel Arguello, (301) 492-4263, for matters related to open enrollment periods and special enrollment periods under part 155.

Anne Pesto, (410) 786-3492, for matters related to eligibility determinations and appeals of eligibility determinations for Exchange participation and insurance affordability programs, and eligibility determinations for exemptions.

Kate Ficke, (301) 492-4256, for matters related to exemptions from the shared responsibility payment.

Christelle Jang, (410) 786-8438, for matters related to the SHOP.

Krutika Amin, (301) 492-5153, for matters related to the Federally-facilitated Exchange user fee.

Leigha Basini, (301) 492-4380, for matters related to essential health benefits, network adequacy, essential community providers, and other standards for QHP issuers.

Ielnaz Kashefipour, (301) 492-4376, for matters related to standardized options and third party payment of premiums and cost sharing.

Rebecca Zimmermann, (301) 492-4396, for matters related to stand-alone dental plans.

Cindy Chiou, (301) 492-5142, for matters related to QHP issuer oversight.

Pat Meisol, (410) 786-1917, for matters related to cost-sharing reductions and the premium adjustment percentage.

Nidhi Singh Shah, (301) 492-5110, for matters related to patient safety standards.

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

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that website to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the

headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

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Acronyms and Abbreviations

Affordable Care Act The collective term for the Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended

APTC	Advance payments of the premium tax credit
AV	Actuarial value
CBO	Congressional Budget Office
CFR	Code of Federal Regulations
CHIP	Children’s Health Insurance Program
CMP	Civil money penalties
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-sharing reduction
ECN	Exemption certificate number
ECP	Essential community provider
EHB	Essential health benefits
ERISA	Employee Retirement Income Security Act of 1974 (Pub. L. 93-406)
FFE	Federally-facilitated Exchange
FF-SHOP	Federally-facilitated Small Business Health Options Program
FPL	Federal poverty level
FR	Federal Register
FTE	Full-time equivalent
GDP	Gross Domestic Product
HCC	Hierarchical condition category
HHS	United States Department of Health and Human Services
HIOS	Health Insurance Oversight System
HIPAA	Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191)

IRS	Internal Revenue Service
MEC	Minimum essential coverage
MLR	Medical loss ratio
NAIC	National Association of Insurance Commissioners
NHEA	National Health Expenditure Accounts
OMB	Office of Management and Budget
OPM	United States Office of Personnel Management
PHS Act	Public Health Service Act
PII	Personally Identifiable Information
PMPM	Per member per month
PRA	Paperwork Reduction Act of 1995
PSO	Patient safety organization
QHP	Qualified health plan
SADPs	Stand-alone dental Plans
SBE	State-based Exchange
SBE-FP	State-based Exchange on the Federal platform
SHOP	Small Business Health Options Program
The Code	Internal Revenue Code of 1986 (26 U.S.C. 1, et seq.)

I. Executive Summary

The Affordable Care Act enacted a set of reforms that are making high quality health insurance coverage and care more affordable and accessible to millions of Americans. These reforms include the creation of competitive marketplaces called Affordable Insurance Exchanges, or “Exchanges” (in this proposed rule, we also call an Exchange a Health Insurance

MarketplaceSM,¹ or MarketplaceSM) through which qualified individuals and qualified employers can purchase health insurance coverage. In addition, many individuals who enroll in qualified health plans (QHPs) through individual market Exchanges are eligible to receive a premium tax credit to make health insurance more affordable, and reductions in cost-sharing payments to reduce out-of-pocket expenses for health care services. These Affordable Care Act reforms also include the premium stabilization programs (that is, risk adjustment, reinsurance and risk corridors) and rules that are intended to mitigate the potential impact of adverse selection and stabilize the price of health insurance in the individual and small group markets. In previous rulemaking, we have outlined the major provisions and parameters related to many Affordable Care Act programs.

In this proposed rule, we seek to improve States' ability to operate efficient Exchanges through a proposal that leverages the economies of scale available through the Federal eligibility and enrollment platform and information technology infrastructure. We propose to codify a new Exchange model – the State-based Exchange on the Federal platform (SBE-FP). This model would enable State-based Exchanges (SBEs) to execute certain processes using the Federal eligibility and enrollment infrastructure. Under the proposal, the SBE-FP would be required to enter into a Federal platform agreement with HHS that would define a set of mutual obligations, including the set of Federal services upon which the SBE-FP relies. Under this Exchange model, certain requirements that were previously only applicable to QHPs offered on a Federally-facilitated Exchange (FFE) and their downstream and delegated entities would apply to QHPs

¹ Health Insurance MarketplaceSM and MarketplaceSM are service marks of the U.S. Department of Health & Human Services.

offered on an SBE-FP and their downstream and delegated entities. In addition, we propose that agents and brokers facilitating enrollments through SBE-FPs would need to comply with the FFE registration and training requirements. For 2017, we propose a user fee for QHPs offered through SBE-FPs to offset Federal costs of providing this infrastructure.

We also propose a number of incremental amendments that we believe will improve the stability of the Exchanges while improving the choices available to consumers and supporting consumers' ability to make informed choices when purchasing health insurance. These include the introduction of "standardized options" in the individual market, which will improve competition and consumer transparency. These amendments are complemented by a series of additional amendments designed to enhance consumers' ability to make informed choices about their health coverage, increase the accessibility of high quality health insurance, and improve competition, transparency, and affordability.

Our proposal for standardized options is intended to simplify the consumer shopping experience by allowing consumers to more easily compare plans across issuers in the individual market FFEs. We propose a standardized option with a specified cost-sharing structure at each of the bronze, silver (with cost-sharing reduction (CSR) plan variations), and gold metal levels. We do not propose to restrict issuers' non-standardized option offerings. We anticipate differentially displaying these standardized options to allow consumers to compare plans based on differences in price and quality rather than cost-sharing structure.

We are also proposing to standardize a number of policies relating to network adequacy for QHPs on the FFEs. We propose a quantitative network adequacy threshold to be selected by the State and a Federal default network adequacy standard that would apply otherwise, that is based on the standard currently used for review and several provisions relating to provider

transition for QHPs. We also discuss in this proposed rule a standardized categorization of network depth for QHPs in these Exchanges and their display on HealthCare.gov. Finally, we propose a standard for when an enrollee receives an essential health benefit at an in-network setting provided by an out-of-network provider.

As part of our efforts to provide consumers simplicity and transparency in their choices, we are considering giving the FFEs the authority to selectively contract with issuers. We would use this authority primarily to strengthen oversight in the short term.

We also seek to improve consumers' ability to make choices regarding health insurance coverage by ensuring they receive high-quality assistance in their interactions with the Exchange. The proposed rule would amend program requirements for Navigators, certain non-Navigator assistance personnel, and certified application counselors. These amendments would require Navigators to assist consumers with certain post-enrollment issues, serve underserved and vulnerable populations, and require Navigators and non-Navigator assistance personnel to complete training prior to conducting outreach and education activities. We would also amend our rules regarding the use of gifts by Navigators, certain non-Navigator assistance personnel and certified application counselors. In addition, we propose that certified application counselor designated organizations would be required to submit data and information related to the organization's certified application counselors, upon the request of the Exchanges in which they operate.

We believe transparency is critical to informed decision-making, and this proposed rule includes several proposals to increase transparency. This proposed rule proposes provisions to enhance the transparency of rates in all States and the effectiveness of the rate review program.

In this proposed rule, we propose several provisions regarding when consumers may choose and enroll in plans. This rule proposes dates for the individual market annual open enrollment period for the 2017 benefit year. For 2017, we propose to maintain the same open enrollment period we adopted for 2016 – that is, November 1, 2016, through January 31, 2017.

We also propose to codify a number of Exchange policies relating to exemptions in order to provide certainty and transparency around these policies for all stakeholders.

The HHS Notice of Benefit and Payment Parameters for 2014 (78 FR 15410) (2014 Payment Notice) finalized the risk adjustment methodology that HHS will use when it operates risk adjustment on behalf of a State. Risk adjustment factors reflect enrollee health risk and the costs of a given disease relative to average spending. Last year, we recalibrated the HHS risk adjustment models for 2016 by using 2011, 2012, and 2013 claims data from the Truven Health Analytics 2010 MarketScan® Commercial Claims and Encounters database (MarketScan) to develop updated risk factors. Similarly, this year we propose to do so using the 2012, 2013, and 2014 claims data, when the 2014 MarketScan data become available.

If any reinsurance contribution amounts remain after calculating reinsurance payments for the 2016 benefit year (including after HHS would increase the coinsurance rate to 100 percent for the 2016 benefit year), we propose to lower the 2016 attachment point of \$90,000 to pay out any remaining contribution amounts for the 2016 benefit year. We also propose several changes to the risk corridors program for 2015 and 2016. We propose that, for 2015 risk corridors and MLR reporting, if the issuer reported a certified estimate of 2014 cost-sharing reductions on its 2014 MLR and Risk Corridors Annual Reporting Form that is lower than the actual cost-sharing reductions provided, HHS would make an adjustment to the issuer's 2015 risk corridors payment or charge amount in order to address the impact of the inaccurate

reporting on the risk corridors and MLR calculations for the 2014 benefit year. We also propose that the issuer must adjust the cost-sharing reduction amounts it reports for the 2015 MLR and risk corridors reporting cycle by any difference between 2014 reported and actual cost-sharing reductions amounts.

We also propose that for the 2015 and later benefit years, the issuer must true up claims liabilities and reserves used to determine the allowable costs reported for the risk corridors program for the preceding benefit year to reflect the actual claims payments made through June 30 of the year following the benefit year. In addition, we propose changes to the definition of “unpaid claim reserves” and related requirements for reporting incurred claims for the MLR program beginning with the 2015 reporting year to require issuers to utilize a 6-month (rather than a 3-month) claims run out period.

In addition to provisions aimed at stabilizing premiums, we propose several provisions related to cost sharing. First, we propose the premium adjustment percentage for 2017, which is used to set the rate of increase for several parameters detailed in the Affordable Care Act, including the maximum annual limitation on cost sharing for 2017. We propose the maximum annual limitations on cost sharing for the 2017 benefit year for cost-sharing reduction plan variations. This proposed rule also proposes standards for stand-alone dental plans (SADPs) related to the annual limitation on cost sharing, and would amend standards related to the acceptance of third party payments for premiums and cost sharing by QHP issuers.

This proposed rule includes several incremental improvements that seek to ensure Americans have access to not only affordable, but also robust, high-quality health care coverage. This proposed rule would amend requirements for QHPs, including essential community providers (ECPs) and meaningful difference requirements. There are also proposed technical

amendments to QHP issuer oversight provisions. This rule proposes amendments to further strengthen the patient safety requirements for QHP issuers offering coverage through Exchanges.

For consumers purchasing coverage through the Small Business Health Options Program (SHOP), we propose a new “vertical choice” model for Federally-facilitated SHOPs for plan years beginning on or after January 1, 2017, under which employers would be able to offer qualified employees a choice of all plans across all available levels of coverage from a single issuer.

Finally, in this proposed rule, as outlined, we propose adjustments to our programs and rules, as we do each year, so that our rules and policies reflect the latest market developments. We propose the following changes and clarifications to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Affordable Care Act health insurance reform requirements. We propose revisions to the definitions of small employer and large employer to bring them into conformance with recently enacted legislation. We also propose provisions to ensure that a network plan in the small group market with a limited service area can be appropriately rated based on geography. We propose that an issuer subject to the guaranteed availability requirements may – in the limited circumstances of when the exception to the guaranteed renewability requirement related to discontinuing a particular product, or the exception related to discontinuing all coverage in a market, applies – deny coverage to individuals and employers. Lastly, we propose provisions regarding the application of the actuarial value (AV) and single risk pool provisions to student health insurance coverage.

II. Background

A. Legislative and Regulatory Overview

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this proposed rule, we refer to the two statutes collectively as the “Affordable Care Act.”

Subtitles A and C of title I of the Affordable Care Act reorganized, amended, and added to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets.

Section 2701 of the PHS Act, as added by the Affordable Care Act, restricts the variation in premium rates charged by a health insurance issuer for non-grandfathered health insurance coverage in the individual or small group market to certain specified factors. The factors are: family size, rating area, age and tobacco use.

Section 2701 of the PHS Act operates in coordination with section 1312(c) of the Affordable Care Act. Section 1312(c) of the Affordable Care Act generally requires a health insurance issuer to consider all enrollees in all health plans (except for grandfathered health plans) offered by such issuer to be members of a single risk pool for each of its individual and small group markets. States have the option to merge the individual market and small group market risk pools under section 1312(c)(3) of the Affordable Care Act.

Section 2702 of the PHS Act, as added by the Affordable Care Act, requires health insurance issuers that offer health insurance coverage in the group or individual market in a State

to offer coverage to and accept every employer and individual in the State that applies for such coverage unless an exception applies.²

Section 2703 of the PHS Act, as added by the Affordable Care Act, and sections 2712 and 2741 of the PHS Act, as added by HIPAA and codified prior to the enactment of the Affordable Care Act, require health insurance issuers that offer health insurance coverage in the group or individual market to renew or continue in force such coverage at the option of the plan sponsor or individual unless an exception applies.

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

Section 2794 of the PHS Act, as added by the Affordable Care Act, directs the Secretary of HHS (the Secretary), in conjunction with the States, to establish a process for the annual review of “unreasonable increases in premiums for health insurance coverage.”³ The law also requires health insurance issuers to submit to the Secretary and the applicable State justifications for unreasonable premium increases prior to the implementation of the increases. Section 2794(b)(2) of the PHS Act further specifies that beginning with plan years starting in 2014, the Secretary, in conjunction with the States, will monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

² Before enactment of the Affordable Care Act, the Health Insurance Portability and Accountability Act of 1996 amended the PHS Act (formerly section 2711) to generally require guaranteed availability of coverage for employers in the small group market.

³ The implementing regulations in part 154 limit the scope of the requirements under section 2794 of the PHS Act to health insurance issuers offering health insurance coverage in the individual market or small group market. See Rate Increase Disclosure and Review; Final Rule, 76 FR 29964, 29966 (May 23, 2011).

Section 1252 of the Affordable Care Act provides that any standard or requirement adopted by a State under title I of the Affordable Care Act, or any amendment made by title I of the Affordable Care Act, shall be applied uniformly to all health plans in each insurance market to which the standard and requirement apply.

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

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

under the plan does not exceed the limitations described in sections 1302(c)(1) and (2) of the Affordable Care Act.

Section 1302(d) of the Affordable Care Act describes the various levels of coverage based on actuarial value. Consistent with section 1302(d)(2)(A) of the Affordable Care Act, actuarial value is calculated based on the provision of EHB to a standard population. Section 1302(d)(3) of the Affordable Care Act directs the Secretary to develop guidelines that allow for de minimis variation in AV calculations.

Section 1311(b)(1)(B) of the Affordable Care Act directs that the Small Business Health Options Program assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market. Sections 1312(f)(1) and (2) of the Affordable Care Act define qualified individuals and qualified employers. Under section 1312(f)(2)(B) of the Affordable Care Act, beginning in 2017, States will have the option to allow issuers to offer QHPs in the large group market through an Exchange.⁴

Section 1311(c)(1)(B) of the Affordable Care Act requires the Secretary to establish minimum criteria for provider network adequacy that a health plan must meet to be certified as a QHP.

Section 1311(c)(5) of the Affordable Care Act requires the Secretary to continue to operate, maintain, and update the Internet portal developed under section 1103 of the Affordable Care Act to provide information to consumers and small businesses on affordable health insurance coverage options.

⁴ If a State elects this option, the rating rules in section 2701 of the PHS Act and its implementing regulations will apply to all coverage offered in such State's large group market (except for self-insured group health plans) pursuant to section 2701(a)(5) of the PHS Act.

Section 1311(c)(6)(B) of the Affordable Care Act states that the Secretary is to set annual open enrollment periods for Exchanges for calendar years after the initial enrollment period.

Sections 1311(d)(4)(K) and 1311(i) of the Affordable Care Act direct all Exchanges to establish a Navigator program.

Section 1311(h)(1) of the Affordable Care Act specifies that a QHP may contract with health care providers and hospitals with more than 50 beds only if they meet certain patient safety standards, including use of a patient safety evaluation system, a comprehensive hospital discharge program, and implementation of health care quality improvement activities. Section 1311(h)(2) of the Affordable Care Act also provides the Secretary flexibility to establish reasonable exceptions to these patient safety requirements and section 1311(h)(3) of the Affordable Care Act allows the Secretary flexibility to issue regulations to modify the number of beds described in section 1311(h)(1)(A) of the Affordable Care Act.

Section 1321(a) of the Affordable Care Act provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs and other components of title I of the Affordable Care Act. Section 1321(a)(1) directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the Affordable Care Act with respect to, among other things, the establishment and operation of Exchanges.

Sections 1313 and 1321 of the Affordable Care Act provide the Secretary with the authority to oversee the financial integrity of State Exchanges, their compliance with HHS standards, and the efficient and non-discriminatory administration of State Exchange activities. Section 1321 of the Affordable Care Act provides for State flexibility in the operation and enforcement of Exchanges and related requirements.

When operating an FFE under section 1321(c)(1) of the Affordable Care Act, HHS has the authority under sections 1321(c)(1) and 1311(d)(5)(A) of the Affordable Care Act to collect and spend user fees. In addition, 31 U.S.C. 9701 permits a Federal agency to establish a charge for a service provided by the agency. Office of Management and Budget (OMB) Circular A-25 Revised establishes Federal policy regarding user fees and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public.

Section 1321(c)(2) of the Affordable Care Act authorizes the Secretary to enforce the Exchange standards using civil money penalties (CMPs) on the same basis as detailed in section 2723(b) of the PHS Act. Section 2723(b) of the PHS Act authorizes the Secretary to impose CMPs as a means of enforcing the individual and group market reforms contained in Part A of title XXVII of the PHS Act when a State fails to substantially enforce these provisions

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

Section 1341 of the Affordable Care Act requires the establishment of a transitional reinsurance program in each State to help pay the cost of treating high-cost enrollees in the individual market in benefit years 2014 through 2016. Section 1342 of the Affordable Care Act directs the Secretary to establish a temporary risk corridors program that reduces the impact of inaccurate rate setting from 2014 through 2016. Section 1343 of the Affordable Care Act establishes a permanent risk adjustment program to provide increased payments to health

insurance issuers that attract higher-risk populations, such as those with chronic conditions, funded by payments from those that attract lower-risk populations; thereby, reducing incentives for issuers to avoid higher-risk enrollees.

Sections 1402 and 1412 of the Affordable Care Act provide for, among other things, reductions in cost sharing for essential health benefits for qualified low- and moderate-income enrollees in silver level health plans offered through the individual market Exchanges. These sections also provide for reductions in cost sharing for Indians enrolled in QHPs at any metal level.

Section 5000A of the Internal Revenue Code of 1986 (the Code), as added by section 1501(b) of the Affordable Care Act, requires all non-exempt individuals to maintain minimum essential coverage (MEC) for each month or make the individual shared responsibility payment. Section 5000A(f) of the Code defines minimum essential coverage as any of the following: (1) coverage under a specified government sponsored program; (2) coverage under an eligible employer-sponsored plan; (3) coverage under a health plan offered in the individual market within a State; and (4) coverage under a grandfathered health plan. Section 5000A(f)(1)(E) of the Code authorizes the Secretary of HHS, in coordination with the Secretary of the Treasury, to designate other health benefits coverage as minimum essential coverage.

The Protecting Affordable Coverage for Employees Act (Pub. L. 114-60) amended section 1304(b) of the Patient Protection and Affordable Care Act and section 2791(e) of the PHS Act to amend the definition of small employer in these statutes to mean, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. It also

amended these statutes to make conforming changes to the definition of large employer, and to provide that a State may treat as a small employer, with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

1. Premium Stabilization Programs

In the July 15, 2011 **Federal Register** (76 FR 41929), we published a proposed rule outlining the framework for the premium stabilization programs. We implemented the premium stabilization programs in a final rule, published in the March 23, 2012 **Federal Register** (77 FR 17219) (Premium Stabilization Rule). In the December 7, 2012 **Federal Register** (77 FR 73117), we published a proposed rule outlining the benefit and payment parameters for the 2014 benefit year to expand the provisions related to the premium stabilization programs and set forth payment parameters in those programs (proposed 2014 Payment Notice). We published the 2014 Payment Notice final rule in the March 11, 2013 **Federal Register** (78 FR 15409).

In the December 2, 2013 **Federal Register** (78 FR 72321), we published a proposed rule outlining the benefit and payment parameters for the 2015 benefit year to expand the provisions related to the premium stabilization programs, setting forth certain oversight provisions and establishing the payment parameters in those programs (proposed 2015 Payment Notice). We published the 2015 Payment Notice final rule in the March 11, 2014 **Federal Register** (79 FR 13743).

In the November 26, 2014 **Federal Register** (79 FR 70673), we published a proposed rule outlining the benefit and payment parameters for the 2016 benefit year to expand the provisions related to the premium stabilization programs, setting forth certain oversight

provisions and establishing the payment parameters in those programs (proposed 2016 Payment Notice). We published the 2016 Payment Notice final rule in the February 27, 2015 **Federal Register** (80 FR 10749).

2. Program Integrity

In the June 19, 2013 **Federal Register** (78 FR 37031), we published a proposed rule that proposed certain program integrity standards related to Exchanges and the premium stabilization programs (proposed Program Integrity Rule). The provisions of that proposed rule were finalized in two rules, the “first Program Integrity Rule” published in the August 30, 2013 **Federal Register** (78 FR 54069) and the “second Program Integrity Rule” published in the October 30, 2013 **Federal Register** (78 FR 65045).

3. Exchanges

We published a request for comment relating to Exchanges in the August 3, 2010 **Federal Register** (75 FR 45584). We issued initial guidance to States on Exchanges on November 18, 2010. We proposed a rule in the July 15, 2011 **Federal Register** (76 FR 41865) to implement components of the Exchanges, and a rule in the August 17, 2011 **Federal Register** (76 FR 51201) regarding Exchange functions in the individual market, eligibility determinations, and Exchange standards for employers. A final rule implementing components of the Exchanges and setting forth standards for eligibility for Exchanges was published in the March 27, 2012 **Federal Register** (77 FR 18309) (Exchange Establishment Rule).

We established standards for SHOP in the 2014 Payment Notice and in the Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 interim final rule, published in the March 11, 2013 **Federal Register** (78 FR 15541). The provisions established in the interim final rule were finalized in the second Program Integrity Rule. We also set forth standards

related to Exchange user fees in the 2014 Payment Notice. We established an adjustment to the FFE user fee in the Coverage of Certain Preventive Services Under the Affordable Care Act final rule, published in the July 2, 2013 **Federal Register** (78 FR 39869) (Preventive Services Rule).

In a final rule published in the July 17, 2013 **Federal Register** (78 FR 42823), we established standards for Navigators and non-Navigator assistance personnel in FFEs and for non-Navigator assistance personnel funded through an Exchange establishment grant. This final rule also established a certified application counselor program for Exchanges and set standards for that program.

4. Essential Health Benefits and Actuarial Value

On December 16, 2011, HHS released a bulletin⁵ (the EHB Bulletin) that outlined an intended regulatory approach for defining EHB, including a benchmark-based framework. HHS also published a bulletin that outlined its intended regulatory approach to calculations of AV on February 24, 2012.⁶ A proposed rule relating to EHBs and AVs was published in the November 26, 2012 **Federal Register** (77 FR 70643). We established requirements relating to EHBs and AVs in the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule, which was published in the February 25, 2013 **Federal Register** (78 FR 12833) (EHB Rule).

5. Market Rules

A proposed rule relating to the 2014 health insurance market rules was published in the November 26, 2012 **Federal Register** (77 FR 70584). A final rule implementing the health

⁵ “Essential Health Benefits Bulletin.” December 16, 2011. Available at: https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

⁶ “Actuarial Value and Cost-Sharing Reductions Bulletin.” February 24, 2012. Available at: <https://www.cms.gov/CCIIO/Resources/Files/Downloads/Av-csr-bulletin.pdf>.

insurance market rules was published in the February 27, 2013 **Federal Register** (78 FR 13406) (2014 Market Rules).

A proposed rule relating to Exchanges and Insurance Market Standards for 2015 and Beyond was published in the March 21, 2014 **Federal Register** (79 FR 15808) (2015 Market Standards Proposed Rule). A final rule implementing the Exchange and Insurance Market Standards for 2015 and Beyond was published in the May 27, 2014 **Federal Register** (79 FR 30240) (2015 Market Standards Rule).

6. Rate Review

A proposed rule to establish the rate review program was published in the December 23, 2010 **Federal Register** (75 FR 81003). A final rule with comment period implementing the rate review program was published in the May 23, 2011 **Federal Register** (76 FR 29963) (Rate Review Rule). The provisions of the Rate Review Rule were amended in final rules published in the September 6, 2011 **Federal Register** (76 FR 54969), the February 27, 2013 **Federal Register** (78 FR 13405), the May 27, 2014 **Federal Register** (79 FR 30339), and the February 27, 2015 **Federal Register** (80 FR 10749).

7. Medical Loss Ratio

We published a request for comment on section 2718 of the PHS Act in the April 14, 2010 **Federal Register** (75 FR 19297), and published an interim final rule with a 60-day comment period relating to the MLR program on December 1, 2010 (75 FR 74863). A final rule with a 30-day comment period was published in the December 7, 2011 **Federal Register** (76 FR 76573). An interim final rule with a 60-day comment period was published in the December 7, 2011 **Federal Register** (76 FR 76595). A final rule was published in the **Federal Register** on May 16, 2012 (77 FR 28790).

B. Stakeholder Consultation and Input

HHS has consulted with stakeholders on policies related to the operation of Exchanges, including the SHOP and the premium stabilization programs. We have held a number of listening sessions with consumers, providers, employers, health plans, the actuarial community, and State representatives to gather public input. We consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners (NAIC), regular contact with States through the Exchange Establishment grant and Exchange Blueprint approval processes, and meetings with Tribal leaders and representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties. We considered all public input we received as we developed the policies in this proposed rule.

C. Structure of Proposed Rule

The regulations outlined in this proposed rule would be codified in 45 CFR parts 144, 146, 147, 153, 154, 155, 156 and 158. The proposed regulations in part 144 would, consistent with recent legislation, revise the definitions of “large employer” and “small employer.”

The proposed regulations in parts 146 and 147 would codify an exception to the guaranteed availability requirement when the exception to the guaranteed renewability requirement related to discontinuing a particular product or discontinuing all coverage in a market applies.

The proposed regulations in part 147 would clarify the definition of principal business address for purposes of geographic rating. We further propose provisions regarding the treatment of student health insurance coverage with regard to the AV and single risk pool requirements.

The proposed regulations in part 153 amend the audit provision for the reinsurance program to clarify that this authority also extends to third parties who assist contributing entities with their obligations under this program. The proposed regulations also include the risk adjustment user fee for 2017 and outline certain modifications to the HHS risk adjustment methodology. We propose to clarify reporting requirements for the risk adjustment, reinsurance, and risk corridors.

The proposed regulations in part 154 outline certain modifications to enhance the transparency and effectiveness of the rate review program. We propose to collect a Unified Rate Review Template from all issuers offering single risk pool coverage in the individual and small group market, including coverage with rate decreases or unchanged rates, as well as rates for new plans. We also announce our intention to disclose all proposed rate increases for single risk pool coverage at a uniform time on the CMS website, including rates with increases of less than 10 percent. We also reiterate the process for establishing the uniform timeline that proposed rate increases subject to review and all final rate increases (including those not subject to review) for single risk pool coverage must be posted at a uniform time by States with Effective Rate Review Programs. Finally, we specify the rate filing requirements for student health insurance coverage.

The proposed regulations in part 155 include a clarification related to the functions of an Exchange, and would establish the individual market open enrollment period for the 2017 benefit year. Certain proposals in part 155 are related to the eligibility and verification processes related to eligibility for insurance affordability programs. We also propose to amend and clarify rules related to enrollment of qualified individuals into QHPs. We describe changes to the process of submitting certain exemption applications and options for State Exchanges to handle exemptions. The proposed regulations also include a Federal platform agreement through which a State

Exchange may rely on the FFE for certain functions as an SBE-FP. We propose that QHP issuers on an SBE-FP be required to comply with certain provisions relating directly to the eligibility and enrollment platform, and propose to require that SBE-FPs promulgate regulations at least as stringent as a number of FFE regulations, to maintain consistency of the HealthCare.gov experience. We also make various proposals related to the SHOs. We propose to amend the standards applicable to the consumer assistance functions performed by Navigators, non-Navigator assistance personnel, and certified application counselors. We also discuss our approach to denial of QHP certification, and outline proposed modifications to standards for FFE-registered agents and brokers and requirements for HHS-approved vendors of FFE training.

The proposed regulations in part 156 set forth proposals related to cost sharing, including the premium adjustment percentage, the maximum annual limitation on cost sharing, and the reductions in the maximum annual limitation for cost-sharing plan variations for 2017. We propose a clarification to the administrative appeals process applicable to the premium stabilization, Exchange financial assistance, and FFE user fee programs. Part 156 also includes proposals related to essential health benefits, including clarification to the policy regarding additional State-required benefits. We propose amendments to network adequacy requirements (including application of out-of-network costs to the annual limitation on cost sharing for EHBs covered under QHPs in the small group and individual markets), and essential community provider requirements. We propose establishing standardized options for cost-sharing structures, indexing for the stand-alone dental plan annual limitation on cost sharing, changes to our process for updating the AV Calculator for QHPs, meaningful difference standards for QHPs, and minor changes to QHP issuer oversight standards. We also propose additional modifications to

acceptance of third party payments by QHP issuers and the next phase for patient safety standards for issuers of QHPs offered on Exchanges.

The proposed amendments to the regulations in part 158 propose revisions related to the definitions of “large employer” and “small employer” consistent with recent legislation, as well as revisions related to the reporting of incurred claims.

III. Provisions of the Proposed HHS Notice of Benefit and Payment Parameters for 2017

A. Part 144 – Requirements Relating to Health Insurance Coverage

1. Definitions (§144.103)

Under §144.103, the term “plan year” means, for a group health plan, the year that is designated as the plan year in the plan document of the group health plan. However, if the plan document does not designate a plan year or if there is no plan document, then the plan year is—

- The deductible or limit year used under the plan;
- If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;
- If the plan does not impose deductible or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or
- In any other case, the plan year is the calendar year.⁷

⁷ Under §147.104(b)(1)(i), in the small group market, including under §155.725 in the SHOP, issuers generally must permit small employers to purchase coverage at any point during the year. In the SHOP, the employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage. With respect to an employer that purchases coverage in the small group market in a State that has elected to merge its individual and small group risk pools under section 1312(c) of the Affordable Care Act, the plan year will begin on the qualified employer's effective date of coverage, which might be any day during the year, and end on December 31 of the calendar year in which coverage first became effective.

We are not proposing any changes to the definition of “plan year” in this proposed rule. However, we note that whichever definition applies under §144.103, we interpret the term plan year to mean a period that is no longer than 12 months with respect to grandfathered and non-grandfathered group health plans. Plan years that exceed 12 months are inconsistent with the Affordable Care Act, including the rate review and single risk pool requirements, which both contemplate 12-month or shorter plan years. The Departments of Labor and the Treasury, which respectively have jurisdiction over parallel definitions in the Employee Retirement Income Security Act of 1974 (ERISA) and the Code, have advised HHS that they concur with this interpretation.

Also under §144.103, because of the original Affordable Care Act definitions, the term large employer currently is defined to mean, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of plan years beginning before January 1, 2016, a State may elect to define large employer by substituting “51 employees” for “101 employees.” The term small employer currently is defined to mean, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of plan years beginning before January 1, 2016, a State may elect to define small employer by substituting “50 employees” for “100 employees.” These regulatory definitions were consistent with section 1304(b) of the Affordable Care Act and section 2791(e) of the PHS Act.

However, both of those sections have recently been amended by the Protecting Affordable Coverage for Employees Act (Pub. L. 114-60). Therefore, we propose to revise the regulatory definitions of large employer and small employer in §144.103 to conform to this legislation. Specifically, we propose to revise the regulatory definition of large employer to mean, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year, but would provide that a State may elect to define large employer by substituting “101 employees” for “51 employees.” Conversely, we propose to revise the regulatory definition of small employer to mean, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year, but would provide that a State may elect to define small employer by substituting “100 employees” for “50 employees.” Consistent with section 1304(b) of the Affordable Care Act and section 2791(e) of the PHS Act, we also propose to codify statutory language providing that in the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a large employer or a small employer be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

Finally, we propose to correct a cross-reference in the definition of excepted benefits under §144.103, which should refer to the group market provisions in §146.145(b) as opposed to §146.145(c).

B. Part 146 – Requirements for the Group Health Insurance Market

1. Guaranteed Availability of Coverage for Employers in the Small Group Market
(§146.150)

Part 146 includes pre-Affordable Care Act HIPAA requirements on group health insurance issuers, including §146.150, which requires health insurance issuers in the small group market to guarantee the availability of coverage, with some specific exceptions. We propose to add paragraph (g) to §146.150, providing an exception to the guaranteed availability requirement when the exceptions to the guaranteed renewability requirement in §146.152(c) or (d) related to discontinuing a particular product or all coverage in a market apply. For a further discussion of this proposal, see the discussion of §147.104, “Guaranteed Availability of Coverage,” in this proposed rule at part 147, “Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets.”

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

1. Fair Health Insurance Premiums (§147.102)

Under section 2701 of the PHS Act and regulations at §147.102, the rating area for a small group plan is the group policyholder’s principal business address. We propose to amend §147.102(a)(1)(ii) to provide that if the employer has registered an in-State principal business address with the State, that location is the principal business address. We note that an in-State address registered solely for purposes of service of process would not be considered the employer’s principal business address, unless it is a substantial worksite for the employer’s business. If an in-State principal business address is not registered with the State or is only registered for purposes of service of process and is not a substantial worksite, the employer

would designate as its principal business address the business address within the State where the greatest number of employees work in the applicable State.

When a network plan offered in a State has a limited service area, the policy described above could result in an issuer having to make a plan available to an employer (because the employer has an employee who lives, works, or resides in the service area), but not be able to apply a geographic rating factor under the current rule, because the issuer might not have established rates applicable to the location of the employer's principal business address outside the plan's service area.

We propose to amend §147.102 to provide for an additional principal business address to be identified within a plan's service area so that the plan can be appropriately rated for sale to the employer. In such instances, the additional principal business address would be the business address within the plan's service area where the greatest number of employees work as of the beginning of the plan year, or, if there is no such business address, an address within the rating area selected by the employer that reasonably reflects where the greatest number of employees within the plan's service area live or reside as of the beginning of the plan year.

We note that SHOPS, including the Federally-facilitated Small Business Health Options Programs (FF-SHOPs), may use the address that was used to establish a qualified employer's eligibility for participation in the SHOP to determine the applicable geographic rating area when calculating premiums for participating employers. The SHOPS, including the FF-SHOPs, may not be able to accommodate multiple principal business addresses within a State for premium calculation purposes. As a result, when a single application is completed in a State, plan availability and premium calculations will be based on the principal business address entered on the FF-SHOP employer user interface.

Under §147.102(b), States have considerable flexibility in establishing rating areas. Rating areas must be based on counties, three-digit zip codes, or metropolitan statistical areas and non-metropolitan statistical areas, and generally will be presumed adequate if State-established rating areas are no greater in number than the number of metropolitan statistical areas in the State plus one. States may seek approval from CMS for a greater number of rating areas provided they are actuarially justified, are not unfairly discriminatory, reflect significant differences in health care unit costs, lead to stability in rates over time, and apply uniformly to all issuers in a market.

We have observed wide variations in the size of rating areas in the various States. We are concerned that, within States, this could lead to pockets of smaller rating areas with higher-risk groups, which potentially compromises the risk-spreading objective that the single risk pool requirement is intended to achieve. At the same time, States are the primary regulators of health insurance, and we believe it is important to recognize the unique needs of each State. We also recognize the consumer disruption that could result from changes to rating areas. Therefore, we seek comments on whether we should seek more uniformity in the size of rating areas or establish a minimum size for rating areas, and if so, how that should be achieved, consistent with the principle of flexibility for States. For example, to help ensure uniformity in rating areas, we could require that each rating area in a State be one geographically contiguous area, and that the relative population of each rating area not vary by more than a specified percentage. To help ensure that rating areas are sufficiently large, we could direct that each State have a maximum number of rating areas equal to the number of metropolitan statistical areas in the State, plus one. We also seek comment on how we could improve uniformity and sufficient size for risk pooling in a manner that would preserve flexibility to accommodate the unique needs of each State.

We also recognize the inconsistency that can occur between an issuer's rating area and the service area of some of its network-based plans. Under current §155.1055, the service area of a QHP must be established without regard to racial, ethnic, language, health status-related factors, or other factors that exclude specific high utilizing, high cost, or medically underserved populations. We believe it could be beneficial from an insurance market perspective for the rating area and the service area to generally be consistent, to provide that health insurance issuers offer a full array of products in larger geographic areas. We seek comment on whether and how to achieve this objective, including whether to achieve it through regulation, and if so, how our regulations should be revised for this purpose.

Section 147.102(e) provides for a uniform age curve in each State. When a State does not specify an age curve, a Federal default uniform age curve will apply. We are investigating the child age rating factor in the Federal uniform age curve, and seek to determine whether the default factor is appropriate, or fails to adequately differentiate the health risk of children of different ages. We seek comment and data on the most appropriate child age curve, and the policy reasons underlying any recommendation.

2. Guaranteed Availability of Coverage (§147.104)

a. Product Discontinuance and Market Withdrawal Exceptions to Guaranteed Availability

Section 147.104 includes several exceptions to the guaranteed availability requirement. We have been asked whether there is an exception to this requirement in the small group, large group, and individual markets when an issuer avails itself of the exception to the guaranteed renewability requirement in §147.106(c) (discontinuing a particular product), or in §147.106(d) (discontinuing all coverage). The exception to the guaranteed renewability requirement in §147.106(c) requires an issuer to provide notice in writing, in a form and manner specified by the

Secretary, to each plan sponsor or individual, as applicable, (and to all participants and beneficiaries covered under such coverage) of the discontinuation at least 90 calendar days before the date the coverage will be discontinued. The exception to the guaranteed renewability requirement in §147.106(d) requires an issuer to provide notice in writing to the applicable State authority and to each plan sponsor or individual, as applicable (and to all participants and beneficiaries covered under the coverage) of the discontinuation at least 180 calendar days prior to the date the coverage will be discontinued. We have been asked whether the guaranteed availability requirement requires health insurance issuers discontinuing a product, or all coverage, to guarantee the availability of coverage during these 90- and 180-day (or other applicable) time periods. We do not believe an issuer should be required to guarantee the availability of a product the issuer is in the process of discontinuing, while the issuer is attempting to wind down its operations for that product. Therefore, we propose to redesignate paragraphs (e) through (i) as (f) through (j), and add a new paragraph (e) to §147.104, providing for an exception to the guaranteed availability requirement when the exceptions to the guaranteed renewability requirement in §147.106(c) or (d) related to discontinuing a particular product, or the exception related to discontinuing all coverage in a market, apply. The exception would be effective for the duration of the notice periods discussed above. We acknowledge that the statute does not expressly contain such an exception to the guaranteed availability requirement. However, the statutory requirement under the guaranteed renewability provision requires issuers to provide at least 90-day or 180-day advance notice to enrollees prior to discontinuation of the coverage. If additional consumers continue to enroll after notice is given, the issuer would not be able to provide the required advance notice to these new enrollees before discontinuing coverage. Accordingly, we are interpreting the interaction between the guaranteed

availability and guaranteed renewability provisions to permit an issuer to deny enrollments during the applicable product discontinuance or market withdrawal notice period. However, we propose in paragraph (e)(3) that this exception does not relieve issuers of their obligations to existing policyholders, such as enrolling dependents under a special enrollment right during the 90-day or 180-day period.

We understand that some States may wish issuers to guarantee the availability of products until the end of the applicable notice period, and any such requirement would continue to apply.

We also propose a new paragraph (e)(2), under which an issuer that denies coverage under these provisions must apply the denial uniformly to all employers or individuals in the large group, small group, or individual market, as applicable, in the State consistent with applicable State law, and without regard to the claims experience or any health-status related factor relating to those individuals or employers and their employees (or their respective dependents).

We seek comment on these proposals.

b. Minimum Participation and Contribution Rules

Section 2702 of the PHS Act generally requires health insurance issuers in the group and individual markets to guarantee the availability of coverage. In the 2014 Market Rules final rule, we determined that small employers accordingly could not be denied coverage for failure to satisfy minimum participation or contribution requirements. In recognition of the potential for adverse selection, however, under our authority to define open enrollment periods at §147.104, we permitted health insurance issuers offering non-grandfathered plans in the small group market to limit the availability of coverage to small employers that do not meet an issuer's employer

contribution or group participation rules to an annual enrollment period of November 15 to December 15 of each year. We continue to recognize that the use of minimum participation or contribution rules to limit when coverage can be obtained can guard against adverse selection, in that some employers might wait to purchase insurance only when medical need arises. We also acknowledge the possibility that minimum contribution rules might promote employee take-up and help spread insurance risk across a broad and diverse pool of individuals. However, several features of the Affordable Care Act make participation and contribution rules less relevant, including the individual shared responsibility provisions, under which non-exempt individuals must maintain minimum essential coverage (such as might be available through a group health plan) or make an individual shared responsibility payment, and the employer shared responsibility provisions, under which applicable large employers (in general, employers with at least 50 full-time employees (including full-time equivalent employees)) must either offer coverage that is affordable and that provides minimum value to their full-time employees (and their dependents) or potentially make an assessable payment to the IRS.

Based on our experience since the finalization of the rule providing for the November 15 to December 15 enrollment window, we are concerned that the limitation of the enrollment window could result in some applicable large employers that intend to avoid an employer shared responsibility payment by offering coverage being unable to reasonably offer coverage, if a State were to expand the small group market to include employers with up to 100 employees.

In recognition of this dynamic, we note that a State electing to expand its small group market to include employers with up to 100 employees may opt, under its own authority, to prohibit a small group health insurance issuer from restricting the availability of small group coverage based on employer contribution or group participation rules. Alternatively, in cases

where a State expands the definition of a small employer to include up to 100 employees, we could amend the guaranteed availability regulations, with respect to small employers with 51-100 employees or with respect to all small employers altogether, to achieve this objective. We seek comment on such an approach.

3. Guaranteed Renewability of Coverage (§147.106)

The guaranteed renewability provisions of title XXVII of the PHS Act provide that an issuer may discontinue a product offered in the group or individual market if the issuer offers to each plan sponsor or individual who is enrolled in that particular product the option to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer in that market, and complies with other requirements of those sections, as well as with any applicable State law. Title XXVII of the PHS Act includes several exceptions to the guaranteed renewability provisions, including when a group health plan sponsor has violated a material plan provision relating to employer contribution or group participation rules, provided applicable State law allows an exception to guaranteed renewability under such circumstances; and for coverage made available in the individual market, or small or large group market only through one or more bona fide associations, if the individual's or employer's membership in the association ceases. Although the Affordable Care Act removed from title XXVII these exceptions as they applied to guaranteed availability, it did not do so with respect to guaranteed renewability. Therefore, a large employer whose coverage is non-renewed for one of these reasons, and a small employer whose coverage is non-renewed due to membership ceasing in an association, could be seen to have a right to immediately purchase that same coverage (if available in the market) from that same issuer in accordance with guaranteed availability. This renders effectively meaningless these two exceptions to guaranteed

renewability in these contexts. To address this potential ambiguity regarding the interplay between guaranteed renewability and guaranteed availability, we propose to remove these guaranteed renewability exceptions from the regulations at §147.106. We seek comment on other ways in which this ambiguity could be addressed.

4. Student Health Insurance Coverage (§147.145)

a. Index Rate Setting Methodology for Student Health Insurance Coverage

Under 45 CFR 147.145, student health insurance coverage is a type of individual health insurance coverage that, subject to limited exceptions, must comply with the PHS Act requirements that apply to individual health insurance coverage. However, section 1560(c) of the Affordable Care Act provides that nothing in title I of the Affordable Care Act (or an amendment made by title I) is to be construed to prohibit an institution of higher education from offering a student health insurance plan to the extent that the requirement is otherwise permitted under applicable Federal, State, or local law. HHS has exercised its authority under section 1560(c) to modify some of its rules as applied to student health insurance coverage, including those related to the guaranteed availability, guaranteed renewability, and single risk pool requirements.

Our intent in exempting student health insurance coverage from the single risk pool requirement was to provide that student health insurance issuers need not include their student health insurance coverage in their overall individual market (or merged market) risk pool, and also need not have one single risk pool composed of their total statewide book of student health insurance business. Rather, we intended that issuers could establish separate risk pools from their individual health insurance market single risk pool (or merged market risk pool, where applicable) for student health insurance coverage, including by establishing separate risk pools

for different institutions of higher education, or multiple risk pools within a single institution, provided the risk pools were based on a bona fide school-related classification (for example, graduate students and undergraduate students) and not a health status-related factor as described in §146.121. However, we have learned that student health insurance issuers may be using certain rating factors that would be prohibited under the single risk pool regulation in §156.80(d) to establish rates for institutions of higher education, on the basis that student health insurance coverage has been exempted from those single risk pool index rating requirements under our regulations. Examples of such rating factors include the percentage of students enrolled in the coverage, or the length of time the college or university has had coverage through the issuer. Section 156.80(d) requires a health insurance issuer to base its index rate only on the total combined claims costs for providing EHB (subject to certain adjustments).

We do not intend to disrupt rate setting for student health insurance, but we do seek to ensure that rates are based on actuarially justified factors. To clarify our intent, we propose, for plan years beginning on or after January 1, 2017, that student health insurance coverage be subject to the index rate setting methodology of the single risk pool provision in the regulation at §156.80(d). However, student health insurance issuers still would be permitted to establish separate risk pools from their individual health insurance market single risk pool (or merged market risk pool, where applicable) for student health insurance coverage, including by establishing separate risk pools for different institutions of higher education, or multiple risk pools within a single institution, provided they are based on a bona fide school-related classification (for example, graduate students and undergraduate students) and not a health status-related factor as described in §146.121. Consistent with our single risk pool policy, the index rates for these risk pools would be based upon actuarially justified estimates of claims.

Permissible plan-level adjustments to these index rates would be limited to those permitted under our rules. This approach would continue to allow rates for student health insurance coverage to reflect the unique characteristics of the student population at the particular institution, while more clearly delineating our intent with regard to the treatment of student health insurance coverage. We seek comment on any potential operational challenges associated with this proposal, including potential challenges related to filing rates for student health insurance coverage and how this policy might be adjusted to address those challenges.

b. Actuarial Value Requirements for Student Health Insurance Plans

Many colleges and universities have reported to us that they offer student health insurance plans that are rich in benefits (for example, providing an actuarial value of 96 percent) and that they are reluctant to reduce the level of benefits to meet an actuarial value metal level. Because enrollees in student health insurance plans are not typically selecting among such plans, there is less need for standardization of actuarial levels in this part of the individual market. Therefore, we propose to add an exemption to the requirements for student health insurance coverage in §147.145, under which, for plan years beginning on or after January 1, 2017, student health insurance coverage would be exempt from the actuarial value requirements under section 1302(d) of the Affordable Care Act, as implemented in §§156.135 and 156.140, but would be required to provide an actuarial value of at least 60 percent. To determine a plan's actuarial value for purposes of the application of the 60 percent actuarial value requirement to student health insurance coverage, we propose to require student health insurance coverage issuers to obtain certification by an actuary that the plan provides an actuarial value of at least 60 percent. This determination would be required to be made by a member of the American Academy of

Actuaries, based on analysis in accordance with generally accepted actuarial principles and methodologies.

We considered making modifications to the AV Calculator for the purposes of determining the actuarial value for student health insurance plans. However, the standard population in the AV Calculator is more diverse than the expected population in student health insurance plans, such that the AV Calculator's calculations might be less accurate. That said, we solicit comments on whether the AV Calculator should be used for this purpose.

We also solicit comments on whether to require student health insurance issuers to specify, in their SBCs, summary plan descriptions, enrollment materials, marketing materials, or other materials, the actuarial value of the coverage, the next lowest metal level the coverage would otherwise satisfy, based on its actuarial value, or any other data that would give enrollees and prospective enrollees information about the actuarial value of the coverage.

D. Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the Affordable Care Act

1. Sequestration

In accordance with the OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2016,⁸ both the transitional reinsurance program and permanent risk adjustment program are subject to the fiscal year 2016 sequestration. The Federal government's 2016 fiscal year began on October 1, 2015. The reinsurance program will be sequestered at a rate of 6.8 percent for payments made from fiscal year 2016 resources (that is, funds collected during the

⁸ Available at available at:

https://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/sequestration/2016_jc_sequestration_report_speaker.pdf

2016 fiscal year). To meet the sequestration requirement for the risk adjustment program for fiscal year 2016, HHS will sequester risk adjustment payments made using fiscal year 2016 resources in all States where HHS operates risk adjustment at a sequestration rate of 7.0 percent. HHS estimates that increasing the sequestration rate for all risk adjustment payments made in fiscal year 2016 to all issuers in the States where HHS operates risk adjustment by 0.2 percent will permit HHS to meet the required national risk adjustment program sequestration percentage of 6.8 percent noted in the OMB Report to Congress.

HHS, in coordination with the OMB, has determined that, under section 256(k)(6) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, and the underlying authority for these programs, the funds that are sequestered in fiscal year 2016 from the reinsurance and risk adjustment programs will become available for payment to issuers in fiscal year 2017 without further Congressional action. If the Congress does not enact deficit reduction provisions that replace the Joint Committee reductions, these programs would be sequestered in future fiscal years, and any sequestered funding would become available in the fiscal year following that in which it was sequestered.

2. Provisions and Parameters for the Permanent Risk Adjustment Program

In subparts D and G of 45 CFR part 153, we established standards for the administration of the risk adjustment program. The risk adjustment program is a permanent program created by section 1343 of the Affordable Care Act that transfers funds from lower risk, non-grandfathered plans to higher risk, non-grandfathered plans in the individual and small group markets, inside and outside the Exchanges. In accordance with §153.310(a), a State that is approved or conditionally approved by the Secretary to operate an Exchange may establish a risk adjustment program, or have HHS do so on its behalf.

a. Overview of the HHS Risk Adjustment Model (§153.320)

The HHS risk adjustment model predicts plan liability for an average enrollee based on that person's age, sex, and diagnoses (risk factors), producing a risk score. The HHS risk adjustment methodology utilizes separate models for adults, children, and infants to account for cost differences in each of these age groups. In each of the adult and child models, the relative costs assigned to an individual's age, sex, and diagnoses are added together to produce a risk score. Infant risk scores are determined by inclusion in one of 25 mutually exclusive groups, based on the infant's maturity and the severity of its diagnoses. If applicable, the risk score is multiplied by a cost-sharing reduction adjustment.

The enrollment-weighted average risk score of all enrollees in a particular risk adjustment-covered plan, or 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, the HHS risk adjustment model predicts average group costs to account for risk across plans, which, as we stated in the 2014 Payment Notice, accords with the Actuarial Standards Board's Actuarial Standards of Practice for risk classification.

b. Proposed Updates to the Risk Adjustment Model (§153.320)

We propose to continue to use the same risk adjustment methodology finalized in the 2014 Payment Notice. We propose to make certain updates to the risk adjustment model to incorporate preventive services into our simulation of plan liability, and to reflect more current data. The proposed data updates are similar to the ones we effectuated for 2016 risk adjustment in the 2016 Payment Notice. We propose to recalculate the weights assigned to the various hierarchical condition categories (HCCs) and demographic factors in our risk adjustment models

using the most recent data available. As we previously described, in the adult and child models, enrollee health risks are estimated using the HHS risk adjustment model, which assigns a set of additive factors that reflect the relative costs attributable to demographics and diagnoses. Risk adjustment factors are developed using claims data and reflect the costs of a given disease relative to average spending. The longer the lag in data used to develop the risk factors, the greater the potential that the costs of treating one disease versus another have changed in a manner not fully reflected in the risk factors.

To provide risk adjustment factors that best reflect more recent treatment patterns and costs, we propose to recalibrate the HHS risk adjustment models for 2017 by using more recent claims data to develop updated risk factors. The risk factors published in the 2016 Payment Notice for use in 2016 were developed using the Truven Health Analytics 2011, 2012 and 2013 MarketScan® Commercial Claims and Encounters database (MarketScan); we are proposing to update the risk factors in the HHS risk adjustment model using 2012, 2013, and 2014 MarketScan data. We would publish and finalize the updated factors in the final rule. We seek comment on this proposal.

We are proposing to incorporate preventive services into our simulation of plan liability in the recalibration of the risk adjustment models for 2017. We identified preventive services for the 2012 and 2013 MarketScan samples using procedure and diagnosis codes, prescription drug therapeutic classes, and enrollee age and sex. We relied on lists of preventive services from several major issuers, the preventive services used for the AV Calculator, and Medicare's preventive services benefit to operationalize preventive services definitions for incorporation in the risk adjustment models. We then adjusted plan liability by adding 100 percent of preventive services covered charges to simulate plan liability for all metal levels. We also applied standard

benefit cost sharing rules by metal level to covered charges for non-preventive services. Total adjusted simulated plan liability is the sum of preventive services covered charges, and non-preventive services simulated plan liability.

We re-estimated the risk adjustment models by metal level, predicting plan liability adjusted to account for preventive services without cost sharing. We compared the model coefficients predicting original (that is, non-adjusted for preventive services) and adjusted simulated plan liability. Adjusting for preventive services increases age-sex coefficients relative to HCC coefficients, especially in the higher cost-sharing metal tiers (bronze and silver), and in age/sex ranges with high preventive services expenditures (for example, young adult females). The implication of the changes to the model coefficients is that the risk scores of healthy enrollees (whose risk scores are based solely on model age-sex coefficients) will likely rise relative to the risk scores of the less healthy (whose risk scores include one or more HCC coefficients in addition to an age-sex coefficient), especially in bronze and silver plans. As a result of the risk score changes for individuals, we expect that the incorporation of preventive services would increase the risk scores of bronze and silver plans with healthier enrollees relative to other plans' risk scores when preventive services are taken into account. This incorporation of preventive services will more accurately compensate risk adjustment covered plans with enrollees who use preventive services. We seek comment on this approach.

Additionally, we are evaluating how we may incorporate prescription drug data in the Federally certified risk adjustment methodology that HHS uses when it operates risk adjustment. Prescription drug data could be used in the risk adjustment methodology to supplement diagnostic data by using the prescription drug data as a severity indicator, or as a proxy for diagnoses in cases where diagnostic data are likely to be incomplete. We are

assessing these approaches, with particular sensitivity to reliability and the potential for strategic behavior with respect to prescribing behavior. As we noted in the 2014 Payment Notice, we did not include prescription drugs to predict expenditures to avoid creating adverse incentives to modify discretionary prescribing. We are evaluating whether we can improve the models' predictive power through the incorporation of prescription drugs without unduly incentivizing altered prescribing behavior. We seek comment and any data that may inform effective methods of incorporating prescription drug data in future recalibrations.

Similarly, we believe we could more accurately account for high-cost conditions with new treatments that are not reflected in our model due to lags in the data available to us for recalibration. We believe that stability across our models is important, but seek comment and data that may inform better methods of accurately compensating for new treatments for high cost conditions. For example, we seek comment on whether there are ways to model the severity of these conditions in a manner that will more fully capture the highest cost enrollees.

Lastly, we would like to explore the effect of partial year enrollment in the HHS risk adjustment methodology. We have received input that issuers are experiencing higher than expected claims costs for partial-year enrollees. We have also received input that the methodology does not capture enrollees with chronic conditions who may not have accumulated diagnoses in their partial year enrollment. At the same time, as compared to full year enrollees of the same relative risk, partial year enrollees are less likely to have spending that exceeds the deductible or annual limitation on cost sharing. We seek comment and data on how the methodology could be made more predictive for partial year enrollees.

c. List of factors to be employed in the model (§153.320)

The HHS risk adjustment models predict annualized plan liability expenditures using age and sex categories and the HHS HCCs included in the HHS risk adjustment model. Dollar coefficients were estimated for these factors using weighted least squares regression, where the weight was the fraction of the year enrolled.

We are including the same HCCs that were included in the original risk adjustment calibration in the 2014 Payment Notice. For each model, the factors are the statistical regression dollar values for each HCC in the model divided by a weighted average plan liability for the full modeling sample. The factors represent the predicted relative incremental expenditures for each HCC. The proposed factors resulting from the blended factors from the 2012 and 2013 separately solved models (with the incorporation of preventive services) are shown in the tables below. For a given enrollee, the sums of the factors for the enrollee's HCCs are the total relative predicted expenditures for that enrollee. Table 1 contains factors for each adult model, including the interactions. Table 2 contains the HHS HCCs in the severity illness indicator variable. Table 3 contains the factors for each child model. Table 4 contains the factors for each infant model.

TABLE 1: Adult Risk Adjustment Model Factors

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
<i>Demographic Factors</i>					
Age 21-24, Male	0.242	0.183	0.117	0.077	0.076
Age 25-29, Male	0.249	0.186	0.117	0.074	0.073
Age 30-34, Male	0.296	0.220	0.135	0.082	0.080
Age 35-39, Male	0.356	0.268	0.170	0.104	0.103
Age 40-44, Male	0.435	0.335	0.221	0.143	0.142
Age 45-49, Male	0.518	0.405	0.277	0.188	0.186
Age 50-54, Male	0.662	0.531	0.380	0.274	0.272
Age 55-59, Male	0.755	0.607	0.439	0.318	0.316
Age 60-64, Male	0.907	0.733	0.538	0.395	0.392
Age 21-24, Female	0.404	0.315	0.211	0.144	0.143
Age 25-29, Female	0.491	0.383	0.262	0.181	0.180
Age 30-34, Female	0.613	0.488	0.350	0.259	0.257

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Age 35-39, Female	0.704	0.570	0.423	0.327	0.325
Age 40-44, Female	0.785	0.638	0.477	0.369	0.367
Age 45-49, Female	0.802	0.649	0.480	0.364	0.362
Age 50-54, Female	0.905	0.739	0.554	0.421	0.419
Age 55-59, Female	0.921	0.748	0.554	0.412	0.409
Age 60-64, Female	1.003	0.814	0.601	0.445	0.442
<i>Diagnosis Factors</i>					
HIV/AIDS	5.924	5.438	5.099	5.113	5.114
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	11.809	11.632	11.526	11.587	11.589
Central Nervous System Infections, Except Viral Meningitis	7.068	6.960	6.891	6.914	6.914
Viral or Unspecified Meningitis	4.995	4.743	4.574	4.530	4.530
Opportunistic Infections	9.345	9.238	9.168	9.156	9.156
Metastatic Cancer	24.911	24.456	24.139	24.207	24.209
Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	11.344	10.991	10.744	10.751	10.752
Non-Hodgkin`s Lymphomas and Other Cancers and Tumors	6.079	5.829	5.643	5.597	5.596
Colorectal, Breast (Age < 50), Kidney, and Other Cancers	5.522	5.272	5.082	5.034	5.034
Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	3.188	3.005	2.861	2.807	2.806

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.556	1.392	1.248	1.153	1.152
Pancreas Transplant Status/Complications	5.898	5.665	5.517	5.542	5.543
Diabetes with Acute Complications	1.261	1.113	0.984	0.875	0.873
Diabetes with Chronic Complications	1.261	1.113	0.984	0.875	0.873
Diabetes without Complication	1.261	1.113	0.984	0.875	0.873
Protein-Calorie Malnutrition	14.543	14.553	14.565	14.629	14.630
Mucopolysaccharidos is	2.246	2.121	2.018	1.963	1.962
Lipidoses and Glycogenosis	2.246	2.121	2.018	1.963	1.962
Amyloidosis, Porphyria, and Other Metabolic Disorders	2.246	2.121	2.018	1.963	1.962
Adrenal, Pituitary, and Other Significant Endocrine Disorders	2.246	2.121	2.018	1.963	1.962
Liver Transplant Status/Complications	15.618	15.437	15.325	15.338	15.339
End-Stage Liver Disease	5.957	5.705	5.543	5.560	5.561
Cirrhosis of Liver	2.417	2.245	2.128	2.094	2.093
Chronic Hepatitis	2.212	2.059	1.942	1.881	1.880
Acute Liver Failure/Disease, Including Neonatal Hepatitis	4.584	4.410	4.290	4.284	4.284
Intestine Transplant Status/Complications	35.083	35.028	34.981	35.010	35.009
Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	12.704	12.429	12.241	12.279	12.279
Intestinal Obstruction	6.960	6.679	6.497	6.526	6.527
Chronic Pancreatitis	5.898	5.665	5.517	5.542	5.543

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption	2.929	2.728	2.583	2.538	2.537
Inflammatory Bowel Disease	3.154	2.884	2.680	2.572	2.571
Necrotizing Fasciitis	7.009	6.797	6.650	6.671	6.671
Bone/Joint/Muscle Infections/Necrosis	7.009	6.797	6.650	6.671	6.671
Rheumatoid Arthritis and Specified Autoimmune Disorders	3.718	3.455	3.263	3.242	3.242
Systemic Lupus Erythematosus and Other Autoimmune Disorders	1.235	1.092	0.968	0.880	0.879
Osteogenesis Imperfecta and Other Osteodystrophies	3.474	3.263	3.094	3.035	3.034
Congenital/Developmental Skeletal and Connective Tissue Disorders	3.474	3.263	3.094	3.035	3.034
Cleft Lip/Cleft Palate	1.507	1.336	1.200	1.130	1.130
Hemophilia	42.711	42.402	42.168	42.178	42.179
Myelodysplastic Syndromes and Myelofibrosis	12.218	12.073	11.973	11.984	11.985
Aplastic Anemia	12.218	12.073	11.973	11.984	11.985
Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	9.749	9.576	9.446	9.441	9.441
Sickle Cell Anemia (Hb-SS)	9.749	9.576	9.446	9.441	9.441
Thalassemia Major	9.749	9.576	9.446	9.441	9.441
Combined and Other Severe Immunodeficiencies	5.252	5.095	4.985	4.991	4.992
Disorders of the Immune Mechanism	5.252	5.095	4.985	4.991	4.992

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Coagulation Defects and Other Specified Hematological Disorders	2.989	2.884	2.801	2.774	2.773
Drug Psychosis	3.809	3.542	3.340	3.241	3.240
Drug Dependence	3.809	3.542	3.340	3.241	3.240
Schizophrenia	3.100	2.840	2.647	2.568	2.567
Major Depressive and Bipolar Disorders	1.777	1.601	1.450	1.346	1.344
Reactive and Unspecified Psychosis, Delusional Disorders	1.777	1.601	1.450	1.346	1.344
Personality Disorders	1.188	1.050	0.913	0.805	0.803
Anorexia/Bulimia Nervosa	2.786	2.612	2.469	2.406	2.405
Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	2.824	2.684	2.579	2.531	2.531
Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	1.042	0.933	0.828	0.752	0.751
Autistic Disorder	1.188	1.050	0.913	0.805	0.803
Pervasive Developmental Disorders, Except Autistic Disorder	1.188	1.050	0.913	0.805	0.803
Traumatic Complete Lesion Cervical Spinal Cord	13.957	13.787	13.663	13.665	13.666
Quadriplegia	13.957	13.787	13.663	13.665	13.666
Traumatic Complete Lesion Dorsal Spinal Cord	10.170	10.005	9.884	9.875	9.875
Paraplegia	10.170	10.005	9.884	9.875	9.875
Spinal Cord Disorders/Injuries	6.086	5.864	5.707	5.679	5.679

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	3.246	2.997	2.827	2.787	2.788
Quadriplegic Cerebral Palsy	1.400	1.183	1.020	0.960	0.959
Cerebral Palsy, Except Quadriplegic	0.000	0.000	0.000	0.000	0.000
Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	0.126	0.033	0.000	0.000	0.000
Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	5.285	5.129	5.018	4.995	4.995
Muscular Dystrophy	2.211	2.034	1.907	1.835	1.834
Multiple Sclerosis	9.367	8.954	8.667	8.708	8.710
Parkinson`s, Huntington`s, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	2.211	2.034	1.907	1.835	1.834
Seizure Disorders and Convulsions	1.485	1.319	1.184	1.109	1.108
Hydrocephalus	7.352	7.229	7.123	7.098	7.097
Non-Traumatic Coma, and Brain Compression/Anoxic Damage	9.834	9.691	9.579	9.574	9.574
Respirator Dependence/Tracheostomy Status	37.369	37.364	37.365	37.433	37.434
Respiratory Arrest	11.456	11.296	11.192	11.262	11.264
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	11.456	11.296	11.192	11.262	11.264

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Heart Assistive Device/Artificial Heart	35.695	35.429	35.257	35.324	35.325
Heart Transplant	35.695	35.429	35.257	35.324	35.325
Congestive Heart Failure	3.387	3.271	3.190	3.186	3.186
Acute Myocardial Infarction	10.835	10.482	10.255	10.380	10.382
Unstable Angina and Other Acute Ischemic Heart Disease	5.666	5.370	5.186	5.209	5.210
Heart Infection/Inflammation, Except Rheumatic	6.510	6.365	6.260	6.240	6.239
Specified Heart Arrhythmias	3.099	2.940	2.818	2.765	2.764
Intracranial Hemorrhage	10.244	9.944	9.743	9.761	9.761
Ischemic or Unspecified Stroke	3.640	3.440	3.319	3.331	3.332
Cerebral Aneurysm and Arteriovenous Malformation	4.354	4.138	3.986	3.947	3.946
Hemiplegia/Hemiparesis	6.079	5.979	5.919	5.967	5.967
Monoplegia, Other Paralytic Syndromes	3.944	3.803	3.705	3.688	3.688
Atherosclerosis of the Extremities with Ulceration or Gangrene	11.784	11.679	11.619	11.694	11.695
Vascular Disease with Complications	8.222	8.025	7.892	7.898	7.898
Pulmonary Embolism and Deep Vein Thrombosis	4.155	3.978	3.852	3.829	3.829
Lung Transplant Status/Complications	35.331	35.127	34.994	35.078	35.080
Cystic Fibrosis	12.237	11.906	11.656	11.667	11.667
Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	1.009	0.883	0.768	0.687	0.686
Asthma	1.009	0.883	0.768	0.687	0.686

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Fibrosis of Lung and Other Lung Disorders	2.091	1.961	1.867	1.828	1.827
Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	8.033	7.949	7.895	7.913	7.914
Kidney Transplant Status	10.464	10.180	9.997	9.991	9.991
End Stage Renal Disease	40.683	40.431	40.270	40.401	40.403
Chronic Kidney Disease, Stage 5	2.212	2.102	2.031	2.026	2.026
Chronic Kidney Disease, Severe (Stage 4)	2.212	2.102	2.031	2.026	2.026
Ectopic and Molar Pregnancy, Except with Renal Failure, Shock, or Embolism	1.372	1.177	0.993	0.798	0.794
Miscarriage with Complications	1.372	1.177	0.993	0.798	0.794
Miscarriage with No or Minor Complications	1.372	1.177	0.993	0.798	0.794
Completed Pregnancy With Major Complications	3.837	3.331	3.033	2.879	2.880
Completed Pregnancy With Complications	3.837	3.331	3.033	2.879	2.880
Completed Pregnancy with No or Minor Complications	3.837	3.331	3.033	2.879	2.880
Chronic Ulcer of Skin, Except Pressure	2.399	2.270	2.183	2.168	2.168
Hip Fractures and Pathological Vertebral or Humerus Fractures	9.757	9.532	9.381	9.425	9.426
Pathological Fractures, Except of Vertebrae, Hip, or Humerus	1.951	1.817	1.700	1.626	1.624

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Stem Cell, Including Bone Marrow, Transplant Status/Complications	32.229	32.225	32.223	32.243	32.243
Artificial Openings for Feeding or Elimination	10.912	10.812	10.748	10.791	10.792
Amputation Status, Lower Limb/Amputation Complications	6.029	5.865	5.760	5.790	5.791
<i>Interaction Factors</i>					
Severe illness x Opportunistic Infections	11.440	11.678	11.854	11.949	11.950
Severe illness x Metastatic Cancer	11.440	11.678	11.854	11.949	11.950
Severe illness x Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	11.440	11.678	11.854	11.949	11.950
Severe illness x Non-Hodgkin's Lymphomas and Other Cancers and Tumors	11.440	11.678	11.854	11.949	11.950
Severe illness x Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	11.440	11.678	11.854	11.949	11.950
Severe illness x Heart Infection/Inflammation, Except Rheumatic	11.440	11.678	11.854	11.949	11.950
Severe illness x Intracranial Hemorrhage	11.440	11.678	11.854	11.949	11.950

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Severe illness x HCC group G06 (G06 is HCC Group 6 which includes the following HCCs in the blood disease category: 67, 68)	11.440	11.678	11.854	11.949	11.950
Severe illness x HCC group G08 (G08 is HCC Group 8 which includes the following HCCs in the blood disease category: 73, 74)	11.440	11.678	11.854	11.949	11.950
Severe illness x End-Stage Liver Disease	2.193	2.336	2.443	2.529	2.530
Severe illness x Acute Liver Failure/Disease, Including Neonatal Hepatitis	2.193	2.336	2.443	2.529	2.530
Severe illness x Atherosclerosis of the Extremities with Ulceration or Gangrene	2.193	2.336	2.443	2.529	2.530
Severe illness x Vascular Disease with Complications	2.193	2.336	2.443	2.529	2.530
Severe illness x Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	2.193	2.336	2.443	2.529	2.530
Severe illness x Artificial Openings for Feeding or Elimination	2.193	2.336	2.443	2.529	2.530

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Severe illness x HCC group G03 (G03 is HCC Group 3 which includes the following HCCs in the musculoskeletal disease category: 54, 55)	2.193	2.336	2.443	2.529	2.530

TABLE 2: HHS HCCs in the Severity Illness Indicator Variable

Description
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
Peritonitis/Gastrointestinal Perforation/Necrotizing Enter colitis
Seizure Disorders and Convulsions
Non-Traumatic Coma, Brain Compression/Anoxic Damage
Respirator Dependence/Tracheostomy Status
Respiratory Arrest
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes
Pulmonary Embolism and Deep Vein Thrombosis

TABLE 3: Child Risk Adjustment Model Factors

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
<i>Demographic Factors</i>					
Age 2-4, Male	0.251	0.167	0.082	0.032	0.031
Age 5-9, Male	0.176	0.113	0.048	0.012	0.011
Age 10-14, Male	0.224	0.158	0.084	0.045	0.044
Age 15-20, Male	0.290	0.216	0.134	0.084	0.083
Age 2-4, Female	0.205	0.131	0.061	0.024	0.024
Age 5-9, Female	0.140	0.086	0.033	0.006	0.005
Age 10-14, Female	0.210	0.148	0.083	0.050	0.050
Age 15-20, Female	0.348	0.262	0.165	0.105	0.104
<i>Diagnosis Factors</i>					
HIV/AIDS	3.608	3.174	2.855	2.743	2.742
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	18.093	17.932	17.830	17.855	17.856

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Central Nervous System Infections, Except Viral Meningitis	12.330	12.136	11.998	12.005	12.005
Viral or Unspecified Meningitis	3.826	3.606	3.444	3.341	3.340
Opportunistic Infections	23.638	23.563	23.513	23.505	23.505
Metastatic Cancer	38.499	38.239	38.029	38.030	38.030
Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	13.275	12.966	12.718	12.660	12.660
Non-Hodgkin`s Lymphomas and Other Cancers and Tumors	9.665	9.384	9.151	9.061	9.060
Colorectal, Breast (Age < 50), Kidney, and Other Cancers	3.995	3.755	3.539	3.419	3.417
Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	3.123	2.910	2.725	2.614	2.612
Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.892	1.713	1.548	1.438	1.436
Pancreas Transplant Status/Complications	33.115	32.960	32.863	32.876	32.877
Diabetes with Acute Complications	2.630	2.290	2.028	1.773	1.770
Diabetes with Chronic Complications	2.630	2.290	2.028	1.773	1.770
Diabetes without Complication	2.630	2.290	2.028	1.773	1.770
Protein-Calorie Malnutrition	14.811	14.720	14.655	14.683	14.683
Mucopolysaccharidosis	6.419	6.134	5.907	5.866	5.865
Lipidoses and Glycogenosis	6.419	6.134	5.907	5.866	5.865
Congenital Metabolic Disorders, Not Elsewhere Classified	6.419	6.134	5.907	5.866	5.865

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Amyloidosis, Porphyria, and Other Metabolic Disorders	6.419	6.134	5.907	5.866	5.865
Adrenal, Pituitary, and Other Significant Endocrine Disorders	6.419	6.134	5.907	5.866	5.865
Liver Transplant Status/Complications	33.115	32.960	32.863	32.876	32.877
End-Stage Liver Disease	13.699	13.535	13.419	13.421	13.422
Cirrhosis of Liver	12.715	12.528	12.391	12.343	12.344
Chronic Hepatitis	1.566	1.405	1.257	1.186	1.185
Acute Liver Failure/Disease, Including Neonatal Hepatitis	13.286	13.119	12.987	12.966	12.967
Intestine Transplant Status/Complications	33.115	32.960	32.863	32.876	32.877
Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	16.433	16.077	15.815	15.844	15.845
Intestinal Obstruction	6.156	5.905	5.705	5.620	5.619
Chronic Pancreatitis	9.291	9.008	8.815	8.801	8.800
Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption	2.803	2.658	2.528	2.436	2.435
Inflammatory Bowel Disease	5.919	5.531	5.229	5.120	5.118
Necrotizing Fasciitis	5.073	4.814	4.608	4.555	4.554
Bone/Joint/Muscle Infections/Necrosis	5.073	4.814	4.608	4.555	4.554
Rheumatoid Arthritis and Specified Autoimmune Disorders	3.361	3.116	2.901	2.803	2.801
Systemic Lupus Erythematosus and Other Autoimmune Disorders	1.226	1.061	0.899	0.778	0.776
Osteogenesis Imperfecta and Other Osteodystrophies	1.704	1.565	1.432	1.357	1.356
Congenital/Developmental Skeletal and Connective Tissue Disorders	1.704	1.565	1.432	1.357	1.356
Cleft Lip/Cleft Palate	1.660	1.433	1.242	1.127	1.125
Hemophilia	56.279	55.780	55.399	55.383	55.384

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Myelodysplastic Syndromes and Myelofibrosis	17.181	17.007	16.867	16.847	16.847
Aplastic Anemia	17.181	17.007	16.867	16.847	16.847
Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	7.999	7.705	7.476	7.409	7.407
Sickle Cell Anemia (Hb-SS)	7.999	7.705	7.476	7.409	7.407
Thalassemia Major	7.999	7.705	7.476	7.409	7.407
Combined and Other Severe Immunodeficiencies	6.480	6.287	6.134	6.076	6.075
Disorders of the Immune Mechanism	6.480	6.287	6.134	6.076	6.075
Coagulation Defects and Other Specified Hematological Disorders	5.201	5.051	4.911	4.837	4.835
Drug Psychosis	5.249	4.979	4.782	4.717	4.717
Drug Dependence	5.249	4.979	4.782	4.717	4.717
Schizophrenia	5.328	4.926	4.626	4.528	4.527
Major Depressive and Bipolar Disorders	1.935	1.707	1.495	1.332	1.329
Reactive and Unspecified Psychosis, Delusional Disorders	1.935	1.707	1.495	1.332	1.329
Personality Disorders	0.781	0.645	0.486	0.344	0.341
Anorexia/Bulimia Nervosa	2.818	2.603	2.423	2.357	2.356
Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	3.727	3.503	3.351	3.317	3.317
Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	1.555	1.360	1.203	1.114	1.113
Autistic Disorder	1.867	1.660	1.462	1.308	1.305
Pervasive Developmental Disorders, Except Autistic Disorder	0.923	0.772	0.592	0.421	0.418
Traumatic Complete Lesion Cervical Spinal Cord	13.459	13.418	13.402	13.481	13.482
Quadriplegia	13.459	13.418	13.402	13.481	13.482

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Traumatic Complete Lesion Dorsal Spinal Cord	11.430	11.214	11.066	11.066	11.066
Paraplegia	11.430	11.214	11.066	11.066	11.066
Spinal Cord Disorders/Injuries	5.506	5.254	5.060	4.983	4.982
Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	8.929	8.672	8.473	8.435	8.435
Quadriplegic Cerebral Palsy	4.067	3.800	3.630	3.648	3.648
Cerebral Palsy, Except Quadriplegic	0.974	0.772	0.616	0.531	0.530
Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	1.210	1.053	0.917	0.845	0.843
Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	9.746	9.558	9.412	9.372	9.372
Muscular Dystrophy	3.762	3.552	3.387	3.308	3.307
Multiple Sclerosis	6.689	6.337	6.076	6.037	6.037
Parkinson`s, Huntington`s, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	3.762	3.552	3.387	3.308	3.307
Seizure Disorders and Convulsions	2.136	1.942	1.755	1.619	1.617
Hydrocephalus	6.047	5.916	5.820	5.814	5.814
Non-Traumatic Coma, and Brain Compression/Anoxic Damage	8.776	8.612	8.487	8.448	8.447
Respirator Dependence/Tracheostomy Status	42.997	42.897	42.854	42.982	42.984
Respiratory Arrest	13.335	13.131	12.994	12.998	12.998

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	13.335	13.131	12.994	12.998	12.998
Heart Assistive Device/Artificial Heart	33.115	32.960	32.863	32.876	32.877
Heart Transplant	33.115	32.960	32.863	32.876	32.877
Congestive Heart Failure	7.307	7.189	7.087	7.047	7.046
Acute Myocardial Infarction	11.965	11.749	11.601	11.612	11.613
Unstable Angina and Other Acute Ischemic Heart Disease	6.781	6.652	6.566	6.583	6.584
Heart Infection/Inflammation, Except Rheumatic	16.783	16.643	16.539	16.519	16.519
Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders	6.142	5.922	5.704	5.578	5.575
Major Congenital Heart/Circulatory Disorders	1.945	1.808	1.640	1.529	1.527
Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders	1.370	1.252	1.106	1.021	1.019
Specified Heart Arrhythmias	4.748	4.549	4.375	4.309	4.308
Intracranial Hemorrhage	17.965	17.699	17.514	17.509	17.510
Ischemic or Unspecified Stroke	8.807	8.679	8.600	8.623	8.624
Cerebral Aneurysm and Arteriovenous Malformation	4.116	3.893	3.725	3.664	3.663
Hemiplegia/Hemiparesis	5.352	5.230	5.146	5.127	5.127
Monoplegia, Other Paralytic Syndromes	3.500	3.334	3.220	3.178	3.178
Atherosclerosis of the Extremities with Ulceration or Gangrene	15.636	15.350	15.141	15.046	15.045

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Vascular Disease with Complications	18.385	18.204	18.079	18.077	18.077
Pulmonary Embolism and Deep Vein Thrombosis	15.215	15.029	14.908	14.927	14.928
Lung Transplant Status/Complications	33.115	32.960	32.863	32.876	32.877
Cystic Fibrosis	14.859	14.403	14.062	14.084	14.084
Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	0.484	0.390	0.262	0.170	0.169
Asthma	0.484	0.390	0.262	0.170	0.169
Fibrosis of Lung and Other Lung Disorders	3.395	3.241	3.101	3.038	3.037
Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	9.223	9.149	9.092	9.104	9.104
Kidney Transplant Status	14.429	14.054	13.797	13.798	13.798
End Stage Renal Disease	39.233	39.038	38.913	38.998	38.999
Chronic Kidney Disease, Stage 5	10.493	10.315	10.152	10.039	10.037
Chronic Kidney Disease, Severe (Stage 4)	10.493	10.315	10.152	10.039	10.037
Ectopic and Molar Pregnancy, Except with Renal Failure, Shock, or Embolism	1.160	0.967	0.768	0.565	0.561
Miscarriage with Complications	1.160	0.967	0.768	0.565	0.561
Miscarriage with No or Minor Complications	1.160	0.967	0.768	0.565	0.561
Completed Pregnancy With Major Complications	3.354	2.882	2.584	2.386	2.385
Completed Pregnancy With Complications	3.354	2.882	2.584	2.386	2.385
Completed Pregnancy with No or Minor Complications	3.354	2.882	2.584	2.386	2.385
Chronic Ulcer of Skin, Except Pressure	1.654	1.541	1.428	1.366	1.365
Hip Fractures and Pathological Vertebral or Humerus Fractures	5.891	5.601	5.355	5.259	5.257

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Pathological Fractures, Except of Vertebrae, Hip, or Humerus	1.718	1.565	1.392	1.270	1.268
Stem Cell, Including Bone Marrow, Transplant Status/Complications	33.115	32.960	32.863	32.876	32.877
Artificial Openings for Feeding or Elimination	15.795	15.698	15.662	15.783	15.785
Amputation Status, Lower Limb/Amputation Complications	8.011	7.729	7.525	7.418	7.416

TABLE 4: Infant Risk Adjustment Models Factors

Group	Platinum	Gold	Silver	Bronze	Catastrophic
Extremely Immature * Severity Level 5 (Highest)	409.050	407.618	406.498	406.512	406.513
Extremely Immature * Severity Level 4	203.011	201.612	200.519	200.501	200.502
Extremely Immature * Severity Level 3	54.774	53.619	52.671	52.503	52.501
Extremely Immature * Severity Level 2	54.774	53.619	52.671	52.503	52.501
Extremely Immature * Severity Level 1 (Lowest)	54.774	53.619	52.671	52.503	52.501
Immature * Severity Level 5 (Highest)	193.052	191.689	190.621	190.640	190.641
Immature * Severity Level 4	91.573	90.161	89.057	89.058	89.059
Immature * Severity Level 3	54.774	53.619	52.671	52.503	52.501
Immature * Severity Level 2	31.501	30.277	29.298	29.119	29.116
Immature * Severity Level 1 (Lowest)	31.501	30.277	29.298	29.119	29.116
Premature/Multiples * Severity Level 5 (Highest)	180.068	178.688	177.612	177.587	177.588
Premature/Multiples * Severity Level 4	34.716	33.374	32.329	32.210	32.210
Premature/Multiples * Severity Level 3	18.143	17.052	16.164	15.859	15.855
Premature/Multiples * Severity Level 2	9.619	8.708	7.919	7.456	7.447

Premature/Multiples * Severity Level 1 (Lowest)	6.761	6.055	5.326	4.813	4.803
Term * Severity Level 5 (Highest)	148.077	146.787	145.765	145.664	145.663
Term * Severity Level 4	17.881	16.823	15.955	15.592	15.587
Term * Severity Level 3	6.615	5.913	5.209	4.662	4.651
Term * Severity Level 2	3.999	3.438	2.791	2.206	2.195
Term * Severity Level 1 (Lowest)	1.717	1.385	0.811	0.379	0.371
Age1 * Severity Level 5 (Highest)	55.723	55.014	54.446	54.372	54.371
Age1 * Severity Level 4	9.659	9.128	8.675	8.484	8.481
Age1 * Severity Level 3	3.494	3.127	2.751	2.528	2.524
Age1 * Severity Level 2	2.210	1.911	1.570	1.327	1.323
Age1 * Severity Level 1 (Lowest)	0.603	0.465	0.288	0.206	0.205
Age 0 Male	0.723	0.672	0.641	0.584	0.582
Age 1 Male	0.168	0.148	0.127	0.101	0.100

TABLE 5: HHS HCCS Included in Infant Model Maturity Categories

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

TABLE 6: HHS HCCs Included in Infant Model Severity Categories

Severity Category	HCC
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Severity Category	HCC
Severity Level 5 (Highest)	Metastatic Cancer
Severity Level 5	Pancreas Transplant Status/Complications
Severity Level 5	Liver Transplant Status/Complications
Severity Level 5	End-Stage Liver Disease
Severity Level 5	Intestine Transplant Status/Complications
Severity Level 5	Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis
Severity Level 5	Respirator Dependence/Tracheostomy Status
Severity Level 5	Heart Assistive Device/Artificial Heart
Severity Level 5	Heart Transplant
Severity Level 5	Congestive Heart Failure
Severity Level 5	Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders
Severity Level 5	Lung Transplant Status/Complications
Severity Level 5	Kidney Transplant Status
Severity Level 5	End Stage Renal Disease
Severity Level 5	Stem Cell, Including Bone Marrow, Transplant Status/Complications
Severity Level 4	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
Severity Level 4	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
Severity Level 4	Mucopolysaccharidosis
Severity Level 4	Major Congenital Anomalies of Diaphragm, Abdominal Wall, and Esophagus, Age < 2
Severity Level 4	Myelodysplastic Syndromes and Myelofibrosis
Severity Level 4	Aplastic Anemia
Severity Level 4	Combined and Other Severe Immunodeficiencies
Severity Level 4	Traumatic Complete Lesion Cervical Spinal Cord
Severity Level 4	Quadriplegia
Severity Level 4	Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease
Severity Level 4	Quadriplegic Cerebral Palsy
Severity Level 4	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
Severity Level 4	Non-Traumatic Coma, Brain Compression/Anoxic Damage
Severity Level 4	Respiratory Arrest
Severity Level 4	Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes
Severity Level 4	Acute Myocardial Infarction
Severity Level 4	Heart Infection/Inflammation, Except Rheumatic
Severity Level 4	Major Congenital Heart/Circulatory Disorders
Severity Level 4	Intracranial Hemorrhage
Severity Level 4	Ischemic or Unspecified Stroke
Severity Level 4	Vascular Disease with Complications
Severity Level 4	Pulmonary Embolism and Deep Vein Thrombosis
Severity Level 4	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections

Severity Category	HCC
Severity Level 4	Chronic Kidney Disease, Stage 5
Severity Level 4	Hip Fractures and Pathological Vertebral or Humerus Fractures
Severity Level 4	Artificial Openings for Feeding or Elimination
Severity Level 3	HIV/AIDS
Severity Level 3	Central Nervous System Infections, Except Viral Meningitis
Severity Level 3	Opportunistic Infections
Severity Level 3	Non-Hodgkin`s Lymphomas and Other Cancers and Tumors
Severity Level 3	Colorectal, Breast (Age < 50), Kidney and Other Cancers
Severity Level 3	Breast (Age 50+), Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors
Severity Level 3	Lipidoses and Glycogenosis
Severity Level 3	Adrenal, Pituitary, and Other Significant Endocrine Disorders
Severity Level 3	Acute Liver Failure/Disease, Including Neonatal Hepatitis
Severity Level 3	Intestinal Obstruction
Severity Level 3	Necrotizing Fasciitis
Severity Level 3	Bone/Joint/Muscle Infections/Necrosis
Severity Level 3	Osteogenesis Imperfecta and Other Osteodystrophies
Severity Level 3	Cleft Lip/Cleft Palate
Severity Level 3	Hemophilia
Severity Level 3	Disorders of the Immune Mechanism
Severity Level 3	Coagulation Defects and Other Specified Hematological Disorders
Severity Level 3	Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes
Severity Level 3	Traumatic Complete Lesion Dorsal Spinal Cord
Severity Level 3	Paraplegia
Severity Level 3	Spinal Cord Disorders/Injuries
Severity Level 3	Cerebral Palsy, Except Quadriplegic
Severity Level 3	Muscular Dystrophy
Severity Level 3	Parkinson`s, Huntington`s, and Spinocerebellar Disease, and Other Neurodegenerative Disorders
Severity Level 3	Hydrocephalus
Severity Level 3	Unstable Angina and Other Acute Ischemic Heart Disease
Severity Level 3	Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders
Severity Level 3	Specified Heart Arrhythmias
Severity Level 3	Cerebral Aneurysm and Arteriovenous Malformation
Severity Level 3	Hemiplegia/Hemiparesis
Severity Level 3	Cystic Fibrosis
Severity Level 3	Fibrosis of Lung and Other Lung Disorders
Severity Level 3	Pathological Fractures, Except of Vertebrae, Hip, or Humerus
Severity Level 2	Viral or Unspecified Meningitis
Severity Level 2	Thyroid, Melanoma, Neurofibromatosis, and Other Cancers and Tumors
Severity Level 2	Diabetes with Acute Complications
Severity Level 2	Diabetes with Chronic Complications
Severity Level 2	Diabetes without Complication

Severity Category	HCC
Severity Level 2	Protein-Calorie Malnutrition
Severity Level 2	Congenital Metabolic Disorders, Not Elsewhere Classified
Severity Level 2	Amyloidosis, Porphyria, and Other Metabolic Disorders
Severity Level 2	Cirrhosis of Liver
Severity Level 2	Chronic Pancreatitis
Severity Level 2	Inflammatory Bowel Disease
Severity Level 2	Rheumatoid Arthritis and Specified Autoimmune Disorders
Severity Level 2	Systemic Lupus Erythematosus and Other Autoimmune Disorders
Severity Level 2	Congenital/Developmental Skeletal and Connective Tissue Disorders
Severity Level 2	Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn
Severity Level 2	Sickle Cell Anemia (Hb-SS)
Severity Level 2	Drug Psychosis
Severity Level 2	Drug Dependence
Severity Level 2	Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes
Severity Level 2	Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies
Severity Level 2	Seizure Disorders and Convulsions
Severity Level 2	Monoplegia, Other Paralytic Syndromes
Severity Level 2	Atherosclerosis of the Extremities with Ulceration or Gangrene
Severity Level 2	Chronic Obstructive Pulmonary Disease, Including Bronchiectasis
Severity Level 2	Chronic Ulcer of Skin, Except Pressure
Severity Level 1 (Lowest)	Chronic Hepatitis
Severity Level 1	Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption
Severity Level 1	Thalassemia Major
Severity Level 1	Autistic Disorder
Severity Level 1	Pervasive Developmental Disorders, Except Autistic Disorder
Severity Level 1	Multiple Sclerosis
Severity Level 1	Asthma
Severity Level 1	Chronic Kidney Disease, Severe (Stage 4)
Severity Level 1	Amputation Status, Lower Limb/Amputation Complications
Severity Level 1	No Severity HCCs

d. Cost-sharing reductions adjustments (§153.320)

We propose to continue including an adjustment for the receipt of cost-sharing reductions in the model to account for increased plan liability due to increased utilization of health care services by enrollees receiving cost-sharing reductions. The proposed cost-sharing reduction adjustment factors for 2017 risk adjustment are unchanged from those finalized in the 2016 Payment Notice and are set forth in Table 7. These adjustments are effective for 2015, 2016, and

2017 risk adjustment, and are multiplied against the sum of the demographic, diagnosis, and interaction factors. We will continue to evaluate this adjustment in future years as more data becomes available. We seek comment on this approach.

TABLE 7: Cost-Sharing Reduction Adjustment

Household Income	Plan AV	Induced Utilization Factor
<u>Silver Plan Variant Recipients</u>		
100-150% of FPL	Plan Variation 94%	1.12
150-200% of FPL	Plan Variation 87%	1.12
200-250% of FPL	Plan Variation 73%	1.00
>250% of FPL	Standard Plan 70%	1.00
<u>Zero Cost-Sharing Recipients</u>		
<300% of FPL	Platinum (90%)	1.00
<300% of FPL	Gold (80%)	1.07
<300% of FPL	Silver (70%)	1.12
<300% of FPL	Bronze (60%)	1.15
<u>Limited Cost-Sharing Recipients</u>		
>300% of FPL	Platinum (90%)	1.00
>300% of FPL	Gold (80%)	1.07
>300% of FPL	Silver (70%)	1.12
>300% of FPL	Bronze (60%)	1.15

e. Model performance statistics (\$153.320)

To evaluate the model's performance, we examined its R-squared and predictive ratios. The R-squared statistic, which calculates the percentage of individual variation explained by a model, measures the predictive accuracy of the model overall. The predictive ratios measure the predictive accuracy of a model for different validation groups or subpopulations. The predictive ratio for each of the HHS risk adjustment models is the ratio of the weighted mean predicted plan liability for the model sample population to the weighted mean actual plan liability for the model sample population. The predictive ratio represents how well the model does on average at predicting plan liability for that subpopulation. A subpopulation that is predicted perfectly would have a predictive ratio of 1.0. For each of the HHS risk adjustment models, the R-squared

statistic and the predictive ratio are in the range of published estimates for concurrent risk adjustment models.⁹ Because we are proposing to blend the coefficients from separately solved models based on MarketScan 2012 and 2013 data (and 2012, 2013, and 2014 data in the final rule), we are publishing the R-squared statistic for each model and year separately to verify their statistical validity. The R-squared statistic for each model is shown in Table 8.

TABLE 8: R-Squared Statistic for HHS Risk Adjustment Models

Risk Adjustment Model	R-Squared Statistic	
	2012	2013
Platinum Adult	0.3936	0.3820
Platinum Child	0.2855	0.2774
Platinum Infant	0.2844	0.3215
Gold Adult	0.3895	0.3775
Gold Child	0.2804	0.2722
Gold Infant	0.2823	0.3195
Silver Adult	0.3858	0.3735
Silver Child	0.2757	0.2674
Silver Infant	0.2808	0.3182
Bronze Adult	0.3836	0.3713
Bronze Child	0.2732	0.2649
Bronze Infant	0.2807	0.3181
Catastrophic Adult	0.3836	0.3712
Catastrophic Child	0.2732	0.2648
Catastrophic Infant	0.2807	0.3181

f. Overview of the payment transfer formula (§153.320)

We do not propose to alter our payment transfer methodology. Plan average risk scores will continue to be calculated as the member month-weighted average of individual enrollee risk scores. We defined the calculation of plan average actuarial risk and the calculation of payments and charges in the Premium Stabilization Rule. In the 2014 Payment Notice, we combined those

⁹ Winkleman, Ross and Syed Mehmud. “A Comparative Analysis of Claims-Based Tools for Health Risk Assessment.” Society of Actuaries. April 2007.

concepts into a risk adjustment payment transfer formula. Risk adjustment transfers (payments and charges) will be calculated after issuers have completed risk adjustment data reporting. The payment transfer formula includes a set of cost adjustment terms that require transfers to be calculated at the geographic rating area level for each plan (that is, HHS will calculate two separate transfer amounts for a plan that operates in two rating areas).

The payment transfer formula is designed to provide a per member per month (PMPM) transfer amount. The PMPM transfer amount derived from the payment transfer formula would be multiplied by each plan's total member months for the benefit year to determine the total payment due or charge owed by the issuer for that plan in a rating area.

(1) Overview of the payment transfer formula

Although we do not propose to change the payment transfer formula from what was finalized in the 2014 Payment Notice (78 FR 15430 through 15434), we believe it would be useful to republish the formula in its entirety, since, as noted above, we are proposing to recalibrate the HHS risk adjustment model. Transfers (payments and charges) will be calculated as the difference between the plan premium estimate reflecting risk selection and the plan premium estimate not reflecting risk selection. As finalized in the 2014 Payment Notice, the HHS risk adjustment payment transfer formula is:

$$T_i = \left[\frac{PLRS_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot IDF_i \cdot GCF_i)} - \frac{AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i)} \right] \bar{P}_s$$

Where:

\bar{P}_s = State average premium;

$PLRS_i$ = plan i 's plan liability risk score;

AV_i = plan i 's metal level AV;

ARF_i = allowable rating factor;

IDF_i = plan i 's induced demand factor;

GCF_i = plan i 's geographic cost factor;

s_i = plan i 's share of State enrollment.

The denominator is summed across all plans in the risk pool in the market in the State.

The difference between the two premium estimates in the payment transfer formula determines whether a plan pays a risk transfer charge or receives a risk transfer payment. Note that the value of the plan average risk score by itself does not determine whether a plan would be assessed a charge or receive a payment – even if the risk score is greater than 1.0, it is possible that the plan would be assessed a charge if the premium compensation that the plan may receive through its rating practices (as measured through the allowable rating factor) exceeds the plan's predicted liability associated with risk selection. Risk adjustment transfers are calculated at the risk pool level, and catastrophic plans are treated as a separate risk pool for purposes of risk adjustment.

g. State-submitted Alternate Risk Adjustment Methodology

The Commonwealth of Massachusetts has expressed interest in having an HHS-operated risk adjustment program, beginning in the 2017 benefit year. If HHS operates risk adjustment in Massachusetts for 2017 using the Federally certified methodology we use in all States in which we operate risk adjustment, we would announce this in the final rule.

h. Risk Adjustment User Fee (§153.610(f))

As noted above, if a State is not approved to operate or chooses to forgo operating its own risk adjustment program, HHS will operate risk adjustment on the State's behalf. As described in the 2014 Payment Notice, HHS's operation of risk adjustment on behalf of States is funded through a risk adjustment user fee. Section 153.610(f)(2) provides that an issuer of a risk

adjustment covered plan with the meaning of §153.20 must remit a user fee to HHS equal to the product of its monthly enrollment in the plan and the per enrollee per month risk adjustment user fee specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year.

OMB Circular No. A-25R establishes Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. The risk adjustment program will provide special benefits as defined in section 6(a)(1)(b) of Circular No. A-25R to issuers of risk adjustment covered plans because it will mitigate the financial instability associated with potential adverse risk selection. The risk adjustment program also will contribute to consumer confidence in the health insurance industry by helping to stabilize premiums across the individual and small group health insurance markets.

In the 2016 Payment Notice, we estimated Federal administrative expenses of operating the risk adjustment program to be \$1.75 per enrollee per year, based on our estimated contract costs for risk adjustment operations. For the 2017 benefit year, we propose to use the same methodology to estimate our administrative expenses to operate the program. These contracts cover development of the model and methodology, collections, payments, account management, data collection, data validation, program integrity and audit functions, operational and fraud analytics, stakeholder training, and operational support. To calculate the user fee, we divide HHS's projected total costs for administering the risk adjustment programs on behalf of States by the expected number of enrollees in risk adjustment covered plans (other than plans not subject to market reforms and student health plans, which are not subject to payments and charges under

the risk adjustment methodology HHS uses when it operates risk adjustment on behalf of a State) in HHS-operated risk adjustment programs for the benefit year.

We estimate that the total cost for HHS to operate the risk adjustment program on behalf of States for 2017 will be approximately \$52 million, and that the risk adjustment user fee would be \$1.80 per enrollee per year. The risk adjustment user fee contract costs for 2017 include costs related to 2017 risk adjustment data validation, and are slightly higher than the 2016 contract costs as the result of some contracts that were rebid. We do not anticipate Massachusetts' decision to use the Federal risk adjustment methodology will substantially affect the risk adjustment user fee rate for 2017.

3. Provisions and Parameters for the Transitional Reinsurance Program

The Affordable Care Act directs that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market from 2014 through 2016. In the 2014 Payment Notice, we expanded on the standards set forth in subparts C and E of the Premium Stabilization Rule and established the reinsurance payment parameters and uniform reinsurance contribution rate for the 2014 benefit year. In the 2015 Payment Notice, we established the reinsurance payment parameters and uniform reinsurance contribution rate for the 2015 benefit year and certain oversight provisions related to the operation of the reinsurance program. In the 2016 Payment Notice, we established the reinsurance payment parameters and uniform reinsurance contribution rate for the 2016 benefit year and certain clarifying provisions related to the operation of the reinsurance program.

a. Decreasing the Reinsurance Attachment Point for the 2016 Benefit Year

Section 1341(b)(2)(B) of the Affordable Care Act directs the Secretary, in establishing standards for the transitional reinsurance program, to include a formula for determining the

amount of reinsurance payments to be made to non-grandfathered, individual market issuers for high-risk claims that provides for the equitable allocation of funds. In the Premium Stabilization Rule (77 FR 17228), we provided that reinsurance payments to issuers of reinsurance-eligible plans will be made for a portion of an enrollee's claims costs paid by the issuer (the coinsurance rate, meant to reimburse a proportion of claims while giving issuers an incentive to contain costs) that exceeds an attachment point (when reinsurance would begin), subject to a reinsurance cap (when the reinsurance program stops paying claims for a high-cost individual). The coinsurance rate, attachment point, and reinsurance cap together constitute the uniform reinsurance payment parameters.

We finalized in the 2015 Payment Notice (79 FR 13777) that HHS will use any excess contributions for reinsurance payments for a benefit year by increasing the coinsurance rate for that benefit year up to 100 percent before rolling over any remaining funds in the next year. If any contribution amounts remain after calculating reinsurance payments for the 2016 benefit year (and after HHS increases the coinsurance rate to 100 percent for the 2016 benefit year), we propose to decrease the 2016 attachment point of \$90,000 to pay out any remaining contribution amounts in an equitable manner for the 2016 benefit year. We believe that expending all remaining reinsurance contribution funds as payments for the 2016 benefit year will support the reinsurance program's goals of promoting nationwide premium stabilization and market stability in the early years of Exchange operations while providing issuers with incentives to continue to effectively manage enrollee costs. The final attachment point and coinsurance rate for the 2016 benefit year will be calculated based on total available reinsurance collections and accepted reinsurance payment requests. We seek comment on this proposal.

b. Audit Authority Extends to Entities that Assist Contributing Entities (§153.405(i))

In accordance with §153.405(i), HHS or its designee has the authority to audit a contributing entity to assess compliance with the reinsurance program requirements. In 2014, HHS implemented a streamlined approach through which a contributing entity, or a third party such as a third party administrator or an administrative services-only contractor acting on behalf of a contributing entity, could register on Pay.gov, calculate the annual enrollment count and schedule reinsurance contribution payments. During the 2014 contribution submission process, many third party administrators and administrative services-only contractors assisted contributing entities by calculating the contributing entity's annual enrollment count and maintaining the records necessary to validate that enrollment. To ensure that reported annual enrollment counts are calculated correctly in accordance with §§153.405(d) through 153.405(g) and applicable guidance, we propose to amend §153.405(i) to specify that the audit authority extends to any third party administrators, administrative services-only contractors, or other third parties that complete any part of the reinsurance contribution submission process on behalf of contributing entities or otherwise assist contributing entities with compliance with the requirements for the transitional reinsurance program. This would include third party administrators, administrative services-only contractors or other third parties that provide contributing entities with their annual enrollment counts or maintain records to substantiate the annual enrollment counts, even if the third party does not submit the annual enrollment count to HHS. Additionally, we propose to amend §153.405(i) to specify that a contributing entity that chooses to use a third party administrator, administrative services-only contractor, or other third party to complete the reinsurance contribution submission process on its behalf must ensure that this third party administrator, administrative services-only contractor, or other third party cooperate with any audit under this section. Contributing entities, not third party administrators,

administrative services-only contractors, or other third parties, remain responsible for the payment of reinsurance contributions. We seek comment on these amendments.

4. Provisions for the Temporary Risk Corridors Program

This section contains proposals related to the temporary risk corridors program, and therefore applies only to issuers of QHPs, as defined at §153.500, with respect to the benefit years 2014 through 2016.

a. Risk Corridors Payment Methodology (§153.510(g))

To ensure the integrity of data used in risk corridors and MLR calculations, in prior guidance¹⁰ we indicated that we would propose in the HHS Notice of Benefit and Payment Parameters for 2017 an adjustment to correct for any inaccuracies in risk corridors payment and charge amounts that could result from issuers reporting a certified estimate of cost-sharing reductions on the 2014 MLR and Risk Corridors Annual Reporting Form.¹¹ The use of a certified estimate that is lower than the actual cost-sharing reductions provided would affect the MLR calculation and the risk corridors financial transfers by increasing incurred claims and allowable costs, thereby increasing the MLR and potentially increasing the risk corridors payment or lowering the risk corridors charge. We believe that requiring an update of these reported amounts through recalculation of the risk corridors and MLR amounts for the 2014 benefit year will be disruptive to the market and consumers, as well as administratively burdensome and difficult to operationalize for issuers and HHS. Therefore, consistent with our

¹⁰ https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Advance-CSR-Payment-and-RC-MLR-submission_6192015.pdf

¹¹ https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Advance-CSR-Payment-and-RC-MLR-submission_6192015.pdf

earlier guidance, we are proposing to add a new paragraph (g) to the risk corridors payment methodology set forth in §153.510 to propose that if the issuer reported a certified estimate of 2014 cost-sharing reductions on its 2014 MLR and Risk Corridors Annual Reporting Form that is lower than the actual cost-sharing reductions provided (as calculated under §156.430(c) for the 2014 benefit year, which will take place in the spring of 2016), HHS would make an adjustment to the amount of the issuer's 2015 benefit year risk corridors payment or charge measured by the full difference between the certified estimate reported and the actual cost-sharing reductions provided as calculated under §156.430(c) in order to address the impact of the inaccurate reporting on the risk corridors and MLR calculations for the 2014 benefit year. We seek comment on this proposal.

b. Risk Corridors Data Requirements (§153.530)

Due to the fact that the actual value of cost-sharing reductions provided by an issuer was not available in time for risk corridors and MLR reporting for 2014, for the purpose of adjusting allowable costs in the risk corridors calculation and incurred claims in the MLR calculation for 2014, HHS instructed issuers to report the amount of the cost-sharing reduction portion of the advance payments received by the issuer for 2014 (to the extent not reimbursed to the provider furnishing the item or service).¹² Additionally, issuers were permitted to report a certified estimate of the amount of cost-sharing reductions provided in 2014 (to the extent not reimbursed to the provider furnishing the item or service) in their risk corridors and MLR reporting for the 2014 benefit year.

¹² https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Advance-CSR-Payment-and-RC-MLR-submission_6192015.pdf

We propose to amend §153.530 to add a new paragraph (b)(2)(iii) to require an issuer to adjust the cost-sharing reduction amount it reports on its 2015 risk corridors and MLR forms by the difference (if any) between the reported cost-sharing reduction amount used to adjust allowable costs and incurred claims on the 2014 MLR Annual Reporting Form and the actual cost-sharing reductions provided by the issuer for the 2014 benefit year (as calculated under §156.430(c) for the 2014 benefit year, which will take place in the spring of 2016). Issuers must report the amount as calculated under §156.430(c) when reporting risk corridors and MLR for the applicable benefit year. As discussed elsewhere in this preamble, we are proposing to modify the issuer data reporting requirements in §153.710(h)(1)(iii) to reflect this change.

In addition, in the May 23, 2012 Premium Stabilization Rule (77 FR 17220), we defined “allowable costs” to reference the MLR term “incurred claims” and to include quality improvement activity expenditures as defined in the MLR rule. Incurred claims, as defined in §158.140 for the MLR program, are generally comprised of claims incurred during the reporting year and paid through the applicable run-out period beyond the end of the year, plus the liabilities and reserves estimating claims incurred during the reporting year but still unpaid at the end of the run-out period, with certain other adjustments.

Thus, the MLR definition of incurred claims relies only on reserves and liabilities at the end of the reporting year, rather than a trued up year-over-year change in reserves and liabilities. In the MLR calculation, these drawbacks are mitigated to some extent because the MLR calculation is based on 3 years of data, and consequently the estimates of unpaid claims are trued up over the following 2 years. However, because the risk corridors calculation is based on only a single year of data, an issuer’s estimate of unpaid claims is never trued up, and consequently any

inaccuracy in these estimates can have a significant impact on the accuracy of the risk corridors payment or charge calculation.

Therefore, to preserve the integrity of the risk corridors program, we propose to amend §153.530 to add a new paragraph (b)(2)(iv) to require issuers to adjust the claims reported as allowable costs for the 2015 and later benefit years by the amount by which the issuer's estimate of unpaid claims for the preceding benefit year exceeded (or fell below) the actual payments that the issuer made after the date of the estimate for claims attributable to the preceding benefit year. For example, if in calculating its 2014 allowable costs, an issuer overestimated the amount of claims it incurred in 2014 that were unpaid as of March 31, 2015, then under this proposal, in calculating its 2015 allowable costs, the issuer would be required to subtract the amount by which its March 31, 2015 claims estimate exceeded the actual payments for 2014 claims that the issuer made between March 31, 2015 and June 30, 2016 (the claims reserves and liabilities valuation dates for the 2014 and 2015 benefit years, respectively). We seek comment on the most appropriate way to true up estimates of unpaid claims for 2016. For example, we could provide for a 2017 payment or charge (calculated with 2018 MLR), provide for a simplified true-up process, require that the 2016 estimate be based on actual 2014 and 2015 amounts, or provide for no true-up at all in the final year.

5. Distributed Data Collection for the HHS-operated Programs

a. Interim Dedicated Distributed Data Environment Reports (§153.710(d))

Effective for the 2016 benefit year, we propose deleting §153.710(d), which sets forth an interim discrepancy reporting process by which an issuer must notify HHS of any discrepancy it identifies between the data to which the issuer has provided access to HHS through its dedicated distributed data environment (that is, an issuer's EDGE server) and the interim dedicated

distributed data environment report, or confirm to HHS that the information in the interim report accurately reflects the data to which the issuer has provided access to HHS through its dedicated distributed data environment in accordance with §153.700(a) for the timeframe specified in the report. Many issuers viewed the interim discrepancy process for the 2014 benefit year as an additional burden and an administrative reporting exercise that they had to complete in order to preserve their appeal rights. The process also required significant resources and extensive support from HHS. Additionally, the information collected during the 2014 interim formal discrepancy process largely focused on the problems that issuers were encountering with the data submission process, as opposed to issues involving the dedicated distributed data environment report matching the data the issuer made accessible in its environment. HHS is committed to working with issuers prior to the data submission deadline to address any data issues so that reinsurance payment and risk adjustment transfer calculations can be made accurately and timely. After the initial submission period and prior to the data submission deadline (that is, April 30 of the year following the applicable benefit year), issuers should identify any problems that the issuer is experiencing in loading complete and accurate data; HHS must know about these data issues during this period to assist issuers in addressing these issues prior to the data submission deadline and in advance of reinsurance payment and risk adjustment transfer calculations. Throughout the data collection period, HHS will continue to maintain a help desk to assist issuers with data submission errors and to provide technical assistance. We believe that removing the requirement to file an interim discrepancy report starting in the 2016 benefit year will alleviate the administrative burden on issuers and HHS, as well as streamline outreach and communications during the data submission window. In light of this proposal, we propose to remove any cross-references to the interim discrepancy reporting process currently codified at

§153.710(d) in §§153.710 and 156.1220. We also propose conforming amendments to redesignate paragraph (e) as paragraph (d), as well as to revise and redesignate paragraph (f) as (e). We seek comment on this proposal and the proposed effective date.

b. Evaluation of Quality and Quantity of EDGE Data Submissions (§153.710(f))

Under §153.740(b), if an issuer of a risk adjustment covered plan fails to provide HHS with access to the required data in a dedicated data environment such that HHS cannot apply the applicable Federally certified risk adjustment methodology to calculate the risk adjustment payment transfer amount for the risk adjustment covered plan in a timely fashion, HHS will assess a default risk adjustment charge. Similarly, under §§153.420 and 153.740(a), an issuer of a reinsurance-eligible plan will forfeit reinsurance payments it otherwise might have received if the issuer fails to establish a dedicated data environment or fails to meet certain data requirements. HHS released guidance on April 24, 2015, entitled “Evaluation of EDGE Data Submissions” describing the approach it would use, starting with data submissions for the 2014 benefit year, to evaluate whether an issuer provided access in a dedicated data environment to data that was sufficient for HHS to calculate reinsurance payments and apply the HHS risk adjustment methodology.¹³ The approach evaluated the sufficiency of an issuer’s data in terms of the quantity and quality of the data. In this rulemaking, we propose to codify this practice for future benefit years to support the integrity of payments and charges made under the HHS-operated risk adjustment program and payments under the reinsurance program, both of which depend upon the submission of accurate and complete data by issuers to their EDGE servers.

¹³ <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/EDGE-guidance-42415-final.pdf>.

Consistent with the approach for review of 2014 benefit year data, to determine if an issuer meets data quantity standards, HHS would compare an issuer's self-reported baseline data on its total enrollment and claims counts by market to the issuer's data submitted to its dedicated data environment. An issuer with a low enrollment count following the submission deadline would be subject to a default risk adjustment charge under §153.740(b). An issuer with a low claims count following the submission deadline would be subject to a default risk adjustment charge if the default charge is lower than the charge it would have received through the risk adjustment transfer calculation. Additionally, an issuer with either a low enrollment count or a low claims count would forgo reinsurance payments for any claims that it failed to submit. HHS proposes to set forth in guidance, on an annual basis, the appropriate threshold by which HHS will deem data sufficient as to quantity for a given benefit year. HHS will also specify in guidance the format and timeline for submission of baseline data to HHS.

To determine if an issuer meets the data quality standards required for HHS to calculate reinsurance payments and apply the HHS risk adjustment methodology, HHS proposes to perform an outlier analysis using select metrics that target reinsurance data quality and risk adjustment data quality. For the 2014 benefit year, HHS used the following five key metrics: percentage of all enrollees with at least one HCC; average number of conditions per enrollee with at least one HCC; issuer average risk score; percentage of individual market enrollees with reinsurance payments; and average reinsurance payment per enrollee for which the issuer would receive reinsurance payments. Similar to data quantity, HHS plans to describe in guidance, on an annual basis, the metrics used for a given benefit year. An issuer may be assessed a risk adjustment default charge if it does not meet data quality standards on any of the risk adjustment

metrics and may forfeit reinsurance payments it might otherwise have received if it does not meet data quality standards for any of the reinsurance metrics.

HHS would conduct these data quality and quantity analyses after the deadline for submission of data specified in §153.730 (that is, April 30, of the year following the applicable benefit year). In §153.710, we propose to add a paragraph (f). In the new paragraph (f), we propose to specify that HHS will assess default risk adjustment charges based on these analyses no later than the date of the notification provided by HHS under §153.310(e) (that is, June 30 of the year following the applicable benefit year); and to describe the responsibilities of issuers in relation to the quality and quantity analyses. In §153.710(f)(1), we propose to codify the requirement for issuers to provide baseline data on their total enrollment and claims counts by market, in a format and on a timeline that we intend to specify in guidance. In §153.710(f)(2), we propose that if HHS identifies a data anomaly that would cause the data that a risk adjustment covered plan or a reinsurance-eligible plan made available through a dedicated data environment to fail HHS's quality thresholds, the issuer may, within 10 calendar days of receiving notification of the anomaly, submit an explanation of the anomaly for HHS to consider in determining whether the issuer met the reinsurance and risk adjustment data requirements.

HHS expects to perform informal data sufficiency analyses throughout the data submission process. Issuers are encouraged to provide explanations and corrected enrollment or claims counts at any time during the data submission process. The timeframe we propose in §153.710(f)(2) would apply to the final data sufficiency analyses only, which are performed following the deadline for submission of data specified in §153.730 (that is, April 30, of the year following the applicable benefit year). We seek comment on this proposal.

c. Data requirements (§153.710(g))

We are proposing to make conforming amendments to the introductory language at §153.710(g)(1) to remove the cross-references to the interim discrepancy reporting process currently codified at §153.710(d). However, because we have learned in the first year of the implementation of the premium stabilization and Exchange financial assistance programs that flexibility is often needed in reporting the amounts on risk corridors and MLR forms, we also propose that HHS have the ability to modify these instructions in sub-regulatory guidance. Our intent in issuing any such guidance would be to avoid having the application of the instructions in exceptional circumstances lead to unfair or misleading financial reporting. We propose to capture this flexibility through a new proposed paragraph at §153.710(g)(3).

We also propose to change §153.710(g)(1)(iii) to require an issuer to report the amount of cost-sharing reductions calculated under §156.430(c) in its annual MLR and risk corridors report, regardless of whether the issuer had any unresolved discrepancy under §156.1210, or whether the issuer had submitted a request for reconsideration under §156.1220(a)(1)(v). Additionally, consistent with the process outlined in §153.710(g)(2), we propose to require an issuer to adjust the cost-sharing reduction amount it reports on its 2015 risk corridors and MLR forms by the difference (if any) between the reported cost-sharing reduction amount used to adjust allowable costs and incurred claims on the 2014 MLR Annual Reporting Form and the amount of cost-sharing reductions as calculated under §156.430(c) for the 2014 benefit year.

Consistent with the approach currently outlined in §153.710(g)(2), we propose to amend this paragraph to require an issuer to report any adjustment made or approved by HHS for any risk adjustment payment or charge, reinsurance payment, cost-sharing reduction payment to reflect actual cost-sharing reduction amounts received, or risk corridors payment or charge, where the adjustment has not been accounted for in a prior MLR and Risk Corridors Annual

Reporting Form in the next following year. By way of example, if an issuer's risk adjustment charges or payments are adjusted as a result of the administrative appeals process, the issuer should adjust these reported amounts in the next MLR and risk corridors reporting cycle, after the appeal has been resolved. Similarly, if HHS makes changes to an issuer's risk adjustment charges or payments after the risk corridors and MLR reporting cycle has closed for the applicable reporting year, the issuer should adjust these reported amounts in the next MLR and risk corridors reporting cycle to account for the difference between the reported amounts and the amounts actually received or paid for the previous benefit year. However, if an issuer is notified about the modification during an open MLR and risk corridors submission period, it must report the modified amounts in that open reporting cycle.

We also propose to clarify in §153.710(g)(1)(iii) that cost-sharing reduction amounts to be reported under this section must exclude amounts reimbursed to providers of services or items. This clarifying language is consistent with how the instructions for cost-sharing reductions amounts are reported under §153.530(b)(2)(iii) (risk corridors data requirements) and §158.140(b)(iii) (MLR data requirements).

Lastly, we propose to revise paragraph (g)(1)(iv) to require that for medical loss ratio reporting only, issuers should report the risk corridors payment to be made or charge assessed by HHS, as reflected under §153.510.

d. Good Faith Safe Harbor

In the second Program Integrity Rule, we finalized §153.740(a), which permits HHS to impose civil money penalties upon issuers of risk adjustment covered plans and reinsurance-eligible plans for failure to adhere to certain standards relating to their dedicated distributed data environments. In the preamble to that rule, we stated that if we are able to determine that an

issuer of a risk adjustment covered plan or reinsurance-eligible plan is making good faith efforts to comply with the standards set forth in §153.740(a), consistent with our policy codified at §156.800(c), we would not seek to impose CMPs for noncompliance with those standards during 2014 (78 FR 65061). In the 2016 Payment Notice (80 FR 10780), we extended the good faith safe harbor to the 2015 calendar year, and stated that we would not apply the good faith safe harbor to non-compliance with dedicated distributed data environment standards applicable during the 2016 calendar year, even where the non-compliance relates to data for the 2015 benefit year. As we have previously said, we are not proposing to extend the good-faith safe harbor. Starting in the 2016 calendar year and beyond, civil money penalties may be imposed if an issuer of a risk adjustment covered plan or reinsurance-eligible plan fails to establish a dedicated distributed data environment in a manner and timeframe specified by HHS; fails to provide HHS with access to the required data in such environment in accordance with §153.700(a) or otherwise fails to comply with the requirements of §§153.700 through 153.730; fails to adhere to the reinsurance data submission requirements set forth in §153.420; or fails to adhere to the risk adjustment data submission and data storage requirements set forth in §§153.610 through 153.630, even if the issuer has made good faith efforts to comply with these requirements.

e. Default Risk Adjustment Charge (§153.740(b))

In the second Program Integrity Rule and the 2015 Payment Notice, HHS indicated that a default risk adjustment charge will be assessed if an issuer does not establish a dedicated distributed data environment or submits inadequate risk adjustment data. In the 2016 Payment Notice, we established how a default risk adjustment charge will be allocated among risk adjustment covered plans.

As described in the second final Program Integrity Rule, the total risk adjustment default charge for a risk adjustment covered plan would equal a per member per month amount multiplied by the plan's enrollment.

$$T_n = C_n * E_n$$

Where:

T_n = total default risk adjustment charge for a plan n ;

C_n = the PMPM amount for plan n ; and

E_n = the total enrollment (total billable member months) for plan n .

In the second final Program Integrity Rule, we provided that E_n could be calculated using an enrollment count provided by the issuer, using enrollment data from the issuer's MLR and risk corridors filings for the applicable benefit year, or other reliable data sources.

In the 2015 Payment Notice, we determined that we would calculate C_n – the PMPM amount for a plan – equal to the product of the Statewide average premium (expressed as a PMPM amount) for a risk pool and the 75th percentile plan risk transfer amount expressed as a percentage of the respective Statewide average PMPM premiums for the risk pool. The nationwide percentile would reflect only plans in States where HHS is operating the risk adjustment program and would be calculated based on the absolute value of plan risk transfer amounts. The PMPM amount determined using the method described here would be multiplied by the non-compliant plan's enrollment, as determined using the sources finalized in the second final Program Integrity Rule, to establish the plan's total default risk adjustment charge.

For the second year of risk adjustment, the 2015 benefit year, we are proposing to calculate C_n in the same manner, but increased to the 90th percentile plan risk transfer amount expressed as a percentage of the respective Statewide average PMPM premiums for the risk

pool. We believe that the 75th percentile was reasonable for the initial year of risk adjustment, as we did not yet know the distribution of risk adjustment transfers and issuers were more likely to experience technical difficulties in establishing a dedicated distributed data environment. In the second year of risk adjustment, now that issuers have set up EDGE servers and participated in the calculation of risk adjustment transfers, we believe that adjusting the default charge upwards to the 90th percentile of plan risk transfer amounts expressed as a percentage of the respective Statewide average PMPM premiums for the risk pool will encourage continued compliance with risk adjustment data submission requirements. We are concerned that, absent this change, some issuers may prefer receiving a default charge at the 75th percentile over participating in the risk adjustment program; a default charge at this level lacks sufficient deterrent value. In contrast, we believe the proposed 90th percentile default charge will adequately incentivize issuers to participate in the risk adjustment program. We seek comment on this approach.

For the 2016 benefit year, we propose a separate calculation of C_n for issuers where E_n Statewide, in the individual and small group markets combined, is 500 billable member months or less. For these issuers, we are proposing to calculate C_n , or the PMPM charge for a plan, as 14 percent of premium, which we have calculated as the mean charge as a percent of premium of issuers with 500 billable member months or fewer in the 2014 benefit year in the small group market. We are basing the charge itself on the experience of small group issuers in the 2014 benefit year, as we believe that individual market issuers are more likely to set up an EDGE server because of the availability of reinsurance. Limiting the applicability in the 2016 benefit year of this default charge to issuers with 500 billable member months or fewer is intended to ensure that the only issuers with this option are ones that are so small that their removal from the overall risk adjustment risk pool would have a minimal impact on transfers nationwide. In 2014,

approximately 125 issuers would have had fewer than 500 member months in the individual and small group markets combined. Of those approximately 125 small issuers, 80 were assessed risk adjustment charges greater than the proposed default charge of 14 percent of premium PMPM. Those charges amounted to less than 0.09 percent of total risk adjustment charges assessed nationally. Assuming every one of those issuers elect to accept the proposed 14 percent default risk charge, and none of the small issuers that owed risk adjustment payments, or with charges below 14 percent of premium PMPM, did so (which we believe unlikely, due to the administrative expenses of setting up an EDGE server), the assessment of the proposed 14 percent of premium default charge on those 80 issuers (and only those 80 issuers) would have resulted in a 0.05 percent (that is, one twentieth of one percent) reduction in risk adjustment charges collected nationally. Because issuers of this size are immaterial to the overall risk adjustment risk pools and have a disproportionately high operational burden to comply with risk adjustment data submission requirements, we believe that a separate default charge for these issuers would promote efficiency and data quality in the risk adjustment program. We propose to establish this risk adjustment default charge as the mean charge in the small group for these small issuers, or 14 percent of statewide average premium PMPM, to compensate on average for the absence of these immaterial amounts in the affected risk pools. We intend that this policy would apply only to the very smallest issuers, in recognition of the disproportionately high operational burden on these issuers, and seek comment on this approach.

f. Insolvent Issuers

We are aware that a health insurance issuer may become insolvent or exit a market during a benefit year. In some cases, another entity, such as another issuer or liquidator may take over the issuer's operations, or a State guaranty fund may become responsible for paying claims for

the insolvent issuer. In some instances when this occurs, both the entity seeking to acquire business from an insolvent issuer and the insolvent issuer lack a full year's data to submit for the risk adjustment or reinsurance programs.

To address this concern, we propose to clarify that an entity acquiring or entering into another arrangement with an issuer to serve the current enrollees under a plan, or a State guaranty fund that is responsible for paying claims on behalf of the insolvent issuer, with substantially the same terms may accrue the previous months of claims experience for purposes of risk adjustment and reinsurance to fully reflect the enrollees' risk and claims costs. We propose the "substantially the same" standard because we understand that in many of these situations an acquiring entity's platform may require some adjustments to the plan arrangements. To meet this standard would require the carryover of accumulators for deductibles and annual limitations on cost sharing. If the "substantially the same" standard is met, and the insolvent issuer and acquiring entity agree that the acquiring entity will accrue the previous months of claims experience, the acquiring entity must take responsibility for submitting to HHS complete and accurate claims and baseline information for that benefit year (including data from the insolvent issuer) in accordance with HHS's operational guidance. We also recognize that guaranty funds may not meet all of the requirements to be considered a risk adjustment covered plan or reinsurance eligible plan (for example, they may not meet the definition of "health insurance issuer"), and so we propose to permit a guaranty fund to participate in those programs notwithstanding these definition, to the extent it has taken over liability for a risk adjusted covered plan or reinsurance eligible plan during a benefit year.

We seek comment on these policies, including with respect to permissible ways in which the acquiring entity's arrangements may differ and other ways of ensuring the submission of the

data necessary for HHS to calculate the risk adjustment financial transfer amounts and the reinsurance payment amounts when another party will take over operations of the insolvent issuer, or pay claims on behalf of the insolvent issuer, during a benefit year. We also solicit comments on whether additional flexibility is needed with respect to the data submission requirements for the reinsurance and risk adjustment programs, such as with respect to the definition of a “paid claim” to account for situations when an issuer is unable to pay claims for covered services, for example, due to insolvency.

E. Part 154 – Health Insurance Issuer Rate Increases: Disclosure and Review Requirements

1. General Provisions

This section includes proposals related to the rate review program under part 154. The amendments in this part would apply to rates filed during the 2016 calendar year for coverage effective on or after January 1, 2017.

2. Disclosure and Review Provisions

a. Rate Increases Subject to Review (§154.200)

In §154.200, we propose amending paragraph (c)(2) to provide that a rate increase for single risk pool coverage¹⁴ beginning on or after January 1, 2017 meets or exceeds the applicable threshold for review if the average increase, including premium rating factors described in §147.102 of the subchapter, for all enrollees weighted by premium volume for any plan within

¹⁴ The phrase “single risk pool coverage” is used to describe non-grandfathered health insurance coverage in the individual or small group (or merged) market that is subject to all of the single risk pool provisions at 45 CFR 156.80. Although we are proposing that student health insurance plans be subject to the index rating methodology specified in 45 CFR 56.80(d), such plans would not have to be included in an issuers’ individual (or merged) market single risk pool. Rather they could be included in one or more separate risk pools. Student health plan issuers submit the required rate filing information using the Rate Review Justification Template rather than the Unified Rate Review Template. Student health insurance plans are referred to as “non-single risk pool coverage” for purposes of the requirements established in 45 CFR part 154.

the product meets or exceeds the applicable threshold. We previously provided that a rate increase for single risk pool coverage beginning on or after January 1, 2017 meets or exceeds the applicable threshold if an increase in the plan-adjusted index rate for any plan within the product meets or exceeds the applicable threshold.

We propose this change under paragraph (c)(2) because the plan-adjusted index rate does not reflect changes to adjustments for rating area, family size, age, or tobacco factors. Therefore, it would be possible for an issuer to change geographic rating area factors such that members in a certain rating area receive a larger increase, even though the overall rate increase would not be subject to rate review because the plan-adjusted index rate does not increase by 10 percent or more. We believe the annual review of unreasonable increases must include review of the underlying rates that are used to develop the premiums, as opposed to the actual premiums themselves. We do not expect this to result in additional rate increases that meet the threshold, but will measure rate increases in plans more accurately. We seek comment on this proposal. Consistent with the approach finalized in the 2016 Payment Notice (80 FR 10781), we note that starting with rates filed for single risk pool coverage beginning on or after January 1, 2017, rate increases would be calculated at the plan level as opposed to the product level when determining whether an increase is subject to review. We are not proposing any changes to that policy.

b. Submission of Rate Filing Justification (§154.215)

Under §154.215, health insurance issuers are currently required to submit a Rate Filing Justification for all single risk pool coverage products (including new or discontinued products) when any plan within a product in the individual or small group (or merged) market is subject to a rate increase, regardless of the size of the increase. This requirement was established, in part, to carry out the Secretary's responsibility, in conjunction with the States, under section

2794(b)(2)(A) of the PHS Act to monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange beginning in 2014. However, our experience with the rate review program has shown that premium increases cannot reasonably be monitored without evaluating the net effect on premiums, including the impact of rate decreases, plans with unchanged rates, and new plans' rates. We therefore propose to revise paragraphs (a) and (b) to address this gap in information.

We propose to revise paragraph (a)(1) to require health insurance issuers to submit the Unified Rate Review Template (also known as Part I of the Rate Filing Justification) for all single risk pool coverage products in the individual or small group (or merged) market, regardless of whether any plan within a product is subject to a rate increase. We note that most issuers offering single risk pool coverage already submit a Unified Rate Review Template because:

- A plan within the issuer's single risk pool has a rate increase;
- The issuer's State regulator requires submission of the Rate Filing Justification for all rates;
- The issuer is seeking to offer a QHP through a Federally-Facilitated or State Partnership Exchange; or
- The issuer chooses to use the Rate Filing Justification to satisfy the requirement to annually set an index rate.

We believe that requiring the submission of the Unified Rate Review Template, rather than requiring submission of a new document, will reduce administrative burden for issuers while providing the Secretary and the States with the information necessary to more effectively carry out their responsibilities to monitor premium increases inside and outside of Exchanges.

We propose to revise paragraph (a)(2) so that issuers must submit a Unified Rate Review Template and an Actuarial Memorandum (also known as Parts I and III of the Rate Filing Justification) when a plan within a product is subject to a rate increase. The Unified Rate Review Template and Actuarial Memorandum are submitted at the risk pool level, but the requirement to submit is based on increases at the plan level. This is the current policy but we are revising regulatory text for clarity.

We propose to revise paragraph (a)(3) to provide that all three parts of the Rate Filing Justification (that is, the Unified Rate Review Template, a written description justifying a rate increase, and the Actuarial Memorandum) must be filed when a plan within a product has a rate increase that is subject to review. The information is submitted at the risk pool level, but the requirement to submit is based on increases at the plan level. This is the current policy but we are revising regulatory text for clarity.

We also propose to revise paragraph (b) to provide that a Unified Rate Review Template, a written description justifying a rate increase, and rate filing documentation (commonly referred to as an Actuarial Memorandum) are part of a Rate Filing Justification. One or all of those parts of the Rate Filing Justification may be required by CMS and the State, depending on the change, if any, to plan rates. We also propose to remove and reserve paragraph (c), as it would be unnecessary in light of the proposed amendments to paragraphs (a) and (b).

These proposed amendments and clarifications will ensure that the rate review process is transparent regardless of whether coverage is included in the individual market or small group market single risk pool, and will allow HHS and the States to more effectively monitor premium increases for coverage offered through or outside of an Exchange. Furthermore, the proposed amendments and clarifications will introduce consistent submission requirements for all issuers

of single risk pool coverage, regardless of whether the issuer is increasing, decreasing, or maintaining rates.

We also remind issuers of student health insurance plans to use the Rate Review Justification (RRJ) module of the Health Insurance Oversight System (HIOS) to submit the required rate filing information.¹⁵ Even though we propose to amend §147.145 in this rulemaking (see III.C.4. of this preamble) to extend the index rate setting methodology to student health insurance plans for plan years beginning on or after January 1, 2017, we do not propose to change the form or manner of submission of rate filing information under 45 CFR part 154 for such coverage. In States without Effective Rate Review programs, issuers would be required to submit Preliminary Justifications for all student health insurance plans with rate increases subject to review to CMS by the earlier of the date that the issuer files the Preliminary Justification with the State or a date prior to implementation of the rate increase. In the States where CMS enforces the Public Health Service Act requirements, as amended by the Affordable Care Act, issuers must submit rate filings for student health insurance plan coverage for (a) rate increases of 10 percent or more into the HIOS RRJ module; and (b) rate increases of less than 10 percent into the HIOS Document Collection Form Filing Module.

We propose to permit the Secretary to specify in guidance, as provided under §154.220(b)(2), different submission deadlines for Rate Filing Justifications for single risk pool coverage plans versus non-single risk pool coverage plans.

¹⁵ See Rate Review Student Health Plans FAQ published on August 12, 2015.
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Rate_Review_Student_Health_Plans_FAQ_20150812_Final.pdf

In accordance with paragraph (h)(2), we intend to make public on an HHS website the information contained in parts I and III of each Rate Filing Justification that is not a trade secret or confidential commercial or financial information, as defined in HHS' Freedom of Information Act regulations, 45 CFR 5.65. We intend to disclose such information for all single risk pool coverage proposed rate increases (regardless of whether the increase is subject to review) and for all final rate increases. We note that we currently make such information available to the public for single risk pool coverage proposed rate increases subject to review and all final rates. The disclosure of information for all single risk pool coverage proposed rate increases, rather than only proposed rate increases subject to review, will provide the public with more comprehensive information and increase the transparency of the rate setting process.

c. Timing of Providing the Rate Filing Justification (§154.220)

Section 154.220 establishes time frames for required rate filing justifications. As previously discussed, we propose to collect a Unified Rate Review Template for all single risk pool coverage products in the individual or small group (or merged) market, regardless of whether any plan within a product is subject to a rate increase. We propose technical changes to the language in this section to align with this proposal to remove references to rate increases and clarify that the time frames listed pertain to all single risk pool coverage products with or without rate changes. Specifically, we propose to revise the introductory language to this section with accompanying edits to the language in paragraphs (b) and (b)(1).

d. Submission and Posting of Final Justifications for Unreasonable Rate Increases
(§154.230)

We propose a technical change to paragraph (c)(2)(i). That paragraph currently includes a reference to §154.215(i) but no such paragraph exists. We propose to fix the typographical error and change the cross reference to §154.215(h).

e. CMS's Determinations of Effective Rate Review Programs (§154.301)

Section 154.301 sets forth criteria for evaluating whether a State has an Effective Rate Review Program in the individual and small group (or merged) markets. In the 2016 Payment Notice (80 FR 10783), we provided that the criteria for determining whether a State has an Effective Rate Review program includes making rate information available to the public at a uniform time (rather than on a rolling basis) for proposed rate increases subject to review and all final rate increases, including those not subject to review (as applicable) for single risk pool coverage in the relevant market segment and without regard to whether coverage is offered through an Exchange or outside of an Exchange. As this was the first year for these uniform posting requirements, and because the uniform timelines were published by CMS well into 2015, CMS understands that some States had significant challenges in meeting the specified timelines for rates filed for coverage beginning on or after January 1, 2016. For rates filed for coverage beginning on or after January 1, 2017, we intend to make a proposed timeline for release of rate information for single risk pool coverage available for comment from States and other stakeholders in December and finalize the timeline no later than March. We believe the comment process will allow States and other stakeholders to identify in advance any challenges that the timeline may pose and allow us to make adjustments as may be necessary to accommodate State-specific needs and other considerations. We also believe this process will better support States that seek to operate an Effective Rate Review program in compliance with these requirements for rates filed for coverage beginning on or after January 1, 2017.

We consider the posting of proposed rate increases that are subject to review and the posting of all final rate increases (including those not subject to review) for single risk pool coverage at a uniform time a criterion for a State retaining its designation as having an Effective Rate Review Program. We will continue to monitor States to ensure that single risk pool coverage rate filings are posted at a uniform time, in the relevant market segment and without regard to whether the coverage is offered through or outside of an Exchange, in accordance with these requirements and guidance issued by CMS.

F. Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

1. General Provisions

a. Definitions (§155.20)

In §155.20, we propose to amend the definition of “applicant” for the small group market so that the term also includes an employer seeking eligibility to purchase coverage through a SHOP, without necessarily enrolling in that coverage themselves. The current definition of an applicant contemplates an employer, employee, or former employee seeking eligibility for enrollment in a QHP through the SHOP for himself or herself. For consistency with our existing regulations governing the SHOP application process at §§155.710 and 155.715 and for consistency with how the small group market typically works, we propose that the term applicant also include an employer who is seeking eligibility to purchase coverage through a SHOP, but who is not seeking to enroll in that coverage himself or herself.

We also propose to amend §155.20 to add a definition for “Federal platform agreement” to apply to this part. We propose to define a Federal platform agreement to mean an agreement

entered into by a State Exchange and HHS, under which the State Exchange elects to rely on the Federal platform to carry out select Exchange functions.

We also propose to modify the definitions of a “small employer” and “large employer” at §155.20 to align with the Protecting Affordable Coverage for Employees Act (Pub. L. 114-60), which was recently enacted, as further described in the preamble for §144.103. As described in that section of the preamble, consistent with section 1304(b) of the Affordable Care Act and section 2791(e) of the PHS Act, we propose to codify that in the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a large employer or a small employer be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. We do not propose to change the applicability of the counting methodology under 4980H(c)(2) of the Code to these definitions, but we propose to eliminate language about the timing of its applicability, which will no longer be relevant when this rule is finalized.

2. General Standards Related to the Establishment of an Exchange

a. Election to Operate an Exchange after 2014 (§155.106)

We propose to modify the timeframes for submission and approval of documentation specifying how an Exchange established by a State or a regional Exchange meets the Exchange approval standards (that is, the Exchange Blueprint). Based on our experience over the last two open enrollment periods, we believe the current Exchange Blueprint application deadlines for States intending to operate a State Exchange do not sufficiently balance the need to provide States with time to adequately prepare their Blueprint applications against the need to ensure HHS has sufficient time to accurately assess a State’s progress and ability to timely build the necessary Exchange information technology. In our experience, the process for seeking approval

to operate a State Exchange involves substantial technical assistance and collaboration between HHS and the State in developing plans to transition from one Exchange operational model and information technology infrastructure to another, including key milestones, deadlines, and contingency measures. Since the completion of some of these key milestones and deadlines would need to occur prior to the submission of the Blueprint application, we propose that we will make that technical assistance available and initiate the transition planning process following submission of a declaration letter from the State, as provided for in the Blueprint approval process. The declaration letter would serve as formal notification to HHS of a State's intent to pursue approval to operate a State Exchange, and will initiate coordination between the State and HHS on a transition plan. We would seek a declaration letter approximately 21 months prior to the beginning of the SBE's first annual enrollment and 9 months prior to the beginning of an SBE-FP's first annual open enrollment.

In §155.106(a)(2), we propose to require States that are establishing a State Exchange (not including a State Exchange using the Federal platform for select functions) to submit an Exchange Blueprint at least 15 months prior to the date the Exchange proposes to begin open enrollment as a State Exchange. We also propose in §155.106(a)(3) to increase the time that the State must have in effect an approved or conditionally approved Exchange Blueprint from 6.5 months to 14 months prior to the date the Exchange proposes to begin open enrollment as a State Exchange. We recognize that in some situations the open enrollment period may not have been established when Blueprints are due. Therefore, we propose in paragraph (a)(5), if the open enrollment period for the year the State intends to begin operating an SBE has not been established, a State should assume open enrollment will begin on the same date as open enrollment is to begin for the year in which they are submitting the Blueprint.

We propose to revise paragraph (b) to clarify that HHS will operate the Exchange if a State Exchange ceases operations.

We propose to add a paragraph (c) to establish requirements for a State that elects to operate an SBE-FP. These States must submit an Exchange Blueprint (or submit an update to an existing approved Exchange Blueprint) at least 3 months prior to the date open enrollment is to begin for the State as an SBE-FP; and must have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment at least 2 months prior to the date on which the Exchange proposes to begin open enrollment as an SBE-FP. If the State Exchange has a conditionally approved Exchange Blueprint application, we propose that it would not be required to submit a new Blueprint application, but must submit any significant changes to that application for HHS approval at least 3 months prior to the date on which the Exchange proposes to begin open enrollment as an SBE-FP. Upon receipt of approval or conditional approval of the Exchange Blueprint or amended Blueprint, and prior to the start of the open enrollment period, we propose that these States must execute a Federal platform agreement and be required to coordinate with HHS on a transition plan.

Lastly, we want to be clear that we are only proposing changes to the timelines for submission of the Blueprint application. We are not otherwise proposing any modifications to the information and documents that States must submit as part of the actual Exchange Blueprint application.

We seek comment on these proposals.

b. Additional Required Benefits (§155.170)

Section 1311(d)(3)(B) of the Affordable Care Act permits a State, at its option, to require QHPs to cover benefits in addition to the essential health benefits, but requires a State to make

payments, either to the individual enrollee or to the issuer on behalf of the enrollee, to defray the cost of these additional State-required benefits. In the 2016 Payment Notice, we instructed States to select a new EHB base-benchmark plan to take effect beginning for the 2017 plan year. The final EHB base-benchmark plans selected as a result of this process have been made publicly available.¹⁶

Section 1311(d)(3)(B) of the Affordable Care Act refers to situations in which the State requires QHPs to cover benefits. That section is not specific to State statutes and we have interpreted that section to apply not only in cases of legislative action but also in cases of State regulation, guidance, or other State action. Therefore, we propose to reword §155.170(a)(2) to make clear that a benefit required by the State through action taking place on or before December 31, 2011 is considered an EHB.

In the EHB Rule (78 FR 12837 through 12838), we discussed §155.170(a)(2), which implements section 1311(d)(3)(B) of the Affordable Care Act. In our discussion of that provision, we provided that “State-required benefits enacted on or before December 31, 2011 (even if not effective until a later date) may be considered EHB, which would obviate the requirement for the State to defray costs for these State-required benefits.” This policy continues to apply. Therefore, benefits required by a State through action taking place after December 31, 2011 that directly apply to the QHPs are not considered EHB (unless enactment is directly attributable to State compliance with Federal requirements, as discussed below).

Although benefits requirements enacted by States after December 31, 2011 that directly apply to the QHP and that were not enacted for purposes of compliance with Federal

¹⁶ Available at https://downloads.cms.gov/cciiio/Final List of BMPs_15_10_21.pdf

requirements are not considered EHB,¹⁷ the base-benchmark plan might cover some of those non-EHB. Nonetheless, issuers must treat those benefits as they would other non-EHB, such as those identified in §156.115(d)¹⁸ and the State must defray the cost. We propose to codify this interpretation in §155.170(a)(2). We seek comment on this proposal.

At §155.170(a)(3), we currently require the Exchange to identify which additional State-required benefits, if any, are in excess of EHB. We propose to amend paragraph (a)(3) to designate the State, rather than the Exchange, as the entity that identifies which State-required benefits are not EHB. We propose this change because we believe insurance regulators are generally more familiar with State-required benefits. We believe each State should determine the appropriate State entity best suited to identify newly required benefits. Additionally, for consistency of terminology, we propose to amend paragraph (a)(3) to replace the reference to “in excess of EHB” to “in addition to EHB.”

In current §155.170(c)(2)(iii), we require QHP issuers to quantify the cost attributable to each additional State-required benefit and report their calculations to the Exchange. We also propose to designate the State as the entity that receives issuer calculations in paragraph (c)(2)(iii). Since the State is required by statute to remit a payment to an enrollee or issuer, we believe the calculation should be sent directly to the State rather than to the Exchange. We seek comment on this proposal.

¹⁷ The 2016 Payment Notice provides that States are not expected to defray the cost of State-required benefits enacted on or after January 1, 2012 that were required in order to comply with new Federal requirements. (80 FR 10749, 10813 (Feb. 27, 2015)).

¹⁸ An issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB.

The 2016 Payment Notice specified that a State may need to supplement habilitative services if the base-benchmark plan does not cover such services. If a State supplements the base-benchmark plan, there is no requirement to defray the cost of the benefits added through supplementation, as long as the State imposes the requirement to comply with the Affordable Care Act or another Federal requirement. Examples of such Federal requirements include: requirements to provide benefits and services in each of the 10 categories of EHB; requirements to cover preventive services; requirements to comply with the Mental Health Parity and Addiction Equity Act; and the removal of discriminatory age limits from existing benefits.

In some States, the base-benchmark plan may be a large group (non-Medicaid HMO) or State employee plan. We have received questions regarding State-required benefits that are embedded in those large group (non-Medicaid HMO) base-benchmark plans. As stated earlier in this section, if the State-required benefit in question was required by State action after December 31, 2011, applies directly to the QHP, and was not enacted for purposes of compliance with Federal requirements, the benefit is not considered EHB, even if the benefit is embedded in the base-benchmark plan. However, a benefit required only in the large group market and reflected in a large group base-benchmark plan is not an EHB for QHPs offered in the individual or small group markets because such a benefit requirement does not apply directly to those plans, and to the extent it is included in the base-benchmark plan, it may be “substituted” for, in accordance with §156.115(b). Therefore, the State would not have to defray the cost of individual and small group market QHPs covering State-required benefits that are required in the large group market only. (However, to the extent the State permits large group plans to be sold as QHPs through the State’s Exchange, the State would have to defray the cost of the large group QHPs covering the mandated benefit.) We note that plans subject to the EHB requirements offered in the individual

and small group markets in those States would have to be substantially equal to the base-benchmark plan, and therefore may cover the State-required benefit as EHB since it is embedded in the base-benchmark plan. In such a case, the benefit is an EHB because it is covered by the base-benchmark plan, but the cost of coverage by individual and small group QHPs does not have to be defrayed, because the State-required benefit does not apply directly to those QHPs.

Some States have imposed new benefit requirements only on individual and small group plans that are not QHPs such that only individual and small group plans sold outside the Exchange must cover the State-required benefit. We note that a QHP generally may be sold outside the Exchanges in which case it would be subject to the new benefit requirements. States are cautioned, however, that imposing different benefit mandates depending on a plan's status as a QHP or because it is sold through the Exchange may violate section 1252 of the Affordable Care Act. Under this section, State standards or requirements implementing, or related to, standards or requirements in title I of the Act must be applied uniformly within a given insurance market. Thus, if a State requires that non-QHPs in the individual or small group market provide any benefits, under section 1252, the State must require QHPs sold through the Exchange to provide those same benefits, and consistent with our earlier stated policy at §155.170(a)(2), States would generally be required to defray the cost of QHPs providing the required benefits if they were required through State action taking place after December 31, 2011.

As noted earlier, the Protecting Affordable Coverage for Employees Act, enacted in October 2015, amended the definitions of small employer and large employer in section 1304(b) of the Affordable Care Act and section 2791(e) of the PHS Act such that a small employer is

generally¹⁹ an employer with 1-50 employees, with the option for States to expand the definition of small employer to 1-100 employees.²⁰ We have proposed amendments to § 144.103 to reflect these statutory amendments.

Several States have enacted benefit requirements that would apply to small group insurance plans offered to employers with 51-100 employees, but not to employers with 1-50 employees. This may arise because the State-required benefit was designed to apply only in the large group market when the large group market included employers with more than 50 employees, but the State has since then availed itself of the option to define a “small employer” as an employer with 1-100 employees.

Section 2702 of the PHS Act and §147.104 generally require an issuer to offer all approved products to any individual or employer in the market for which the product was approved and to accept any individual or employer that applies for any approved product in a given market. If a State elects to expand the definition of small employer so that it covers employers with 1-100 employees, all products approved for sale in the small group market (defined by the State as 1-100 employees) generally must be offered to employers with 1-100 employees. This effectively means that existing State benefits mandates that apply to insurance coverage sold to employers with 51-100 employees would then effectively also apply to all products sold to employers with 1-100 employees. As long as the benefit was required by State

¹⁹ Prior to enactment of the Protecting Affordable Coverage for Employees Act, small employer was defined to mean, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In case of plan years beginning before January 1, 2016, a State was able to elect to define small employer by substituting “50 employees” for “100 employees”. For ease of reference with regard to this section, we will refer to employers as having 1-50 or 1-100 employees.

²⁰ States that elect to extend the small employer definition were requested to notify CMS of their election by October 30, 2015 at marketreform@cms.hhs.gov.

action taken on or before December 31, 2011, the expansion of coverage would not trigger the requirement to defray, because the expansion was required to comply with Federal guaranteed availability laws. If a State does not opt to expand the definition of small employer to 1-100 employees, then any State-required benefits applicable in the large group market (including to employers with 51-100 employees) would continue to not apply in the small group market. If a State-required benefit was imposed by State action taking place January 1, 2012 or later, then defrayal generally would be required.

3. General Functions of an Exchange

a. Functions of an Exchange (§155.200)

We propose to amend §155.200(a) to include reference to subpart M, which establishes oversight and program integrity standards for State Exchanges, and subpart O, which establishes quality reporting standards for Exchanges. These subparts were not originally incorporated into this paragraph because they were finalized after §155.200(a) was finalized. We propose incorporating them now because we view them as providing important safeguards for consumers.

We also propose to amend §155.200 by adding a paragraph (f) to address SBE-FPs. This arrangement is intended to permit a State Exchange to leverage existing Federal assets and operations by relying on HHS services for performing certain Exchange functions, particularly eligibility and enrollment functions. The SBE-FP would also rely on HHS to perform certain consumer call center functions and casework processes, and maintain related information technology infrastructure. The SBE-FP would retain responsibility for plan management functions, subject to certain rules requiring the SBE-FP to require its QHP issuers to comply with certain FFE standards governing QHPs and issuers (as proposed in §155.200(f)(2) of this

proposed rule), and consumer support functions, subject to FFE rules governing consumer assistance functions.

Under §155.200(f)(1), we propose that a State may receive approval or conditional approval to operate an SBE-FP under proposed §155.106(c) and meet its obligations under §155.200(a) by entering into a Federal platform agreement with HHS. In the Federal platform agreement, an SBE-FP would indicate its decision to rely on HHS for services related to the individual market Exchange, the SHOP Exchange, or both the individual market and SHOP Exchanges. The Federal platform agreement would specify the Federal services on which the State Exchange relies, the user fee that HHS will collect from issuers in that SBE-FP for the Federal services (as specified at §156.50(c)(2)), and other mutual obligations relating to the arrangement, including obligations for the transfer of data. We intend to release the Federal platform agreement at a later date. We note that at this point the Federal services on which SBE-FPs may rely will come as an entire package. That is, HHS will not at this time offer a “menu” of Federal services from which an SBE-FP may select some but not other services on the Federal platform. However, we will explore the feasibility of doing so in the future.

The Federal platform agreement would also specify expectations between the State and HHS across various operational areas.

Although the SBE-FPs would retain primary, formal responsibility for overseeing QHPs and issuers, we propose under §155.200(f)(2) to require an SBE-FP to establish and oversee certain requirements for its QHPs and QHP issuers that are no less strict than the requirements that apply to QHPs and QHP issuers on an FFE. We propose these requirements to include the existing and proposed standards under the following sections: §156.122(d)(2) (the requirement for QHPs to make available published up-to-date, accurate, and complete formulary drug list on

its website in a format and at times determined by HHS); §156.230 (network adequacy standards); §156.235 (essential community providers standards); §156.298 (meaningful difference standards); §156.330 (changes of ownership of issuers requirement); §156.340(a)(4) (QHP issuer compliance and compliance of delegated and downstream entities requirements); §156.705 (maintenance of records standard), §156.715 (compliance reviews standard); and §156.1010 (casework standards).

Applying the changes of ownership issuers' requirement to SBE-FPs will help fulfill the Federal platform's need for data and technical consistency. It will ensure that HHS maintains the most accurate and updated information to present to consumers through its branded platform, HealthCare.gov. HHS must be able to monitor and provide regulatory oversight over change in control situations. Change in control has a significant operational impact on the Federal platform and requires the expenditure of considerable technical resources to effectuate the change throughout the multiple systems that constitute the Federal platform.

Applying the formulary drug list, network adequacy, meaningful difference, and essential community providers standards will ensure that all QHPs on HealthCare.gov meet a consistent minimum standard and that consumers obtaining coverage as a result of applying through Healthcare.gov are guaranteed plans that meet these minimum standards. For example, all QHP issuers must meet a "reasonable access" network adequacy standard, but FFE issuers must meet additional network adequacy standards. It is important to HHS that shoppers at HealthCare.gov do not enroll in plans that fail to meet these minimum standards, so we propose that SBE-FPs that wish to rely on the HealthCare.gov platform require its issuers to meet these minimum standards as well, since their consumers are obtaining the coverage through HealthCare.gov. SBE-FPs may exceed these minimum standards to the extent they do not present display

problems on HealthCare.gov. Although the SBE-FPs are legally distinct from FFEs, this difference will not always be apparent to Healthcare.gov consumers. Not having these standards apply may lead to consumer confusion and dilution of consumer goodwill with respect to the plans available on HealthCare.gov. The States would conduct QHP certification reviews for these standards.

Applying the QHP issuer compliance and compliance of delegated or downstream entities requirement at §156.340(a)(4), which involves the maintenance of records standards of §156.705 and the compliance reviews for QHP issuers standards of §156.715, will ensure that the SBE-FP has authority at least as strong as that possessed by HHS to enforce compliance with these standards and will ensure that the SBE-FP and HHS are able to access all records upon request from the issuers in the SBE-FPs.

Applying the casework standards at §156.1010 will ensure that the SBE-FP and HHS can respond to problems about which they both bear responsibility. Since SBE-FPs must use the Health Insurance Casework System (HICS) for handling consumer casework and meeting casework resolution timeframes, the SBE-FP would not be overseeing casework processes. However, as with all other Exchange types, State Departments of Insurance will still handle appropriate consumer complaints related to issuers in their States. For cases that are Exchange-related, or those in which the consumer has chosen to contact the Exchange even after contacting the appropriate Department of Insurance, HHS would oversee the routing and resolution of casework. HHS' intent is to work collaboratively with the SBE-FP, similar to how HHS works with SPMs.

Finally, we propose under §155.200(f)(3) that HHS will work with SBE-FPs to enforce the FFE standards listed under §155.200(f)(2) directly against SBE-FP issuers or plans, when the

SBE-FP is not substantially enforcing one or more of these requirements. In that circumstance, we propose that HHS would have the authority to suppress a plan under §156.815. This will ensure that consumers shopping for coverage on HealthCare.gov have access to plans that are in compliance with the FFE standards with which SBE-FP issuers must comply as a condition of offering QHPs through a State Exchange on the Federal platform.

We intend to work closely and collaboratively with SBE-FPs, and believe that our collaboration with States that currently use the Federal platform with respect to enforcement matters has been close and effective. We seek comments on all aspects of this proposal.

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

We propose two amendments to §155.205 to address functions of an SBE-FP. First, because an SBE-FP relies on HHS to carry out call center functions, we propose to amend §155.205(a) to exempt an SBE-FP from the requirement to operate a toll-free call center, and instead provide that an SBE-FP must at a minimum operate a toll-free telephone hotline to respond to requests for assistance to consumers in their State, in accordance with section 1311(d)(4)(B) of the Affordable Care Act. We seek comments on this proposal.

Secondly, we propose to amend §155.205(b) by adding paragraph (b)(7) to provide that an SBE-FP must, at a minimum, operate an informational Internet website through which consumers can also be directed to HealthCare.gov, in accordance with section 1311(d)(4)(C) of the Affordable Care Act. We seek comments on this proposal.

c. Standards Applicable to Navigators under §§155.210 and 155.215; Standards Applicable to Consumer Assistance Tools and Programs of an Exchange under §155.205(d) and (e); and Standards Applicable to Non-Navigator Assistance Personnel in an FFE and to Non-Navigator Assistance Personnel Funded through an Exchange Establishment Grant (§§155.205, 155.210

and 155.215)

We have previously established a range of consumer assistance programs to help consumers apply for and enroll in QHPs and insurance affordability programs through the Exchange. These consumer assistance programs include the Navigator program described at section 1311(d)(4)(K) and (i) of the Affordable Care Act and §155.210. Among other duties, section 1311(i)(3) of the Affordable Care Act requires Navigators to conduct public education activities to raise awareness of the availability of QHPs; to distribute fair and impartial information concerning enrollment in QHPs and the availability of Exchange financial assistance under the Affordable Care Act; to facilitate enrollment in QHPs; and to provide referrals to certain State agencies for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage.

We have also established under §155.205(d) and (e) that each Exchange must provide consumer assistance, outreach, and education functions. These must include a Navigator program and can include a non-Navigator assistance personnel program.

We propose to amend §155.210(e) by adding a new paragraph (e)(8) that would require Navigators in all Exchanges to provide targeted assistance to serve underserved and/or vulnerable populations within the Exchange service area. Section 155.210(b)(2)(i) already requires Navigators to have expertise in the needs of underserved and vulnerable populations. We believe that also requiring Navigators to provide targeted assistance to underserved and vulnerable populations is critical to improving access to health care for communities that often experience a disproportionate burden of disease. In keeping with the spirit of section 1311(i)(3)(A) of the Affordable Care Act, which directs that Navigator entities must conduct public education activities to raise awareness about the availability of QHPs, we believe that

Navigators should focus their outreach and enrollment assistance efforts on harder-to-reach populations and the remaining uninsured, to build increased awareness of the coverage options available through the Exchange and to help new consumers find affordable health coverage that meets their needs.

Because the characteristics of underserved and vulnerable populations may vary over time and from region to region, we do not propose to define and identify these populations for all Exchanges. Instead, we propose to permit each Exchange to define and identify the underserved and vulnerable populations in its service area, and to update these definitions as necessary. This could include an Exchange allowing its Navigator grantees to propose, for the Exchange's approval (for example, in their grant applications), which communities to target. In Federally-facilitated Exchanges, we would identify populations as vulnerable or underserved through our Navigator Funding Opportunity Announcements, and would give FFE Navigator grant applicants an opportunity to propose additional communities to target during the grant application process. Vulnerable or underserved populations might include, for example, populations that are disproportionately without access to coverage or care, or are at a greater risk for poor health outcomes. We propose that these would be the primary criteria used to identify such populations within the FFEs. Members of these populations could be identified by age groups, demographics, disease, geography, or other characteristics as defined or approved by the Exchange. We believe reaching vulnerable or underserved populations is important to increasing awareness among the remaining uninsured of the coverage options available through the Exchange, helping new consumers find affordable coverage that meets their needs, and narrowing health disparities. In Federally-facilitated Exchanges, our proposal would apply beginning with the application process for Navigator grants awarded in 2018.

We seek comment on all aspects of this proposal, including on how Exchanges, including the FFEs, should identify vulnerable or underserved populations in their service areas, and on the appropriate process and timeframes under which these populations would be identified.

Additionally, although we have not proposed to extend this requirement to certified application counselors and non-Navigator assistance personnel subject to §155.215, we encourage certified application counselors and non-Navigator assistance personnel to prioritize reaching and assisting the vulnerable and underserved populations identified by the Exchange in their communities, and we recognize that many of these assisters already focus their efforts on such populations.

We note that Navigators would not exclusively be serving these target populations, since all Navigators are required to assist any consumer seeking assistance. As we have explained in prior rulemakings, we interpret Navigators' duty to provide fair and impartial information and services under §155.210(e)(2) to require that all Navigators should have the ability to help any individual who seeks assistance, even if that consumer is not a member of the community or group the Navigator intends to target (see 78 FR 20589; 78 FR 42830; 79 FR 30270; 79 FR 30278).

In §155.210, we propose to add paragraph (e)(9) to specify that Navigators in all Exchanges would be required to help consumers with certain other types of assistance, including post-enrollment assistance. This proposal is designed to ensure that consumers would have access to skilled assistance beyond applying for and enrolling in health coverage, including, for example, assistance with the process of filing Exchange eligibility appeals or with applying through the Exchange for exemptions from the individual shared responsibility payment, providing basic information about reconciliation of premium tax credits, and understanding basic

concepts related to using health coverage. Section 1311(i)(3)(D) of the Affordable Care Act and §155.210(e)(4) already expressly require Navigators to provide post-enrollment assistance by referring consumers with complaints, questions, or grievances about their coverage to appropriate State agencies. This suggests that Congress anticipated that consumers would need assistance beyond the application and enrollment process, and that Navigators would maintain relationships with consumers and be a source of such assistance.

Consistent with the requirements under section 1311(i)(3)(B) and (C) of the Affordable Care Act that Navigators distribute fair and impartial information concerning enrollment in QHPs and facilitate enrollment in QHPs, and pursuant to the Secretary's authority under section 1321(a)(1)(A) of the Affordable Care Act, we propose at §155.210(e)(9)(i) to require Navigators in all Exchanges to help consumers with the process of filing appeals of Exchange eligibility determinations. We are not proposing to establish a duty for Navigators to represent a consumer in an appeal, sign an appeal request, or file an appeal on the consumer's behalf. We believe that helping consumers understand Exchange appeal rights when they have received an adverse eligibility determination, and assisting them with the process of completing and submitting appeal forms, would help to facilitate enrollment and would help consumers obtain fair and impartial information about enrollment, including information about available exemptions from the individual shared responsibility payment that would help consumers decide whether or not to enroll in coverage. We would interpret this proposal to include helping consumers file appeals of eligibility determinations made by an Exchange (including SHOP Exchanges) related to enrollment in a QHP, special enrollment periods, exemptions from the individual shared responsibility payment that are granted by the Exchange, participation as an employer in a SHOP, and any insurance affordability program, including eligibility determinations for

Exchange financial assistance, Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Programs.

We also propose at §155.210(e)(9)(ii) to require that Navigators in all Exchanges help consumers understand and apply for exemptions from the individual shared responsibility payment that are granted by the Exchange. We believe that it would be consistent with the Secretary's rulemaking authority under section 1321(a)(1)(A) of the Affordable Care Act to require Navigators to provide assistance with exemptions that the Exchange must grant under section 1311(d)(4)(H) of the Affordable Care Act. Additionally, we believe that this proposal is consistent with Navigators' duty under section 1311(i)(3)(B) of the Affordable Care Act to distribute fair and impartial information concerning enrollment in QHPs, since impartial information concerning the availability of exemptions from the individual shared responsibility payment would help consumers make informed decisions about whether or not to enroll in coverage.

This assistance with Exchange-granted exemptions would include informing consumers about the requirement to maintain minimum essential coverage and the individual shared responsibility payment; helping consumers fill out and submit Exchange-granted exemption applications and obtain any necessary forms prior to or after applying for the exemption; explaining what the exemption certificate number is and how to use it; and helping consumers understand and use the Exchange tool to find bronze plan premiums. This duty would also include explaining the general purpose of Internal Revenue Service (IRS) Form 8965 to consumers, consistent with IRS published guidance on the topic, and explaining how to access this form and related tax information on irs.gov.

Navigators may not provide tax assistance or interpret tax rules within their capacity as Exchange Navigators, and this proposal would not require Navigators to help consumers apply for exemptions claimed through the tax filing process. We would interpret this proposal, however, to require helping consumers generally understand the availability of exemptions claimed through the tax filing process and how to obtain them. This interpretation would help ensure that Navigators share information about the full scope of possible exemptions while not providing actual tax assistance or tax advice. We request comment on whether we should require that, prior to providing this assistance and information, Navigators provide consumers with a disclaimer stating that they are not acting as tax advisers and cannot provide tax advice within their capacity as Exchange Navigators. We seek comment on whether such a disclaimer would help avoid consumer misunderstandings and detrimental reliance on Navigator advice, or whether it might be unnecessary, impractical, or cause consumer confusion.

We also seek comment on whether a Navigator's duty to provide assistance with filing exemption applications under proposed §155.210(e)(9)(ii) and filing appeals of exemption application denials under proposed §155.210(e)(9)(i) should be limited, for example, to consumers who have applied for or have been denied coverage or financial assistance, or whether another limitation should apply. We are cognizant of the resource limitations that Navigators and their funding agencies may face, and do not want to reduce the assistance available to consumers seeking coverage, as opposed to those who only seek to avoid the individual shared responsibility penalty. At the same time, we recognize that consumers may be unable to access coverage for a wide variety of reasons, including their financial circumstances, coverage gaps, and other personal or systemic obstacles, and want to be sure that experienced

help is available so that these consumers are fully aware of and can access their exemptions options. We seek comment on these issues.

In addition, we propose at §155.210(e)(9)(iii) to require Navigators to help consumers with the Exchange-related components of the premium tax credit reconciliation process, such as by ensuring they have access to their Forms 1095-A and receive general, high-level information about the purpose of this form that is consistent with published IRS guidance on the topic. This proposal stems from the requirement under section 1311(i)(3)(B) of the Affordable Care Act that Navigators distribute fair and impartial information concerning the availability of the premium tax credits under section 36B of the Code. Consumers who receive advance payments of the premium tax credit may need help with a variety of issues related to reconciliation. Navigators would be required to help consumers obtain IRS Forms 1095-A and 8962, and the instructions for both, and to provide general information, consistent with applicable IRS guidance, about the significance of the forms. Navigators would also be required to help consumers understand (1) how to report errors on the Form 1095-A; (2) how to find silver plan premiums using the Exchange tool; and (3) the difference between advance payments of the premium tax credit and the premium tax credit and the potential implications for enrollment and re-enrollment of not filing a tax return and reconciling any advance payments of the premium tax credit that were paid on consumers' behalf.

As noted above, Navigators may not provide tax assistance or advice, or interpret tax rules and forms within their capacity as Exchange Navigators, but their expertise related to the consumer-facing aspects of the Exchange, including eligibility and enrollment rules and procedures, uniquely qualifies them to help consumers understand and obtain information from the Exchange that is necessary to the premium tax credit reconciliation process. Because this

proposal would include a requirement that Navigators provide consumers with information and assistance understanding the availability of IRS resources, Navigators would be expected to familiarize themselves with the availability of materials on [irs.gov](https://www.irs.gov), including the Form 8962 instructions, IRS Publication 974 Premium Tax Credit, and relevant FAQs, and to refer consumers with questions about tax law to those resources or to other resources, such as free tax return preparation assistance from the Volunteer Income Tax Assistance or Tax Counseling for the Elderly programs. Again, we request comment on whether we should require that, prior to providing this information and assistance, Navigators provide consumers with a disclaimer stating that they are not acting as tax advisers and cannot provide tax advice within their capacity as Exchange Navigators.

To help ensure consumers have seamless access to Exchange-related tax information beyond the basic information that Navigators can provide, we propose at 155.210(e)(9)(v) that Navigators be required to refer consumers to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Exchange application and enrollment process, exemptions from the requirement to maintain minimum essential coverage and the individual shared responsibility payment, and premium tax credit reconciliation.

We interpret the Navigator duties to facilitate enrollment in QHPs in section 1311(i)(3)(C) of the Affordable Care Act, to distribute fair and impartial information concerning enrollment in QHPs under section 1311(i)(3)(B) of the Affordable Care Act, and to conduct public education activities to raise awareness about the availability of QHPs in section 1311(i)(3)(A) of the Affordable Care Act to include helping consumers understand the kinds of decisions they will need to make in selecting coverage, and how to use their coverage after they

are enrolled. We have previously stated that one overall purpose of consumer assistance programs is to help consumers become fully informed and health literate. (See 79 FR 30276.) To improve consumers' health literacy related to coverage generally, and to ensure that individual consumers are able to use their coverage meaningfully, we propose at §155.210(e)(9)(iv) to require Navigators in all Exchanges to help consumers understand basic concepts related to health coverage and how to use it. These activities could be supported through the use of existing resources such as the HHS "From Coverage to Care" initiative, which we encourage Navigators to review, and which are now available in multiple languages at <https://marketplace.cms.gov/c2c>. This proposal would improve consumers' access to health coverage information not just when selecting a plan, but also when using their coverage. For example, Navigators could help consumers understand (1) key terms used in health coverage materials, such as "deductible" and "coinsurance," and how they relate to the consumer's health plan; (2) the cost and care differences between a visit to the emergency department and a visit to a primary care provider under the coverage options available to the consumer; (3) how to identify in-network providers to make and prepare for an appointment with a provider; (4) how the consumer's coverage addresses steps that often are taken after an appointment with a provider, such as making a follow-up appointment and filling a prescription; and (5) the right to coverage of certain preventive health services without cost sharing. We anticipate that this assistance would vary depending on each consumer's needs and goals. We invite comment on whether we should provide additional specificity for Navigators related to this proposed duty to help consumers understand and use their coverage, and if so, which additional topics should be included.

We note that under §155.215(b)(2), Navigators in FFEs must already be trained on the tax implications of enrollment decisions, the individual responsibility to have health coverage, eligibility appeals, and rights and processes for QHP appeals and grievances. To ensure that Navigators in all States receive training in every area for which there would be a corresponding Navigator duty, we propose to require all Exchanges, including State Exchanges, to provide training that would prepare Navigators for the additional areas of responsibility proposed in this rulemaking. In proposed §155.210(b)(2)(v) through (viii), therefore, we would require Exchanges to develop and disseminate training standards to be met by all entities and individuals carrying out Navigator functions to ensure expertise in: the process of filing appeals of Exchange eligibility determinations; general concepts regarding exemptions from the requirement to maintain minimum essential coverage and the individual shared responsibility payment, including the application process for exemptions granted through the Exchange, and IRS resources on exemptions; the Exchange-related components of the premium tax credit reconciliation process and IRS resources on this process; and basic concepts related to health coverage and how to use it.

We note that providing assistance with certain other post-enrollment issues already falls within the scope of existing required Navigator duties. We interpret the requirement to facilitate enrollment in a QHP under section 1311(i)(3)(C) of the Affordable Care Act, and the requirement at §155.210(e)(2) to provide information that assists consumers with submitting the eligibility application, to include assistance with updating an application for coverage through an Exchange, including reporting changes in circumstances and assisting with submitting information for eligibility redeterminations.

Additionally, Navigators are already permitted, but not required, to help with a variety of other post-enrollment issues. For example, we interpret the requirements in §155.210(e)(1) and (2) that Navigators conduct public education activities to raise awareness about the Exchange and provide fair and impartial information about the application and plan selection process to mean that Navigators may educate consumers about their rights with respect to coverage available through an Exchange, such as nondiscrimination protections, prohibitions on preexisting condition exclusions, and preventive services available without cost-sharing. We also interpret these requirements, together with the requirement in section 1311(i)(3)(B) of the Affordable Care Act that Navigators distribute fair and impartial information concerning enrollment in QHPs, and the availability of Exchange financial assistance, to mean that Navigators may assist consumers with questions about paying premiums for coverage or insurance affordability programs enrolled in through an Exchange. Finally, we interpret the requirement in section 1311(i)(3)(D) of the Affordable Care Act and §155.210(e)(4) to provide referrals for certain post-enrollment issues to mean that Navigators may help consumers obtain assistance with coverage claims denials. We request comments on whether we should make any of the above interpretations explicit in the regulation and whether there are additional post-enrollment duties required or permitted by these provisions that should be made explicit as either required or simply permitted (but not required) duties, as well as whether there are other forms of post-enrollment assistance that Exchanges should require Navigators to provide, commensurate with their general legal authority, but which are not already specifically required under our regulations.

Although we have not proposed to extend any of the requirements under proposed §155.210(e)(8) or (9) to non-Navigator assistance personnel subject to §155.215, we note that the

requirement to provide information that assists consumers with submitting the eligibility application under §155.210(e)(2), which would include helping consumers report changes in circumstances and submit information for eligibility redeterminations, also applies to certain non-Navigator assistance personnel through §155.215(a)(2)(i). We also note that under §155.215, the training requirements for these non-Navigator assistance personnel are the same as for Navigators in States with an FFE.

We have also not proposed to extend any of these requirements to certified application counselors. However, nothing prevents non-Navigator assistance personnel or certified application counselors from helping with activities that are consistent with their existing regulatory duties. We request comments on whether we should extend these proposed requirements to help with post-enrollment and other activities to these assisters.

We propose to amend §§155.205(d) and 155.215(b)(1)(i) to specify that any individual or entity carrying out consumer assistance functions under §155.205(d) and (e) or §155.210, in both State Exchanges and FFEs, would be required to complete training prior to performing any assister duties, including before conducting outreach and education activities, as well as before providing application and enrollment assistance. Section 155.215(b), which establishes training standards for Navigators and non-Navigator assistance personnel in FFEs and for non-Navigator assistance personnel funded through Exchange Establishment grants under section 1311(a) of the Affordable Care Act, requires that these assisters must obtain certification by the Exchange prior to carrying out any consumer assistance functions under §155.205(d) and (e) or §155.210. We also propose to amend §155.215(b)(1)(i) to specify that the consumer assistance functions referenced in that provision would include outreach and education activities. In addition, we propose to amend §155.205(d) to specify that training would have to be completed not only

before providing the assistance described in that paragraph, but also before conducting the outreach and education activities specified in paragraph (e). These proposals would require that Navigators, non-Navigator assistance personnel subject to §155.215, and other entities and persons providing consumer assistance under §155.205(d) and consumer outreach and education activities under §155.205(e), complete training prior to carrying out any consumer assistance functions, including outreach and education activities.

We note that nothing in the Exchange regulations prohibits individuals or organizations from conducting outreach about Exchanges and providing application and enrollment assistance without being trained and certified as Navigators, non-Navigator assistance personnel, certified application counselors, or other kinds of Exchange-approved assisters. However, this proposal would ensure that individuals and organizations do not perform any Exchange outreach and education activities or application and enrollment assistance while identifying as or holding themselves out to the public as Navigators, non-Navigator assistance personnel, or certified application counselors, prior to completing Exchange requirements, including training and certification. This proposal would also help ensure that Navigators and non-Navigator assistance personnel are providing accurate information when performing outreach and education activities.

Section 155.210(d)(6) currently prohibits Navigators from providing to an applicant or potential enrollee any gifts unless they are of nominal value; or any promotional items that market or promote the products or services of a third party, when those promotional items are being used as an inducement for enrollment. Through a cross-reference to §155.210(d) in §155.215(a)(2)(i) and a parallel provision in §155.225(g)(4), this prohibition also applies to non-Navigator assistance personnel subject to §155.215, and to certified application counselors.

We have received questions indicating that there is general confusion about when gifts and promotional items can be provided to applicants and potential enrollees. To reduce this confusion, we propose to amend §§155.210(d)(6) and 155.225(g)(4) to specify that gifts of any value (including third-party promotional items of any value) should never be provided to applicants or potential enrollees as an inducement for enrollment. We also propose to specify that gifts that are not provided as an inducement for enrollment may be provided to applicants and potential enrollees if they do not exceed nominal value.²¹ This proposed nominal value restriction would apply both to each individual gift and to the cumulative value of multiple gifts, including promotional items, which are provided by these types of assisters to an applicant or potential enrollee. We further propose that the nominal value restriction on the cumulative value of multiple gifts would only apply to single encounters between the assister and an individual applicant or potential enrollee, and not to multiple encounters, so that assisters would not have to collect PII as a means of tracking the number and value of gifts provided to an individual consumer across multiple encounters, such as all encounters in a single calendar year or enrollment season. Since we anticipate that gifts or promotional items of a nominal value, such as pens, magnets or keychains, could be provided to consumers at outreach and education events or at other forums attended by members of the general public, we do not want to establish a nominal value restriction that would be difficult or burdensome for assisters to enforce, or that would require the unnecessary collection of PII from consumers. We would consider a single outreach or educational event to be a “single encounter”; that is, assisters would not be permitted to provide multiple gifts to the same consumer at the same outreach event if the cumulative value

²¹ We have previously defined “nominal value” as a cash value of \$15 or less, or an item worth \$15 or less, based on the retail purchase price of the item, regardless of the actual cost. (79 FR 15831 and 79 FR 30283).

of those gifts exceeded nominal value. We seek comments on all aspects of this proposal, including whether the nominal value restriction should apply to a single encounter with an individual consumer, as proposed, or whether a longer timeframe, such as all encounters with an individual consumer in a calendar year, in an enrollment season, or in total, would be preferable.

Finally, to simplify the rule, we propose to define “gifts,” for purposes of §§155.210(d)(6) and 155.225(g)(4), to include gift items, gift cards, cash cards or cash, as well as promotional items that market or promote the products or services of a third party. We further propose to amend language in §§155.210(d)(6) and 155.225(g)(4) that currently provides that gifts, gift cards, or cash may exceed nominal value for the purpose of providing reimbursement for legitimate expenses incurred by a consumer in an effort to receive Exchange application assistance, such as travel or postage expenses. We propose to amend this language to indicate that the reimbursement of legitimate expenses, such as travel or postage expenses, when incurred by a consumer in an effort to receive Exchange application assistance, would not be considered a gift, and therefore, would not be subject to the proposed restrictions on providing gifts.

Our proposal seeks to strike a balance between permitting these types of assisters to provide small gifts and promotional items as part of creative outreach and education strategies, while ensuring that gifts, including promotional items, are never provided to applicants and potential enrollees to induce enrollment. We believe this outright prohibition on providing gifts and promotional items, of any value, to induce enrollment, is consistent with the duties of these assisters to provide information and services to consumers in a fair, accurate, and impartial manner, including clarifying the distinctions among health coverage options, and helping consumers make informed decisions during the health coverage selection process. We believe it

would be inconsistent with these duties for an assister to try to influence the consumer's decision about whether to enroll in coverage by providing them with a gift to induce enrollment.

In addition, the duty of these assisters to provide information and services in a fair, accurate and impartial manner would make it inappropriate for them to engage in activities that give the appearance that they are endorsing, promoting, or marketing the products or services of third party business interests when performing their authorized activities and services. At the same time, we believe that any appearance that these assisters are endorsing, promoting, or marketing the products or services of a third party, is substantially mitigated if the items are only of nominal value and not provided to induce enrollment, since it is unlikely that gifts of a nominal value will influence a consumer's health coverage selection and enrollment decisions. We also recognize that providing gifts, including promotional items, of a nominal value may help to attract applicants and potential enrollees to engage in a discussion with these assisters during an outreach event and encourage consumers to consider seeking Exchange application assistance. For these reasons, we do not want to entirely prohibit these types of assisters from using gifts and promotional items as part of their outreach efforts.

Finally, we note that existing regulations under §155.210(d)(7) already prohibit the use of Exchange funds to purchase gifts or gift cards, or promotional items that market or promote the products or services of a third party, that would be provided to any applicant or potential enrollee. We do not propose to amend this provision.

We request comments on all aspects of our proposals.

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

Section 1312(e) of the Affordable Care Act directs the Secretary to establish procedures under which a State may permit agents and brokers to enroll qualified individuals and qualified employers in QHPs through an Exchange, and to assist individuals in applying for financial assistance for QHPs sold through an Exchange. Under §155.220, we established procedures to support the States' ability to permit agents and brokers to assist individuals, employers or employees with enrollment in QHPs offered through an Exchange, subject to applicable Federal and State requirements.

At §155.220(c), we established parameters for enrollment of qualified individuals through an Exchange with the assistance of an agent or broker. At §155.220(c)(1), we established that an agent or broker who assists with enrollment through the Exchange must ensure completion of an eligibility verification and enrollment application through the Exchange website as described §155.405. In §155.220(c)(3), we established the standards that apply when a website of an agent or broker is used to complete the QHP selection.

As described at §155.220(d), an agent or broker that enrolls qualified individuals through an Exchange, or assists individuals in applying for Exchange financial assistance, must comply with the terms of a general agreement with the Exchange, as well as register with the Exchange and receive training in the range of QHP options and insurance affordability programs. In addition, all agents and brokers must execute the applicable privacy and security agreement required by §155.260(b) to provide assistance with enrollment through the Exchange.

In §155.220(g), we established standards under which HHS may terminate an agent's or broker's general agreement with the FFEs for cause. We established that HHS may pursue termination with notice of an agent's or broker's agreement with the FFEs if, in HHS's determination, a specific finding of noncompliance or pattern of noncompliance is sufficiently

severe. As established, the termination for cause of the general agreement with notice means that after a 30-day opportunity to resolve the matter, HHS would take necessary steps to prohibit an agent or broker from assisting or enrolling individuals in a QHP offered through an FFE, or a web-broker's ability to securely exchange information with HHS, if the matter is not resolved to the satisfaction of HHS. As of the date of termination, an agent or broker would no longer be registered with the FFEs and would not be able to assist with enrollment through the FFEs or exchange information with HHS. Certain obligations of the agent or broker would survive that termination, including the duty to protect and maintain the privacy and security of personally identifiable information (PII) it has created, collected, accessed, or acquired through its relationship with the FFEs. We established that an agent or broker may be considered noncompliant if HHS finds that the agent or broker violated: (a) any standard specified under §155.220; (b) any term or condition of its agreement with the FFEs required under paragraph (d) of this section, or if, the agent's or broker's FFE privacy and security agreements under §155.260(b) are terminated; (c) any applicable State law; or (d) any other applicable Federal law.

In §155.220(h), we established a one-level process through which an agent or broker may request reconsideration of HHS's decision to terminate for cause an agreement required under §155.220(d). We established that an agent or broker must submit a request for reconsideration to the HHS reconsideration entity within 30 calendar days of the date of the written termination notice from HHS. We established that the HHS reconsideration entity would provide the agent or broker with a written reconsideration decision within 30 calendar days of the date it receives the request for reconsideration. This decision constitutes HHS's final determination.

i. New Exchange Standards for Web-brokers.

As specified at §155.220(c)(1), an agent or broker who assists with an enrollment through the Exchange must ensure that the applicant completes an eligibility verification and enrollment application through the Exchange Internet website. Under this standard, agents and brokers that use a non-Exchange website to assist consumers in the QHP selection and enrollment process (“direct enrollment” through a “web-broker”) must redirect an applicant to go directly to the Exchange website to complete the application and receive an eligibility determination. HHS is considering an option under which an applicant could remain on the web-broker’s website to complete the application and enroll in coverage, and the web-broker’s website can obtain eligibility information from the Exchange to support the consumer in selecting and enrolling in a QHP with Exchange financial assistance. The intent is to have this information exchange occur through an Exchange-approved web service as described below, enhancing the direct enrollment process. This option would provide Exchanges offering direct enrollment and web-brokers more operational flexibility to expand front-end, consumer-facing channels for enrollment through a seamless consumer experience.

HHS solicits comments related to the current consumer experience with web-brokers and the potential integration of the streamlined eligibility application if a non-FFE website is used for the entire process. We request comment on how much flexibility a web-broker should have relative to the consumer experience on its website, using the direct enrollment channel, to provide an end-to-end eligibility and enrollment experience. We propose that web-brokers be required to use the FFE single streamlined application without deviation from the language of the application questions and the sequence of information required for an eligibility determination or redetermination. This will ensure that the information gathered when an applicant completes an application on the Exchange website will also be collected to send to the Exchange for an

eligibility determination or redetermination that is accurate and consistent across any channel used for enrollment. We seek comment on this standard. HHS is also considering how to ensure that consumers understand that they are applying for Exchange coverage, such as through specific branding or wording requirements if a non-FFE front-end website is used for the entire application and enrollment process, and we seek comment on this as well.

Accordingly, we propose to revise §155.220(c)(1) to ensure that an applicant who initiates enrollment directly with the web-broker for enrollment through the Exchange receives an eligibility determination for coverage through the Exchange website or through an Exchange-approved web service via the FFE single streamline application. This maintains the role of the Exchange in determining eligibility. We propose to adopt similar changes to the standards for the use of QHP issuer websites under §156.265(b)(2)(ii). Please see section III.G.4.c for this accompanying preamble discussion. We seek comment on this proposal.

We are also soliciting comments about the current agent and broker provisions in §155.220 as applied to web-brokers. We are interested in feedback on consumer and agent/broker experiences with enrollment through web-brokers, any concerns with privacy and security of the information transmitted through web-brokers by expanding direct enrollment to incorporate the FFE single streamlined application, and suggestions for improvements in the future, such as increased monitoring and oversight activities. For example HHS is considering expanding audits, requiring additional information display requirements (such as the lowest cost plan at each metal level) beyond those outlined in §155.220(c)(3) to ensure that consumers understand basic information about cost and availability of qualified health plans, and requiring HHS approval of alternative enrollment pathway processes. Additional requirements to safeguard consumer information or enhancements to improve the consumer and web-broker

experience are also being considered. These may include establishing more robust privacy and security requirements, requiring adoption of cyber security best practices, additional web-broker reporting requirements and specificity as to the collection and use of consumer information. We note that the current oversight provisions for the general agreement, registration, training, termination, and reconsideration in §155.220(d) through (h), as well as the changes in paragraphs (f), (g), (j), and (k) proposed below, would apply to web-brokers.

ii. New Standards for Termination of Agent and Broker Agreements with the FFEs.

We propose to amend existing paragraph (g)(2)(ii) that an agent or broker may be determined noncompliant if HHS finds that the agent or broker violated any term or condition of the agreement with the FFEs required under paragraph (d) of this section, or any term or condition of an agreement with the FFEs required under §155.260(b).

We propose to add paragraph (g)(5) to §155.220(g) to address suspension or termination of an agent's or broker's agreements with the FFEs in cases involving potential fraud or abusive conduct. These cases would include cases in which there is an allegation of potential fraud or abusive conduct that HHS finds to be credible; or any report of potential fraud or abusive conduct made by a State or Federal agency or law enforcement. We propose to add this paragraph to give HHS authority to act quickly to terminate access to HHS systems in these instances to prevent further harm to consumers and to support the efficient and effective administration of the FFEs.

We propose in §155.220(g)(5)(i)(A) that if HHS reasonably suspects that an agent or broker may have engaged in fraud or abusive conduct using PII of Exchange applicants or enrollees, or in connection with an Exchange enrollment or application, HHS may suspend the agent's or broker's agreement and accompanying registration with the FFEs for up to 90 calendar

days, with the suspension effective as of the date of the notice to the agent or broker. This would apply whether the activity or conduct in question was committed directly by the agent or broker, or through a third party who acts at the direction of or on behalf of the agent or broker. This immediate and temporary suspension would prohibit the agent or broker from assisting with or facilitating enrollment in coverage in a manner that constitutes enrollment through the FFEs, including enrollment through the FFE Application Programming Interface, while the investigation is conducted during this 90-day period. Immediate suspension is critical in these circumstances to stop additional potentially fraudulent enrollments through the FFE during the period of investigation. Although the agent or broker would not be provided with advance notice, we propose under §155.220(g)(5)(i)(B) that the agent or broker may submit evidence to HHS to rebut the allegation during this 90-day period. If HHS determines that the agent or broker satisfactorily addresses the concerns at issue, HHS would lift the temporary suspension and notify the agent or broker. We further propose under §155.220(g)(5)(i)(B) that failure to submit information during this 90-day period may result in termination of the agreement for cause effective immediately under §155.220(g)(5)(ii).

We propose in §155.220(g)(5)(ii) that if HHS reasonably confirms the credibility of an allegation that an agent or broker engaged in fraud or abusive conduct using personally identifiable information of Exchange enrollees or applicants, or in connection with an Exchange enrollment or application, or is notified by a State or law enforcement authority of the State or law enforcement authority's finding or determination of fraud or behavior that would constitute abusive conduct in such a circumstance, HHS will notify the agent or broker and terminate, immediately and permanently, the agent's or broker's agreements with the FFEs for cause. In contrast to termination for other violations listed in §155.220(g), we propose that following an

HHS reasonable confirmation of such an allegation or such a State or law enforcement notification, termination would occur without 30 days' advance notice and would be effective upon the date of the termination notice. An agent or broker who engages in fraud or abusive conduct may pose immediate harm to consumers and to HHS's ability to properly administer the FFEs. Under this scenario, following the reasonable confirmation by HHS (that is, the FFE) of fraud or abusive conduct, HHS would notify the agent or broker of HHS's termination action. We note that we would coordinate with OIG and other State and Federal agencies (including law enforcement) as appropriate when investigating these situations. Similar to any termination for cause described in paragraph (g)(1), any termination notice would include information on the agent's or broker's right to seek reconsideration as described in §155.220(h). HHS currently works with States and local law enforcement to investigate and resolve suspected incidents of fraud. We note that termination proposed in §155.220(g) only applies to the FFE agreement described in paragraph (d) of this section, and the agreements required under §155.260(b)(2). While States remain the primary oversight authority for agents and brokers, HHS reserves the right to take any other permissible enforcement or remedial action against an agent or broker for violation of Federal requirements.

In §155.220(g)(5)(iii), we propose that during the 90-day suspension period, as well as following the termination of the FFE agreements for cause, the agent or broker would not be registered with the FFEs, or be permitted to assist with or facilitate enrollment of qualified individuals, qualified employers, or qualified employees through an FFE, or assist individuals in applying for Exchange financial assistance for QHPs. However, consistent with the FFE agreement described in §155.260(b)(2), the agent or broker must continue to protect any PII accessed during the term of the agreement with the FFEs. Section 155.260(g) includes penalties

for failure to continue protecting PII as described in the §155.260(b)(2) agreement. For consistency with these proposed termination standards, we propose corresponding updates to paragraph (g)(4). We also propose to amend existing paragraph (f)(4) to remove the reference to paragraph (g) for further alignment of these regulatory provisions.

We solicit comment on all aspects of these proposals, including: the appropriate length of time for the temporary suspension period under §155.220(g)(5)(i); whether we should provide authority for HHS to suspend an agent's or broker's agreements with the FFEs for cause for conduct other than potential fraud or abusive conduct; and whether we should include a provision permitting HHS to immediately terminate (that is, without the advance 30-day notice currently provided under §155.220(g)(3)) an agent's or broker's agreements with the FFEs for cause for suspected conduct other than fraud or abusive conduct. We are also considering whether the notice requirements captured in §155.220(f)(3)(i) that currently apply to agent or broker initiated terminations should also be extended to terminations for cause under §155.220(g), including these proposed grounds for termination for cause under §155.220(g)(5). In addition, see §155.430 below for a discussion of proposals related to retroactive termination of coverage for consumers affected by potential fraudulent activity by a third party related to enrollment through the FFEs.

iii. FFE Standards of Conduct for Agents and Brokers.

We propose adding a paragraph §155.220(j) to establish standards of conduct for agents and brokers that assist consumers to enroll in coverage through the FFEs to protect consumers and ensure the proper administration of the FFEs. We are proposing these standards of conduct to protect against agent and broker conduct that is harmful towards consumers, or prevents the efficient operation of the FFEs. In §155.220(j)(1)(i) through (iii), we propose to capture as part

of these standards of conduct the requirements that an agent or broker that assists with or facilitates enrollment of qualified individuals, qualified employers, or qualified employees through an FFE, or assists individuals in applying for Exchange financial assistance for QHPs sold through the FFEs, must (i) have executed the required agreement under §155.260(b)(2); (ii) be registered with the FFEs as described in paragraph (d)(1) of this section; and (iii) comply with the FFE standards of conduct proposed in this paragraph. We note that signing of the FFE agreement as well as all required registration steps must be completed prior to assisting with or facilitating enrollment of qualified individuals, qualified employers, or qualified employees through an FFE, or assisting individuals in applying for Exchange financial assistance for QHPs sold through the FFEs.

In §155.220(j)(2), we propose to capture as part of the standards of conduct the requirements that the agents and brokers described in paragraph (j)(1) must: (i) provide consumers with correct information, without omission of material fact, regarding the FFEs, QHPs (including SADPs²²) offered through the FFEs, and insurance affordability programs, and refrain from marketing or conduct that is misleading or coercive, or discriminates based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation; (ii) provide the FFEs with correct information under section 1411(b) of the Affordable Care Act; (iii) obtain the consent of the individual, employer, or employee prior to assisting with or facilitating enrollment in coverage through an FFE, or assisting with the application for financial assistance for QHPs

²² As detailed in the Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule (77 FR 18310, 18315) (March 27, 2012), with some limited exceptions, SADPs are considered a type of QHP. We expect agents, brokers, and web-brokers registered with the FFEs to comply with applicable rules and requirements in connection with SADPs, just as they must comply with those rules in connection with medical QHPs.

sold through the FFEs; (iv) protect consumer PII in accordance with §155.260(b)(3) and the agreement described in §155.260(b)(2); and (v) comply with all applicable Federal and State laws and regulations. We note that these proposed standards for conduct extend to naming of businesses and websites associated with agents, brokers or web-brokers, and that use of “Exchange,” “Marketplace,” or other words in a name or URL that would reasonably cause confusion with a Federal program or website may be considered misleading under paragraph (j)(1)(i).

In §155.220(j)(3), we propose that an agent or broker will be considered to be in compliance with the standard of conduct requirements to provide consumers and the FFEs with correct information if HHS determines that there was a reasonable cause for any failure to provide correct information and that the agent or broker acted in good faith.

We further propose that violation of these standards of conduct may result in termination for cause of the agent’s or broker’s agreements with the FFEs as described in paragraph §155.220(g) or the imposition of other penalties authorized by law. We will continue to coordinate our enforcement activities with States, other Federal agencies, and local and Federal law enforcement, and anticipate imposing penalties (beyond the termination of the FFE agreements) only in instances where States do not or are unable to act.

We expect that States will continue to license and monitor agents and brokers, and will continue to have primary responsibility to oversee and regulate all agents and brokers, both inside and outside of the Exchanges. All State laws and regulations related to agents and brokers, including State requirements related to appointments, contractual relationships with issuers, and licensing and marketing requirements, will continue to apply. To avoid duplication of oversight activities related to agents and brokers assisting with enrollment through an FFE, we

propose that HHS will continue to focus its oversight activities primarily on ensuring that agents and brokers assisting with enrollment through an FFE meet the standards outlined in §155.220. In particular, HHS plans to focus on protecting the privacy and security of PII of applicants and enrollees through the FFEs, as well as the misuse of such PII, to the extent this is not already covered under existing State or Federal efforts. We will continue to collaborate with State regulators to resolve cases of potential misconduct and to further develop standard operating procedures for the FFEs that will be critical to HHS oversight of agents and brokers registered to assist with enrollment through the FFEs.

iv. Penalties other than termination of the agreements with the FFEs.

In §155.220(k), we propose penalties for agents and brokers registered with the FFEs other than termination of the agreements with the FFEs. In §155.220(k)(1), we propose that if HHS determines that an agent or broker fails to comply with the requirements of §155.220, he or she may be denied the right to enter into an agreement with the FFEs in future years, and may be subject to CMPs as described in §155.285 if the violation involved the provision of false or fraudulent information to an Exchange or the improper use or disclosure of information. In §155.220(k)(2), we propose that the denial of the right to enter into an agreement with the FFEs in future years would be subject to 30 calendar days' advance notice and the reconsideration process established in §155.220(h). The imposition of CMPs for the provision of false or fraudulent information to an Exchange or the improper use or disclosure of information would be subject to the advance notice and appeals process described in §155.285.

We are also proposing a denial of the right to enter into future agreements with the FFEs in cases where an agent or broker has not completed FFE registration requirements, and not entered into the required agreements with the FFEs, but has enrolled qualified individuals,

qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through an FFE, or assisted individual market consumers with submission of applications for Exchange financial assistance through an FFE and has sought compensation based on the enrollment through the FFEs in his or her capacity as an agent or broker. We note that §155.285 applies to agents and brokers, and we propose to specify here that agents and brokers may also be subject to CMPs as described in §155.285 for noncompliance if the violation involved the provision of false or fraudulent information to an Exchange or the improper use or disclosure of information. We seek comment on these additional proposed penalties, including the length of time for which the prohibition on entering into an agreement with the FFEs would apply in these cases.

We intend to continue to collaborate with State regulators to further develop standard operating procedures for an FFE that will be critical to HHS's oversight of agents and brokers registered to assist with enrollment through an FFE and to ensure the efficient and effective administration of the FFEs. We encourage comment on the information required to carry out these activities, and on any definitions, timeframes, or procedures described in our proposed amendments to §155.220.

v. Agents and brokers assisting consumers with enrollment in coverage through SBE-FPs.

We propose adding §155.220(l) to provide that an agent or broker who enrolls qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through an SBE-FP, or assists individual market consumers with submission of applications for Exchange financial assistance through an SBE-FP must comply with all applicable FFE standards in §155.220. We believe it is important to extend the FFE standards in §155.220 to agents and brokers who assist with enrollments through an SBE-FP due to the

HHS's role in operating the FFE infrastructure and the accompanying access that this provides to HHS data systems. We also propose that agents and brokers in SBE-FP States would be able to satisfy the requirement for training in §155.220(d)(2) by taking FFE training offered by a vendor as described in §155.222.

e. Standards for HHS-Approved Vendors of FFE Training for Agents and Brokers
(§155.222)

At §155.222, we previously established a process for HHS to approve vendors to offer training and information verification services through which State licensed agents and brokers could complete the training requirements necessary to assist consumers seeking coverage through the FFEs. As part of an approved training and information verification program, we stated that the vendor must require agents and brokers to successfully complete identity proofing, provide identifying information, and successfully complete the required curriculum. Further, we established that no vendor training program would be recognized unless it included an information verification component under which the vendor confirms the identity and applicable State licensure of the person who is credited with successful completion of the training program.

We propose eliminating the §155.222 requirement that vendors perform information verification functions, including State licensure verification and identity proofing. Section 155.220(e) requires an agent or broker that enrolls qualified individuals through the Exchange or assists with the submission of applications for financial assistance through an Exchange to comply with applicable State law, which includes requirements related to operating as an insurance producer, such as licensure. We expect that QHP issuers will adhere to the §156.340(a)(3) requirement to ensure their delegated and downstream entities, which include affiliated agents and brokers, comply with the standards of §155.220 with respect to assisting

with enrollments in QHPs, including the requirement to comply with applicable State law. The FFE will continue to provide identity proofing services to facilitate the registration of agents or brokers as required by §155.220(d)(1). We propose these changes to avoid duplication of efforts. If QHP issuers are ensuring that their affiliated agents and brokers are complying with State law, such as licensure, it is not necessary for vendors to do so as well. Consistent with this proposal, we propose amending §155.222(a)(1) to provide that a vendor must be approved by HHS, and remove the reference to information verification. We also propose in §155.222(a)(2) to remove the requirements that vendors must require agents and brokers to provide proof of valid State licensure.

Consistent with these changes proposed for §155.222(a), we propose amending §155.222(b)(1) through (5) and (d) to remove standards for information verification, identity proofing, verification of agents' and brokers' valid State licensure, and all related standards that support these functions. We propose to eliminate the requirements in paragraphs (b)(1)(i) through (ii) to submit an application demonstrating prior experience with verification of State licensure and identity proofing; instead, we propose to combine into paragraph (b)(1) the existing requirements to demonstrate prior experience with online training and technical support for a large customer base. In paragraph (b)(2), we propose to eliminate the requirement to adhere to HHS specifications for content, format, and delivery of information verification; separately, in (b)(2), we propose to include SBE-FP States in the requirement to offer continuing education units (CEUs) in five FFE States. In paragraph (b)(3), we propose to eliminate the requirement that vendors collect, store, and share with HHS all data from agent and broker users of the vendor's training; instead we propose that vendors would only be required to collect, store and share with HHS FFE training completion data. In paragraph (b)(4), we propose to amend the

standards for the agreement that vendors must execute with HHS, to eliminate the requirement that vendors implement information verification processes. We propose amending §155.222(b)(5) and (d) to remove references to information verification. We solicit comment on the proposals to eliminate these requirements related to information verification.

We propose adding a paragraph (b)(6) to require vendors to provide technical support to agent and broker users of the vendor's FFE training as specified by HHS. Currently, paragraph (b)(1) requires vendors to demonstrate prior experience with providing technical support to a large customer base. We propose adding this requirement to specify that a vendor must provide tier-one help desk support to assist agents and broker accessing the vendor's FFE training platform from the CMS Enterprise Portal. Tier-one support includes, for any inquiry received by the vendor's help desk, intake, initial response, and resolution of inquiry through a scripted response or re-routing to another help desk. The scope of inquiries that must be answered through scripted response will be provided by HHS in guidance. We seek comments on the requirement that a vendor must provide technical assistance as specified by HHS to agent and broker users of the vendor's FFE training.

We note that HHS has the authority to require approved vendors to provide technical support, as well as FFE training, in accordance with HHS guidelines and in a manner and format that complies with Section 508 of the Rehabilitation Act of 1973. The World Wide Web Consortium's Web Content Accessibility Guidelines (WCAG) 2.0 Level AA standards is an alternative that we propose would also be considered an acceptable national standard for website accessibility. For more information see, the WCAG website at <http://www.w3.org/TR/WCAG20/>.

f. Standards Applicable to Certified Application Counselors (§155.225)

This proposed rule would also require certified application counselor organizations to report performance data to an Exchange, in order to improve the ability of each Exchange to monitor the work of the organizations it has designated as certified application counselor organizations. In accordance with the Secretary's authority under section 1321(a)(1)(A) of the Affordable Care Act to establish standards related to the operation of Exchanges, we propose to amend §155.225(b)(1) to provide that certified application counselor designated organizations must, as a condition of their designation as certified application counselor organizations by the Exchange, provide the Exchange with information and data related to the number and performance of the organization's certified application counselors, and about the consumer assistance being provided by the organization's certified application counselors, upon request, in the form and manner specified by the Exchange.

Section 155.225(b)(1)(ii) already requires certified application counselor designated organizations to maintain a registration process and method to track the performance of certified application counselors, but it does not specify the type of performance information that must be tracked, nor does it require that information to be provided to the Exchange.

The proposed requirement would give Exchanges valuable information to aid in their oversight of certified application counselor programs, and would help improve Exchanges' understanding of the scope of consumer assistance being provided in the Exchange service area. The proposed requirement would also improve the consumer assistance functions of the Exchange in other significant ways, for example, by providing information that could help an Exchange focus its outreach and education efforts, target its recruitment of certified application counselor organizations, and identify the need for increased technical assistance and support for certified application counselor organizations.

Under this proposal, Exchanges could establish reporting standards as they determine appropriate based on their own specific needs and objectives. In States with FFEs, HHS proposes that it would begin collecting information and data from certified application counselor designated organizations on a monthly basis beginning in January 2017. We propose that the kind of information and data that the FFEs would require from these organizations will include, at a minimum, data regarding the number of individuals who have been certified by the organization; the total number of consumers who received application and enrollment assistance from the organization; and of that number, the number of consumers who received assistance applying for and selecting a QHP, enrolling in a QHP, or applying for Medicaid or CHIP. We anticipate that the monthly reports submitted to the FFEs would provide information and data from the preceding month, and would be submitted electronically, through HIOS or another electronic submission vehicle. We also expect that some of the data that FFEs would require from certified application counselor designated organizations would be similar to what is collected from Navigator grantees in the FFEs.²³ We do not expect this information collection to include consumers' PII. HHS recognizes the importance of certified application counselors, and we intend that any FFE information collection would be straightforward and place little additional burden on certified application counselor organizations.

We request comments on this proposal, on the scope of information and data that Exchanges should collect, and on HHS's specific proposals for collecting information and data

²³ The data collection requirements for FFE Navigator grantees in 2015-2016 are specified in the Information Collection Request (OMB control number 0938-1215) under the Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges (see the PRA package associated with 80 FR 36810). http://www.reginfo.gov/public/do/PRAViewDocument?ref_nbr=201507-0938-001

from certified application counselor organizations in the FFEs, including the proposed scope and timing of reports by these organizations to the FFEs.

As discussed earlier in this preamble in a parallel proposal to amend §155.210(d)(6), we propose to amend §155.225(g)(4), which prohibits certified application counselors in all Exchanges from providing certain kinds of gifts and promotional items to an applicant or potential enrollee. For the same reasons discussed above, we propose to amend §155.225(g)(4) consistent with our proposed amendments to §155.210(d)(6).

We seek comment on all aspects of this proposal

g. Privacy and Security of Personally Identifiable Information (§155.260)

Section 155.260(a)(1) refers to insurance affordability programs, as defined in §155.20. We propose to make a technical correction to this paragraph so that §155.300, which contains the definition of insurance affordability programs, is referenced instead.

h. Oversight and monitoring of privacy and security requirements (§155.280)

Section 155.280(a) permits HHS to oversee and monitor the FFEs and non-Exchange entities associated with FFEs to ensure compliance with the privacy and security standards established and implemented by an FFE under §155.260. Section 155.280(a) also provides authority for HHS to monitor State Exchanges for compliance with the privacy and security standards established and implemented by the State Exchanges under §155.260. We propose amending paragraph (a) to permit HHS to also oversee and monitor SBE-FPs' compliance with the privacy and security standards established and implemented by an FFE under §155.260.

4. Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

a. Options for Conducting Eligibility Determinations (§155.302)

We propose to amend §155.302(a) by adding an option for an SBE-FP to satisfy the requirement of conducting eligibility determinations by relying on HHS to carry out eligibility determination activity and other requirements within subpart D, through a Federal platform agreement. We seek comments on this proposal.

b. Eligibility process (§155.310(h))

We propose to amend §155.310(h) related to the requirement that the Exchange must notify an employer that an employee has been determined eligible for Exchange financial assistance upon such determination. This notice serves two main purposes. First, it informs an employer that it may be liable for the payment assessed under section 4980H of the Code because one of the employer's employees was determined eligible for Exchange financial assistance.²⁴ Second, it may reduce an employee's tax liability because in the event an employer prevails in an employer appeal described in §155. 555, the Exchange will redetermine the employee's eligibility (including for Exchange financial assistance) or notify the employee of the requirement to report changes in eligibility, as discussed in the preamble section III.F.6.g of this proposed rule. Currently under §155.310(h), the Exchange is directed to notify an employer that an employee has been determined eligible for Exchange financial assistance. We propose to revise this requirement so that the Exchange must notify an employer that an employee has been

²⁴ Only certain employers (called applicable large employers) are subject to the employer shared responsibility provisions under section 4980H of the Code. In general, applicable large employers must either offer minimum essential coverage that is "affordable" and that provides "minimum value" to their full-time employees (and their dependents), or make an employer shared responsibility payment to the IRS if at least one full-time employee receives the premium tax credit under section 36B of the Code. For more information on which employers are subject the employer shared responsibility provisions and under what circumstances an applicable large employer will be subject to a payment (and how the payments are calculated), see *Shared Responsibility for Employers Regarding Health Coverage; Final Rule*, 79 FR 8544 (Feb. 12, 2014).). Liability for the employer shared responsibility payment is determined independently by the IRS. More information on the IRS process can be found at www.irs.gov.

determined eligible for Exchange financial assistance only if the employee has also enrolled in a QHP through the Exchange. For purposes of this provision, an employee is determined eligible for cost-sharing reductions when the employee is determined eligible for cost-sharing reductions based on income in accordance with §155.305(g) or §155.350(a).

We believe this change better reflects the statutory requirement to send employer notices and will reduce confusion among employers and employees. The relevant statutes that address the employer notice requirement contemplate that employer notices will be provided for enrolled individuals who have been determined eligible for Exchange financial assistance. Sections 4980H(a)(2) and (b)(1)(B) of the Code provide that an assessable payment may be imposed on an employer if at least one full-time employee is certified as having enrolled in a QHP for which Exchange financial assistance is allowed or paid for the employee.

In the case of an employee who has been determined eligible for Exchange financial assistance but has not enrolled in a QHP, it would be inaccurate and confusing to send a notice under §155.310(h) because the employer receiving the notice would not be liable for a payment assessed under section 4980H of the Code if its employee does not enroll in a QHP through the Exchange (even if the employee could have received Exchange financial assistance if the employee had enrolled in a QHP). Furthermore, because sections 36B(b)(1) and (c)(2)(A) of the Code provide that a premium tax credit amount may not be allowed for any month in which, as of the first day of the month a tax filer (or the tax filer's spouse or tax dependent) was not enrolled in a QHP through the Exchange, a notice under §155.310(h) serves no purpose in protecting an employer from potential tax liability under section 4980H or an employee from tax liability under section 36B when the employee has been determined eligible for Exchange financial assistance but has not enrolled in a QHP through the Exchange. We also propose to

revise paragraph (h)(2) so that a notice sent in accordance with §155.310(h) must indicate that an employee has been determined eligible for Exchange financial assistance and has enrolled in a QHP through the Exchange.

Additionally, for purposes of operational efficiency with regard to the timing of the employer notification required under paragraph (h), we propose that the Exchange may choose to either (a) notify employers on an employee-by-employee basis as eligibility determinations are made for Exchange financial assistance and enrollment in a QHP through the Exchange, or (b) notify employers for groups of employees who are determined eligible for Exchange financial assistance and enroll in a QHP through the Exchange. Under both options, the Exchange must notify employers within a reasonable timeframe following any month an employee was determined eligible for either form of Exchange financial assistance and enrolled in a QHP, with the goal to notify employers as soon as possible to provide the greatest benefit to enrollees. We seek comment on these proposals.

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

We propose to revise §155.320(c)(3)(vi) to allow the Exchange to establish a reasonable threshold at which the Exchange must follow the alternate verification process for decreases in the annual household income between the applicant's attestation of projected annual household income and the annual income computed in accordance with §155.320(c)(3)(ii)(A). The reasonable threshold would be subject to approval by HHS. Current regulations require the Exchange to follow the alternate verification process under §155.320(c)(3)(vi) if either (1) the attested annual household income submitted by the consumer is more than 10 percent less than income data received from trusted data sources, or (2) if no data is available from trusted data

sources. We recognize that many consumers have difficulty projecting their annual household income and complying with the verification requirements. Annual household income may fluctuate year to year and throughout the year, making it difficult for consumers to project their income for the year ahead. Income data from trusted data sources can be up to 2 years old. In addition, consumers with lower incomes have a smaller margin for error in dollar terms under the current percentage-based threshold. We recognize that the current threshold of 10 percent may not be adequate to allow for normal variation in a consumer's annual household income, and may be too sensitive a threshold in terms of triggering the alternate verification process. Accordingly, we propose that the Exchange may set a reasonable threshold for when an applicant enters the alternate verification process in cases where the applicant's attestation of projected annual household income is lower than income data received from trusted data sources. A reasonable standard would allow for a realistic variation in a consumer's projected annual household income for the year for which they are seeking coverage from previous years' income data received from trusted data sources and may be defined in terms of a percentage, or a percentage and a fixed dollar amount (for example, the greater of 20 percent or \$5,000). A threshold set less than 10 percent would not be a reasonable standard since it would not allow for small projected reductions in income from a previous year. HHS will provide additional guidance on what constitutes a reasonable threshold. This proposal would allow the Exchange to establish a threshold that effectively maintains program integrity, while minimizing burdens to consumers to the extent possible. It would also allow the Exchange to make adjustments in future years as more data becomes available. We seek comment on this proposal.

In §155.320(d), we make certain proposals related to alternative processes relating to verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan.

In paragraph (d)(3), we propose to redesignate paragraph (d)(3)(i) as (d)(3)(ii) and redesignate paragraph (d)(3)(ii) as (d)(3)(i). To preserve the accuracy of the redesignated paragraph (d)(3)(ii), we propose to update the cross-reference to paragraph (d)(3)(ii) with (d)(3)(i), and paragraph (d)(3)(iii) with (d)(4)(i), discussed below. We also propose to remove paragraph (d)(3)(iii), which requires the Exchange to select a statistically significant random sample of applicants for whom the Exchange does not have data as specified in paragraphs (d)(2)(i) through (iii) and take steps to contact any employer identified on the application for the applicant and the members of his or her household to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. This process is referred to as “sampling.” We propose to modify this requirement, and describe that proposal in our discussion of proposed paragraph (d)(4) below. We believe these amendments to paragraph (d)(3) will organize and simplify the regulatory text.

We propose to add paragraph (d)(4) concerning a survey of verification procedures. In paragraph (d)(4), we propose that the Exchange must follow the procedures described in paragraph (d)(4)(i) or, in the alternative, for benefit years 2016 and 2017, the Exchange may follow the procedures specified in paragraph (d)(4)(ii), for any benefit year for which it does not reasonably expect to obtain sufficient verification data as described in paragraphs (d)(2)(i) through (iii). For the purposes of this section, the Exchange reasonably expects to obtain sufficient verification data for any benefit year when, for the benefit year, the Exchange is able to

obtain data about enrollment in and eligibility for qualifying coverage in an eligible employer-sponsored plan from at least one electronic data source that is available to the Exchange and has been approved by HHS, based on evidence showing that the data source is sufficiently current, accurate, and minimizes administrative burden, as described in paragraph (d)(2)(i).

In paragraph (d)(4)(i), we propose that the Exchange may conduct sampling. This paragraph is substantially the same as current paragraph (d)(3)(iii), with three differences. First, we propose to remove the absolute requirement to conduct sampling, and for benefit years 2016 and 2017, allow the Exchange to implement an alternate process approved by HHS. This proposal and rationale is described in more detail in the discussion of paragraph (d)(4)(ii), below. Second, we propose to remove the language that currently appears in paragraph (d)(3)(iv) since the relief it provided only applied to eligibility determinations that were effective before January 1, 2015. Third, we propose to replace two internal cross-references to paragraph (d)(3)(iii) with appropriate cross-references to paragraph (d)(4)(i).

We propose moving the sampling requirement from paragraph (d)(3) and adding it to new paragraph (d)(4) to more accurately reflect the role of the sampling process. Paragraph (d)(3) contains standards for “[v]erification procedures” applicable to all applicants for Exchange financial assistance. The sampling process, however, does not involve verification of eligibility information for all applicants, and is primarily intended to serve as a way for the Exchange to gain insight into whether consumers provide accurate information on the application regarding their enrollment in and eligibility for qualifying coverage in an eligible employer-sponsored plan and the effectiveness of an Exchange’s verification of such information.

In paragraph (d)(4)(ii), we propose to permit an Exchange the option to implement an alternate process approved by HHS for the benefit years 2016 and 2017. We believe this option

will provide Exchanges with needed flexibility as verification processes are refined and employer databases compiled over the next several years, to improve long-term verification programs. We seek comment on these proposals.

d. Medicare Notices

Over the course of the first two years of Exchange operations, we have realized the importance of providing notification to enrollees in coverage through the Exchange of their potential eligibility for Medicare. We recognize the importance of a smooth transition to Medicare coverage, and seek comment on whether and how to implement a notification that an enrollee may have become eligible for Medicare. For example, for enrollees in an FFE, we are considering “pop up” text on HealthCare.gov for individuals who are going to turn 65 during the benefit year. We seek comment on this and other ways to promote smooth coverage transitions.

5. Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

a. Annual Eligibility Redetermination (§155.335(j))

In the Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges final rule (79 FR 52994, 53000 (Sept. 5, 2014)), we established a renewal and re-enrollment hierarchy at §155.335(j) to minimize potential enrollment disruptions. To further minimize potential disruptions of enrollee eligibility for cost-sharing reductions, we propose to amend §155.335(j)(1) to create a new re-enrollment hierarchy for all enrollees in a silver-level QHP that is no longer available for re-enrollment. Specifically, if such an enrollee’s current silver-level QHP is not available and the enrollee’s current product no longer includes a silver-level QHP available through the Exchange, the enrollee’s coverage would be renewed in a silver-level QHP

in the product offered by the same issuer that is the most similar to the enrollee's current product, rather than in a plan one metal level higher or lower than his or current silver-level QHP, but within the same product. Transitioning enrollees in this manner is an operationally efficient way of maintaining continuity for enrollees eligible for cost-sharing reductions, and, because the benchmark plans for establishing the amount of the premium tax credit for which an eligible taxpayer is eligible is a silver-level plan, continued enrollment in a silver-level plan, as opposed to enrollment in a plan at a different metal level but in the same product is likely to be more consumer protective. We request comment on this proposal, including the best means of determining which product is most similar to the enrollee's current product. We also seek comment on whether the hierarchy should permit a QHP enrollee to be automatically re-enrolled into a plan not available through an Exchange, and under what circumstances such a re-enrollment should occur.

In the 2016 Payment Notice proposed rule, we also noted that we are exploring a change to the re-enrollment hierarchy at §155.335(j), which currently prioritizes re-enrollment with the same issuer in the same or a similar plan. As we discussed in that rulemaking, many consumers place a high value on low premiums when selecting a plan, and the approach we were exploring would recognize that plans that have competitively priced premiums in one year may not continue to be the most competitively priced in subsequent years. As a result, default enrollment in the same or similar plan may sometimes encourage consumers to remain in plans that are significantly more expensive than the lowest cost plans available to the enrollee.

We are considering an approach under which an enrollee in an FFE would be offered a choice of re-enrollment hierarchies at the time of initial enrollment, and could thereby opt into being re-enrolled by default for the subsequent year into a low-cost plan, rather than his or her

current plan or the plan specified in the current re-enrollment hierarchy. The alternative enrollment hierarchy could be triggered if the enrollee's current plan's premium increased from the prior year, or increased relative to the premium of other similar plans (such as plans of the same metal tier), by more than a threshold amount, such as 5 percent or 10 percent. For example, in those conditions, the enrollee would be placed into a QHP of the same metal level with the lowest premium in the enrollee's service area, or perhaps one of three such QHPs with the lowest premiums, by random allocation or another appropriate allocation process. As is the case under the existing approach, a consumer would retain the option to take action to enroll in a different plan during open enrollment if he or she wished to do so.

We received a number of comments regarding the discussion in the 2016 Payment Notice proposed rule. Some commenters supported the approach generally. Other commenters stated that the approach does not give adequate deference to the plan an enrollee has selected during open enrollment, or to the impact of cost sharing. A number of commenters had concerns that consumers may not realize that opting into a default enrollment hierarchy based on low-cost premiums may result in other significant changes to their coverage, and emphasized the importance of education by the Exchanges with respect to this re-enrollment hierarchy. We received a few alternative ideas for re-enrollment hierarchies, including basing re-enrollment on factors consumers identify as most important to them, or basing re-enrollment on the consumer's original choice of premium. Similarly, one commenter suggested implementing this approach only for those consumers currently enrolled in the lowest-cost or second-lowest cost silver plan.

Continuing the discussion in the 2016 Payment Notice, we are requesting further comment on this concept to update our policy in the final rule. In particular, we are interested in understanding how to ensure that consumers understand the increased risk of being re-enrolled

automatically in a plan with a significantly different provider network, benefits, cost-sharing structure, or service area. We seek comment on the timing and form of the notice related to plan re-enrollment that the Federally-facilitated Exchange would provide to consumers opting in to such an enrollment hierarchy. We seek comment on whether hierarchies that considered factors other than metal level or premiums, such as plan type (for example, HMO versus PPO) or network breadth could help to reduce the risk that consumers are re-enrolled automatically into a plan that does not suit their needs. We are interested in comments on what premium growth in the current plan (or what growth relative to other similar plans) would trigger re-enrollment into a low-cost plan, and how to determine which enrollees get assigned to which plans, for example if enrollees are allocated among one of the three lowest cost QHPs of the metal level in the enrollee's service area. We seek comment on how best to deal with the risk of providing small plans with excess enrollment, in order to avoid destabilizing such plans with a deluge of new enrollments. As we did last year, we seek comment on how these types of default re-enrollment procedures have functioned in other programs and settings, and what lessons can be drawn from those experiences. Finally, we seek comment on the appropriate timeframe for implementing such an alternative hierarchy.

b. Enrollment of Qualified Individuals into QHPs (§155.400)

i. Rules for First Month's Premium Payments for Individuals Enrolling with Regular, Special, and Retroactive Coverage Effective Dates.

We propose to amend §155.400(e) related to the payment of the first month's premium (that is, binder payments), including deadlines, to codify previously released guidance in section

8.2 of the updated Federally-facilitated Marketplace and Federally-facilitated Small Business Health Options Program Enrollment Manual,²⁵ that specified our interpretation of these requirements. Specifically, we propose to amend §155.400(e)(1)(i) and (ii) to provide that, for prospective coverage, the binder payment must consist of the first month's premium. To provide added flexibility for issuers, we also would add to the rule to specify that the deadline for a binder payment related to prospective coverage with a prospective special effective date, would have to be no earlier than the coverage effective date and no later than 30 calendar days from the date the issuer receives the enrollment transaction or the coverage effective date, whichever is later. This would align the requirement for enrollments with prospective special effective dates with the requirement for enrollments with regular effective dates. We propose to add §155.400(e)(1)(iii) to reflect our interpretation, intended to limit the risk that issuers would provide retroactive coverage without receiving sufficient premium payments from enrollees, that applicants requesting coverage being effectuated under retroactive effective dates, such as coverage in accordance with a special enrollment period or a successful eligibility appeal, must pay a binder payment that consists of all premium due (meaning the premium for all months of retroactive coverage). If the applicant pays only the premium for one month of coverage, we propose that the issuer would be required to enroll the applicant in prospective coverage in accordance with regular effective dates. We also propose to specify that the deadline for payment of all premium due must be no earlier than 30 calendar days from the date the issuer receives the enrollment transaction or notification of the enrollment. This change to the binder payment rules is intended to allow issuers flexibility to set a reasonable deadline for enrollees to

²⁵ Available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updated_ENR_Manual.pdf

submit payment of retroactive premium, the total amount of which may consist of payment for several months of coverage.

Based on our experience implementing the grace period provisions under our previous rulemaking, particularly in cases involving advance payments of the premium tax credit, that require full payments of amounts due to avoid being put in a grace period and to avoid termination of enrollment, we have identified the need for additional flexibility for issuers to establish reasonable policies regarding premium collection that would allow issuers to collect a minimal amount of premium less than that which is owed without necessarily triggering the consequences for non-payment of premiums. For example, in the Exchange Establishment Rule, we established that enrollees receiving advance payments of the premium tax credit have to pay full payments of all outstanding premiums owed in order to avoid entering a grace period or having their coverage terminated. In response to requests from issuers, we propose to add flexibility to this rule to allow issuers the option to adopt a premium payment threshold policy to avoid situations in which an enrollee who owes only a de minimis amount of premium has his or her enrollment terminated for non-payment of premiums.

Accordingly, at new §155.400(g), we propose to codify a provision related to premium payment threshold policies, thereby allowing additional issuer flexibility regarding when amounts collected will be considered to satisfy the obligation to pay amounts due, so long as issuers implement such a policy uniformly and without regard to health status and that the premium payment threshold adopted is reasonable. This would allow issuers flexibility to effectuate an enrollment, not to place an enrollee in a grace period for failure to pay 100 percent of the amount due, or not to terminate enrollments after exhaustion of the applicable grace period for enrollees who owe only a small amount of premium within the threshold.

We seek comment on these proposals.

ii. Reliance on HHS to Carry Out Enrollment and Related Functions.

We also propose to amend §155.400 by adding a new paragraph (h) to reflect that SBE-FPs must rely on HHS to implement the functions related to eligibility and enrollment within subpart E, through the Federal platform agreement. This reflects that eligibility and enrollment functions must be performed together in the FFE, and that neither function can be performed separately by an SBE-FPs at this time. We seek comments on this proposal.

c. Annual Open Enrollment Period (§155.410)

In §155.410, we propose to amend paragraph (e), which provides the dates for the annual open enrollment period in which qualified individuals and enrollees may apply for or change coverage in a QHP. We propose to amend paragraph (e)(2) to define the open enrollment period for coverage year 2017, which would be November 1 through January 31. We also propose to amend the annual open enrollment period coverage effective date provisions in paragraphs (f)(2)(i) through (iii) to include the coverage effective dates for 2017.

We propose this time period and these coverage effective dates to remain consistent with the 2016 open enrollment period. This time frame will continue to partially overlap with the annual open enrollment period for Medicare and most employer offerings, which will benefit consumers by facilitating smooth transitions between coverage and creating process efficiencies for issuers handling enrollments and re-enrollments during the same period. We seek comments on this proposal.

We are also considering defining the open enrollment period for coverage year 2018, and seek comment on what that period should be. For example, we could incrementally shift to an earlier open enrollment period, while maintaining the same duration, such that the open

enrollment period for benefit year 2018 would run from October 15, 2017 through January 15, 2018. Alternatively, we could shift to an earlier open enrollment period and shorten its duration simultaneously, such that the open enrollment period would run from October 15, 2017 through December 15, 2017. We note that open enrollment periods for health coverage typically end before the end of the year prior to the benefit year to promote full-year coverage. However, in the short run, as eligible consumers are learning about their options and the individual shared responsibility requirement and newly insured consumers are learning how to re-enroll into coverage for the next benefit year, we note that there is value in a longer open enrollment period. We would also face significant operational limitations in moving the beginning of the open enrollment period to an earlier time. However, if we do not shift the beginning of the open enrollment period to an earlier date, ending the period before the end of the year would result in a shorter open enrollment period. We seek comment on the length, start, and end of the open enrollment period for 2018 and subsequent years.

d. Special Enrollment Periods (§155.420)

Special enrollment periods are available to consumers under a variety of circumstances as described in §155.420. We seek comment and any available data on existing special enrollment periods.

In addition, we have heard concerns that these special enrollment periods may be subject to abuse. We seek comment regarding this, and data, if available. Elsewhere in this document, we propose an amendment to §155.430(b)(2)(vi) that would allow the Exchange to initiate cancellation or retroactive termination of an enrollee's enrollment, after a determination has been made that the enrollment was due to fraudulent activity. We believe this proposal would provide us with an important tool for addressing potential gaming of these rules.

e. Termination of coverage (§155.430)

Under our current rules, §155.430(b)(1) requires an Exchange to permit an enrollee to cancel or terminate his or her coverage in a QHP following appropriate notice to the Exchange or the QHP issuer. We propose to add paragraph (b)(1)(iv) to allow an enrollee to retroactively cancel or terminate his or her enrollment in a QHP through the Exchange in the limited circumstances set forth below. For enrollees whose enrollment or continued enrollment in a QHP resulted from an error, misconduct, or fraud committed by an entity other than the enrollee, we aim to increase flexibility under the regulations to permit such enrollees to avoid the consequences of that entity's actions by canceling the QHP coverage. To this end, we propose to redesignate current paragraph (b)(2)(vi) as (b)(2)(vii) and add a new paragraph (b)(2)(vi) to permit the Exchange to cancel an enrollee's enrollment in a QHP under certain circumstances. This rule would permit cancellations of fraudulent enrollments that the Exchange discovers, even if the enrollee is never aware of the enrollment.

New paragraph (b)(1)(iv)(A) would provide that the enrollee would be permitted to retroactively terminate his or her coverage or enrollment if he or she demonstrates to the Exchange that he or she attempted to terminate his or her coverage or enrollment and experienced a technical error that did not allow the enrollee to effectuate termination of his or her coverage or enrollment through the Exchange. Such an enrollee would have 60 days after he or she discovered the technical error to request retroactive termination. This aligns with our standard 60-day window for special enrollment periods.

We propose a new paragraph (d)(9), which would provide that the retroactive termination date under paragraph (b)(1)(iv)(A) would be no sooner than 14 days after the earliest date that the enrollee could demonstrate that he or she contacted the Exchange to terminate his or her

coverage or enrollment through the Exchange, unless the issuer agrees to an earlier effective date as set forth in §155.430(d)(2)(iii). This 14-day window aligns with the regulation on voluntary, enrollee-initiated prospective terminations.

We propose in paragraph (b)(1)(iv)(B) to provide for cancellation for an enrollee who demonstrates to the Exchange that his or her enrollment in a QHP through the Exchange was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. Such an enrollee would have 60 days from the point he or she discovered the unintentional, inadvertent, or erroneous enrollment to request cancellation, to align with our standard 60-day special enrollment period window. In determining whether an enrollee has demonstrated to the Exchange that his or her enrollment meets the criteria for cancellation under this paragraph, the Exchange would examine the totality of the circumstances surrounding the enrollment, such as whether the enrollee was enrolled in other minimum essential coverage at the time of his or her QHP enrollment and whether he or she submitted claims for services rendered to the QHP. These factors would serve to indicate the intentions of the enrollee and whether the enrollment really was undesired and would be weighed in making a determination whether a cancellation is warranted. This approach offers a broad and fair analysis of the enrollee's intentions and balances the interests and protection of consumers with the interests of issuers. For example, we believe that, without additional evidence to the contrary, one reasonably could assume that an enrollee who was enrolled in other minimum essential coverage at the time of his or her QHP enrollment and who submitted no claims to that QHP likely did not intend to enroll in such QHP. Conversely, claims submitted by an enrollee to the QHP would weigh against the enrollee's

request for cancellation because, barring contrary evidence, the Exchange would view submittal of such claims to constitute a ratification of the enrollee's contract with the QHP issuer, even if the enrollee did not intend to enroll in QHP coverage. We seek comment on what other factors are indicative of an enrollee's bona fide intent and can limit "gaming," and should be considered in this analysis.

In paragraph (b)(1)(iv)(C), we propose to allow cancellations for enrollees who are enrolled in a QHP without their knowledge or consent due to the fraudulent activity of any third party, including third parties who have no connection with the Exchange. Such an enrollee would have 60 days from the point at which he or she discovered the fraudulent enrollment to request cancellation, to align with our standard 60-day special enrollment period window.

New paragraph (d)(10) would provide that for cancellation or retroactive terminations granted in accordance with paragraphs (b)(1)(iv)(B) and (C), the cancellation or termination date would be the original coverage effective date or a later date, as determined appropriate by the Exchange, based on the circumstances of the cancellation or termination.

Under our current rules, §155.430(b)(2) allows the Exchange to initiate termination of an enrollee's coverage or enrollment in a QHP through the Exchange, and permits a QHP issuer to terminate such coverage or enrollment in certain circumstances. Amended paragraph (b)(2)(ii)(A) reflects the change to §156.270(d) and (g) that gives an enrollee who, upon failing to timely pay premium, is receiving advance payments of the premium tax credit (APTC), a three-month grace period. The changes to §156.270 are described in section "Termination of Coverage or Enrollment for Qualified Individuals" of the preamble.

We propose in new paragraph (b)(2)(vi) that the Exchange could cancel an enrollee's enrollment that the Exchange determines was due to fraudulent activity, including fraudulent activity by a third party with no connection with the Exchange.

New paragraph (d)(11) would provide that for cancellations granted in accordance with paragraph (b)(2)(vi), the cancellation date would be the original coverage effective date. The Exchange only would send the cancellation transaction following reasonable notice to the enrollee (recognizing that where no contact information is available that notice may be impossible or impracticable).

Our current guidance recognizes that at some point, the Exchange must discontinue the ability for enrollees to retroactively adjust coverage for the preceding coverage year. To this end, we are considering codifying a deadline for requesting cancellations or retroactive terminations. We seek comment on these proposals.

6. Appeals of Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

a. General Eligibility Appeals Requirements (§155.505)

In §155.505, we make certain proposals related to the general eligibility appeals requirements. Currently, paragraph (b)(1) of this section states that an applicant or enrollee has the right to appeal an eligibility determination made in accordance with subpart D. This right includes the right to appeal determinations of eligibility for QHP enrollment periods, such as special enrollment periods. To clarify the scope of applicants' and enrollee's right to appeal, we are proposing to add paragraph (b)(1)(iii) which would more explicitly state that applicants and enrollees have the right to appeal a determination of eligibility for an enrollment period. This

change would apply to appeals provided by the HHS appeals entity and a State Exchange appeals entity.

Similarly, we propose new paragraph (b)(5) to clarify that applicants and enrollees have the right to appeal a decision issued by the State Exchange appeals entity. Section 155.520(c) already provides that an appellant who disagrees with a decision of a State Exchange appeals entity may request an appeal to the HHS appeals entity within 30 days of the notice of appeal decision. New paragraph (b)(5) would clarify applicants' and enrollees' existing right to appeal any decision issued by a State Exchange appeals entity in accordance with §155.545(b), in addition their right to appeal a denial of a request to vacate a dismissal made by a State Exchange appeals entity, as described in §155.505(b)(4).

Finally, in paragraph (b)(4), we propose to correct a typographical error by replacing the word "or" with the word "of," and to replace "pursuant to" with "under," so the last clause of the paragraph would read, "...made under paragraph (c)(2)(i) of this section...". We seek comment on these proposals.

b. Appeals Coordination (§155.510)

We propose to revise §155.510(a)(1) to give the appeals entity and agencies administering insurance affordability programs more flexibility in obtaining documentation and information from appellants. To minimize burden on appellants, §155.510(a)(1) currently prohibits the appeals entity or agency administering insurance affordability programs from asking an appellant to provide information or documentation that the appellant already provided. However, when such information or documentation is not available to the appeals entity or agency, this provision may also prevent the appeals entity or agency from obtaining information

that is necessary to properly adjudicate the appellant's appeal. As a result, the appeals entity is deprived of documentation that could support a decision favorable to the appellant.

Accordingly, we propose to revise paragraph (a)(1) to allow the appeals entity, the Exchange, or the agency administering insurance affordability programs to request information or documentation from the appellant that the appellant already has provided if the agency does not have access to such information or documentation and cannot reasonably obtain it. We believe this revision balances the need to minimize the burden on the appellant as well as the need to ensure that all information necessary for the appellant's appeal is available to the appeals entity, Exchange, or agency administering the insurance affordability program, which ultimately will inure to the appellant's benefit by helping to ensure a correct appeal decision and eligibility determination. We seek comment on this proposal.

c. Appeal Requests (§155.520)

We propose to add paragraph (d)(2)(i)(D), concerning appellants whose appeal request is determined invalid for failure to request an appeal by the date determined in paragraph (b) or (c) of this section. Currently, when an appellant's request is invalid because it is untimely, it is not possible for the appellant to cure the defect as contemplated under §155.520(d)(2)(i)(C).

Therefore, the appeals entity dismisses the appeal in accordance with §155.530(a)(3). If the appellant makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated, the appeals entity must vacate the dismissal in accordance with §155.530(d). Accordingly, an appellant who shows good cause why his or her appeal should proceed even though the appeal request was untimely (for example, an appellant who was unable to submit a timely appeal request because he or she was hospitalized with a serious condition) currently may proceed with an appeal, but the process is circuitous.

This proposed addition of (d)(2)(i)(D) would require the appeals entity to notify an appellant that, in the event the appeal request is invalid because it was not timely submitted, the appeal request may be considered valid if the applicant or enrollee demonstrates within a reasonable timeframe determined by the appeals entity that failure to timely submit was due to exceptional circumstances and should not preclude the appeal. This would allow the appellant to demonstrate before the appeal is dismissed that failure to submit a timely appeal request was due to exceptional circumstances constituting good cause why the appeal should proceed, which would minimize burden on the appellant as well as administrative burden on the appeals entity.

The appeals entity may determine what constitutes an exceptional circumstance that should not preclude an appeal notwithstanding the appellant's failure to timely submit an appeal request. An appeals entity may, for instance, find that circumstances making timely submission impossible constitute an exceptional circumstance. A weather emergency, such as a blizzard, a hurricane or a tornado, may cause power outages making it impossible to prepare, mail, or fax appeal requests to the appeals entity. Similarly, such disasters may cause consumers to lose access to the documents they need to complete and submit appeal requests. Likewise, if a consumer suffers a catastrophic medical event and is consequently unable to submit an appeal request on time, the appeals entity may determine that this constitutes an exceptional circumstance under the proposed exception.

The appeals entity may also determine what is considered a reasonable timeframe for an appellant to demonstrate an exceptional circumstance. For example, if an appellant was unable to send an appeal request on time due to a snow storm and power outage and sent the request four months after the snow storm and power outage had been resolved, the appeals entity may find that the appellant experienced an exceptional circumstance as contemplated by this proposed

rule, but that the appellant waited an unreasonable amount of time to demonstrate it. Without such flexibility for the appeals entity, appellants who experienced an exceptional circumstance would have an unlimited amount of time to request that the appeals entity consider their appeal. We seek comment on this proposal.

d. Dismissals (§155.530)

We propose to revise §155.530(a)(4) to allow an appeal to continue when an appellant dies if the executor, administrator, or other duly authorized representative of the estate requests to continue the appeal. We seek comment on this proposal.

e. Informal Resolution and Hearing Requirements (§155.535)

In §155.535, we propose amendments to the informal resolution and notice of hearing requirements. In §155.535(a), we propose a change to clarify that the requirements of the informal resolution process described in paragraphs (a)(1) through (4) apply to both the HHS appeals entity and a State Exchange appeals entity.

In §155.535(b), we propose providing two exceptions to the requirement that the appeals entity must send written notice to the appellant of the date, time, and location or format of the hearing no later than 15 days prior to the hearing date. In paragraph (b)(1), we propose an exception when an appellant requests an earlier hearing date. Currently, the 15-day notice requirement prevents an appellant from selecting a hearing date within 15 days even if such a date is available and desired by the appellant. In paragraph (b)(2), we propose an exception to the notice requirement under paragraph (b) when a hearing date sooner than 15 days is necessary to process an expedited appeal, as described in §155.540(a), and the appeals entity and appellant have mutually agreed to the date, time, and location or format of the hearing. If finalized, this amendment would create efficiency for the appeals process as a whole and create a more

agreeable experience for the appellant. In addition, it would allow for an earlier hearing when there is an immediate need for a health service. We seek comment on these proposals.

f. Appeal Decisions (§155.545)

We propose several changes to §155.545. In paragraph (b)(1), we propose to remove the third appearance of the word “of” to correct a typographical error. We also propose to revise paragraph (c)(1)(i) to include cross references to §155.330(f)(4) and (5), which discuss effective dates for certain special enrollment periods described in §155.420. This change aligns with our proposed change §155.505(b) to clarify that applicants and enrollees have the right to appeal a determination of eligibility for an enrollment period.

Finally, we propose to revise §155.545(c)(1)(ii) so that the coverage effective date for eligible appellants requesting a retroactive appeal decision effective date is the coverage effective date that the appellant did receive or would have received if the appellant had enrolled in coverage under the incorrect eligibility determination that is the subject of the appeal. This is consistent with the coverage effective dates consumers receive in comparable situations when given the option for retroactive coverage, such as in the case of certain special enrollment periods. We seek comment on this proposal.

g. Employer Appeals Process (§155.555)

We also propose to amend §155.555(l) to give the Exchange more operational flexibility in implementing an employer appeal decision. Currently under §155.555(l), when an employer appeal decision affects an employee's eligibility, the Exchange is directed to redetermine the employee's eligibility and the eligibility of the employee's household members, if applicable. An employer's appeal decision may affect an employee's eligibility when the employer prevails in the appeal by establishing that it does offer the employee employer-sponsored coverage that

meets the minimum value standard and is affordable for the employee, and the HHS appeals entity therefore finds that the employee is not eligible for Exchange financial assistance.

We propose to amend §155.555(l) by revising paragraph (l) and adding paragraphs (l)(1) and (2). Under proposed paragraph (l), after receipt of the notice under paragraph (k)(3) of this section, the Exchange must follow the requirements in either paragraph (l)(1) or (2) if the appeal decision affects the employee's eligibility. Under proposed paragraph (l)(1), the Exchange must promptly redetermine the employee's eligibility and the eligibility of the employee's household members, if applicable, in accordance with the standards specified in §155.305, as currently provided in paragraph (l). Under proposed paragraph (l)(2), the Exchange must promptly notify the employee of the requirement to report changes in eligibility as described in §155.330(b)(1). The FFE intends to implement the latter procedure to give employees the opportunity to report any additional changes in their eligibility information to help ensure the most accurate redetermination of eligibility for insurance affordability programs. We believe this amendment will also give the Exchange greater operational flexibility.

Additionally, we propose to make a technical correction to §155.555(e)(1) by removing the cross-reference to paragraph (d)(3) of this section, which does not exist, and replacing it with paragraph (d)(1)(iii). We seek comment on these proposals.

7. Exchange Functions in the Individual Market: Eligibility Determinations for Exemptions
 - a. Eligibility Standards for Exemptions (§155.605)

We are proposing to clarify and streamline policies related to exemptions and are proposing to amend §155.605 to reflect those changes. The proposed changes will simplify and streamline the process for members of health care sharing ministries, members of Indian tribes, and incarcerated individuals by directing consumers solely to the tax filing process to claim these

exemptions. To claim one of these exemptions on a tax return, the individual needs only to file IRS Form 8965, *Health Coverage Exemptions*, with his or her tax return. Presently, the Exchange process requires that an application be submitted to the Exchange, and the Exchange review, process, and respond to the application. If the individual does not complete the Exchange application with all required information, the individual will be asked to submit the missing information before the application can be processed. The follow-up steps may result in a significant delay to the individual's application if he or she does not submit the information on a timely basis. Further, the Exchange may only grant certain exemptions on a retrospective basis so that the individual may need to submit multiple applications throughout the year. Finally, the Exchange may not grant exemptions for members of health care sharing ministries and individuals who were incarcerated for the previous year if the individual requests the exemption after December 31 of the previous year. This adds confusion when many individuals are preparing their tax returns, assessing their exemption eligibility and discovering that they can apply with the Exchange. Corresponding requirements do not exist in the tax return process; consumers simply claim the exemption on IRS Form 8965 when filing the tax return. Therefore, we propose that the Exchange would no longer make eligibility determinations for exemptions based on membership in a health care sharing ministry, membership in an Indian tribe, or incarceration status, and therefore propose to delete paragraphs (d) through (f). We propose to redesignate paragraph (g) as paragraph (d).

We also propose to add a new paragraph (e), under which we propose that certain exemptions authorized under Section 5000(A) of the Internal Revenue Code may be claimed during the tax filing process without obtaining an exemption certificate number (ECN) from the Exchange. In previous guidance, we identified these exemptions and provided that they may be

claimed on a tax return without obtaining an ECN.²⁶ The IRS has also published guidance identifying these exemptions, and allowing eligible individuals to claim the exemption without first obtaining an ECN.²⁷ These proposed regulations codify our prior guidance.

An ECN is not required for an exemption that can be claimed on a tax return. Rather, an individual can simply list the appropriate code to claim the exemption per the instructions to Form 8965. The varying requirements between the IRS and the Exchange exemption processes may cause confusion for applicants. Further, we intend to permit individuals who have already been granted an ECN from the Exchange on a continuing basis (such as for members of Federally recognized tribes or individuals eligible for services through an Indian health care provider) to use their ECN on their Federal income tax return to claim this exemption until such time that they no longer are eligible for this exemption. An individual will be able to obtain information about his or her ECN after the Exchange ceases processing tribal membership exemptions. We also propose a clarifying amendment to §155.605(b) to remove the cross-reference to paragraphs (f)(2) and (g) and replace it with paragraphs (c)(2) and (d). We seek comment on all aspects of this proposal.

We propose to redesignate §155.605(g), which discusses hardship exemptions, as §155.605(d), and reorganize and revise the newly redesignated paragraph (d). In newly redesignated §155.605(d)(1), we propose to limit the amount of time a general hardship exemption may cover to the remainder of the calendar year from the date the hardship

²⁶ HHS Centers for Medicare & Medicaid Services, Shared Responsibility Guidance-Filing Threshold Hardship Exemption (Sept. 18, 2014), available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Filing-Threshold-Exemption-Guidance-9-18-14.pdf>.

²⁷ Notice 2014-76, 2014-50 I.R.B. 946 (December 8, 2014), available at <https://www.irs.gov/pub/irs-irbs/irb14-50.pdf>.

commenced plus the next calendar year, plus the month before the hardship began. We believe that such a maximum period for the hardship exemption provides the individual with a sufficient period of time during which he or she will be covered by the exemption, and sufficient time for the individual to recover from the hardship. We propose that an individual would need to submit a new hardship exemption application to the Exchange to request subsequent hardship exemptions on the same basis, however the Exchange may use the proof of hardship submitted with the previous application as long as it is within 3 years of an individual's initial application for the hardship exemption. We propose that individuals would not be required to submit additional proof within 3 years of their initial application because we believe that this proof would be sufficiently current to support an additional exemption application. We seek comment on this proposal, in particular with respect to the timeframes – both the maximum timeframe for the length of the hardship exemption, and the 3-year timeline for submission of new supporting evidence.

Next, we propose to revise newly redesignated §155.605(d)(2) to set out specific examples of events and circumstances that qualify an individual for a hardship exemption under the umbrella of the general set of events and circumstances described under newly redesignated §155.605(d)(1). We note that these specific proposed criteria are not intended to limit the Exchange's ability to determine individuals' eligibility for a hardship exemption based on other criteria provided through guidance, covering a specified duration, such as the exemption available to individuals enrolled in CHIP Buy-In plans in 2014. The specific illustrative criteria we propose to add are:

- Homelessness;
- Eviction or facing eviction or foreclosure;

- Received a shut-off notice from a utility company;
- Experienced domestic violence;
- Experienced the death of a family member;
- Experienced a fire, flood or other nature or human-caused disaster that caused substantial damage to your property;
- Filed for bankruptcy;
- Experienced unexpected increases in necessary expenses due to caring for an ill, disabled or aging family member;
- Seeking categorical Medicaid eligibility under section 1902(f) of the Social Security Act (the Act) for “209(b)” States (codified at §435.121);
- Seeking Medicaid coverage provided to medically needy individuals under section 1902(a)(10)(C) of the Act that is not included as government-sponsored minimum essential coverage under IRS regulations and not recognized as MEC by the Secretary of HHS in accordance with the CMS State Health Official (SHO) Letter #14-002;
- Enrolled in Medicaid coverage provided to a pregnant woman that is not included as government-sponsored minimum essential coverage under IRS regulations and not recognized as minimum essential coverage by the Secretary of HHS in accordance with CMS SHO #14-002;
- Enrolled in CHIP coverage provided to an unborn child that includes comprehensive prenatal care for the pregnant mother; or
- As a result of an eligibility appeals decision the individual is eligible for enrollment in a qualified health plan through the Exchange, lower costs on the individual’s monthly premiums or CSRs for a time period when the individual was not enrolled in a QHP through the Exchange.

These criteria were previously laid out in Exchange guidance, and capture many of the reasons why an individual has requested a hardship exemption to date. We seek comment on this proposal.

We propose to revise newly redesignated paragraph (d)(3) to require that a hardship event or circumstance must have occurred within 3 years from the date of the individual's hardship application submitted to the Exchange. This proposed paragraph is in line with the requirement that an Exchange may only accept an application for a hardship exemption up to 3 calendar years after the month or months during which the applicant attests that the hardship occurred under §155.610(h). The same hardship event or circumstance may qualify an individual for two ECNs that cover a period of 4 years total.

For example, assume an individual experiences a hardship event in January 2015 and submits a hardship application to the Exchange in February 2015. If the individual otherwise qualifies for the exemption, the individual may be granted an ECN spanning December 2014 through December 2016. If the individual submits a second hardship application in January 2017 noting that the exemption is requested for the same event covered by the original ECN that occurred in January 2015, the individual may be granted a second ECN that extends through December 2018.

Next, consider an individual who experiences a hardship event in January 2015 and submits a hardship application to the Exchange in January 2018. The individual is eligible for a hardship exemption from December 2014 through December 2016, and the individual may request a second ECN to cover through December 2018.

Finally, consider an individual who experiences a hardship event in January 2015 and submits a hardship application to the Exchange in January 2019. The individual is not eligible

for an exemption for the January 2015 event because it happened more than 3 years from the date of the individual's exemption application. However, if the individual can show the Exchange that the event continued or a new hardship qualifying event occurred anytime from January 2016 to January 2019, the individual would be eligible for a hardship exemption. We seek comment on this proposal and on whether 3 years is the appropriate length of time, or whether a shorter period is warranted.

In addition, we propose to amend newly redesignated §155.605(d)(5), which provides an exemption for a calendar year to an individual who has been determined ineligible for Medicaid for one or more months during a benefit year solely as a result of a State not implementing section 2001(a) of the Affordable Care Act. We propose to remove the requirement to obtain an eligibility determination from the individual's appropriate State Medicaid office. Instead, we propose that this exemption be made available to an individual who would be determined ineligible for Medicaid for one or more months during a benefit year solely as a result of a State not implementing section 2001(a) of the Affordable Care Act. By removing the requirement to obtain a Medicaid determination, we believe that we are reducing State administrative costs and are alleviating a significant burden on individuals who do not request this exemption until the previous calendar year has passed and are therefore unable to obtain a Medicaid determination for the previous year. We anticipate that this proposed change will simplify the process for filing an exemption application with the Exchange. We seek comment on this proposal.

Finally, we propose §155.605(e)(4) to allow individuals to claim the exemption described in section F of I.R.S. Notice 2014-76 (Dec. 8, 2014), relating to certain individuals who reside in a State that did not expand Medicaid eligibility, on their Federal income tax return without first obtaining an ECN from the Exchange. We propose to allow this exemption to be claimed

beginning for the 2015 tax year so that there is no gap in the ability for consumers to claim this exemption on a tax return.

b. Required Contribution Percentage (§155.605(e)(3))

Under section 5000A of the Code, an individual must have minimum essential coverage for each month, qualify for an exemption, or make a shared responsibility payment with his or her Federal income tax return. Under section 5000A(e)(1) of the Code, an individual is exempt if the amount that he or she would be required to pay for minimum essential coverage (the required contribution) exceeds a particular percentage (the required contribution percentage) of his or her actual household income for a taxable year. In addition, under §155.605(g)(2) (redesignated as §155.605(d)(2)), an individual is exempt if his or her required contribution exceeds the required contribution percentage of his or her projected household income for a year. Finally, under §155.605(g)(5) (redesignated as §155.605(d)(5)), certain employed individuals are exempt if, on an individual basis, the cost of individual coverage is less than the required contribution percentage, but the aggregate cost of individual coverage through employers exceeds the required contribution percentage, and no family coverage is available through an employer at a cost less than the required contribution percentage.

Section 5000A established the 2014 required contribution percentage at 8 percent. For plan years after 2014, section 5000A(e)(1)(D) of the Code and 26 CFR 1.5000A-3(e)(2)(ii) provide that the required contribution percentage is the percentage determined by the Secretary that reflects the excess of the rate of premium growth between the preceding calendar year and 2013, over the rate of income growth for that period.

In the 2015 Market Standards Rule (79 FR 30302), we established a methodology for determining the excess of the rate of premium growth over the rate of income growth for plan

years after 2014. We also said future adjustments would be published annually in the HHS notice of benefit and payment parameters.

Under the HHS methodology, the rate of premium growth over the rate of income growth for a particular calendar year is the quotient of (x) 1 plus the rate of premium growth between the preceding calendar year and 2013, carried out to ten significant digits, divided by (y) 1 plus the rate of income growth between the preceding calendar year and 2013, carried out to ten significant digits.²⁸

As the measure of premium growth for a calendar year, we established in the 2015 Market Standards Rule that we would use the premium adjustment percentage. The premium adjustment percentage is based on projections of average per enrollee employer-sponsored insurance premiums from the National Health Expenditure Accounts (NHEA), which are calculated by the CMS Office of the Actuary.²⁹ In §156.130 of this proposed rule, we propose the 2017 premium adjustment percentage of 1.1325256291 (or about 13.3 percent) over the period from 2013 to 2016. This reflects an increase of about 5.1 percent for 2015-2016.

As the measure of income growth for a calendar year, we established in the 2015 Market Standards Rule that we would use per capita Gross Domestic Product (GDP), using the projections of per capita GDP used for the NHEA, which is calculated by the Office of the Actuary.

²⁸ We also defined the required contribution percentage at § 155.600(a) to mean the product of 8 percent and the rate of premium growth over the rate of income growth for the calendar year, rounded to the nearest one-hundredth of one percent.

²⁹ For any given year the premium adjustment percentage is the percentage (if any) by which the most recent NHEA projection of per enrollee employer-sponsored insurance premiums for the current year exceeds the most recent NHEA projection of per enrollee employer-sponsored insurance premiums for 2013.

However, as noted in the 2015 Market Standards Rule (79 FR 30304), we stated that we would consider alternative measures of income and premium growth should projections of those measures become available. As part of its projections of National Health Expenditures, the Office of the Actuary published projections of personal income (PI) for the first time in September 2014 and subsequently in July 2015. As a result, we are considering substituting this new measure of per capita PI for per capita GDP in the calculation for the required contribution percentage. We believe per capita PI better aligns with the statutory intent of measuring the income of an individual than per capita GDP. The projections of PI published by the Office of the Actuary are consistent with the measure published by the Bureau of Economic Analysis, which reflects income received by individuals from all sources, including income from participation in production. Specifically, it includes compensation of employees (received), supplements to wages and salaries, proprietors' income with adjustments for inventory valuation and capital consumption, personal income receipts on assets, rental income, and personal current transfer receipts, less contributions for government social insurance.

The Office of the Actuary's PI projection is generated using the University of Maryland's Long Term Inter-industry Forecasting Tool. The Long Term Inter-industry Forecasting Tool model is a macro-economic model that is based on the historical relationships that exist between PI growth, GDP growth, and changes in other macro-economic variables. For instance, the correlation between PI and GDP is influenced by fluctuations in taxes and government transfer payments, depreciation of capital stock, and retained earnings and transfer payments of private

business.³⁰ Estimates of GDP in the NHE projections reflect economic assumptions from the 2015 Medicare Trustees Report and are updated to incorporate the latest available consensus data from the monthly Blue Chip Economic Indicators. These same economic assumptions are used for producing projections of PI and employer-sponsored insurance premiums, so using this estimate will generate an internally consistent estimate of the growth in premiums relative to growth in income. We welcome comments on whether to substitute per capita PI for per capita GDP in the calculation to establish the rate of income growth for the required contribution percentage.

We will continue to consider other changes to the measures of income per capita and premium growth as additional information becomes available and as we gain experience with the current measures, and seek comment on other indices that we should develop or consider. For example, we have considered a measure of per capita personal income that does not include government transfers such as social security, Medicare, and Medicaid. We welcome comments on whether we should seek to develop such a measure of income, and whether we should use this or another alternative measure to establish the rate of income growth for the required contribution percentage.

Since updating the required contribution percentage for 2017 requires calculating the cumulative difference between premium growth and income growth between the preceding calendar year and 2013, we propose to replace per capita GDP with per capita PI for all years beginning in 2013 and then calculate cumulative income growth through 2016. We propose this

³⁰ Projections of PI and GDP are available from Table 1 at: Centers for Medicare & Medicaid Services. National Health Expenditure Data: Projected. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>

retrospective approach as it allows for consistency across all years with the most recent data available. We note that potential future changes based on new data that are not available for 2013 may be made on a prospective basis.

Under this proposal, using the NHEA data, the rate of income growth for 2017 is the percentage (if any) by which the most recent projection of per capita PI for the preceding calendar year (\$49,875 for 2016) exceeds the per capita PI for 2013, (\$44,925), carried out to ten significant digits. The total rate of income growth for the 3-year period from 2013-2016 is estimated to be 1.1101836394 (or about 11.0 percent). This reflects an increase of about 2.68 percent for 2015-2016.

Thus, using the proposed 2017 premium adjustment percentage, the excess of the rate of premium growth over the rate of income growth for 2013-2016 is $1.1325256291 / 1.1101836394$, or 1.0201245892. This results in a required contribution percentage for 2017 of 8.00×1.0201245892 , or 8.16 percent, when rounded to the nearest one-hundredth of one percent, an increase of 0.37 percentage points from 2016. The required contribution percentage is also used for 36B(b)(3)(A) and (c)(2)(C).

c. Eligibility Process for Exemptions (§155.610)

In §155.610, we propose to delete a cross-reference and add a paragraph about the handling of incomplete exemption applications received by the Exchange.

First, we propose to strike the cross-reference to paragraph (f) in §155.610(h)(1) as we propose elsewhere in this proposed rule that the Exchange will no longer process exemption applications related to membership in an Indian tribe.

Second, we propose to add new paragraph §155.610(k) regarding how the Exchange will handle incomplete exemption applications submitted to the Exchange. We propose that the

Exchange will handle incomplete exemption applications similarly to how it handles incomplete health coverage applications under §155.310(k). Specifically, when the Exchange receives an application that does not contain sufficient information to make an eligibility determination, the Exchange will: (1) provide notice to the applicant indicating that information necessary to complete an eligibility determination is missing, specifying the missing information, and providing instructions on how to provide the missing information; (2) provide the applicant with a period of no less than 10 and no more than 90 days starting from the date on which the notice is sent to the applicant to provide the information needed to complete the application to the Exchange; and (3) if the Exchange does not receive the requested information, the Exchange will notify the applicant that the Exchange will not process the application and will provide appeal rights to the applicant. We seek comment on this proposal.

d. Verification Process Related to Eligibility for Exemptions (§155.615)

In §155.615, we propose deletions related to exemptions that we are proposing elsewhere in this proposed rule to remove from the Exchange exemption eligibility determination process, and an addition to align with newly added paragraphs pertaining to a general hardship exemption.

First, we propose conforming edits to delete §155.615(c), (d), (e), and (f)(3) in accordance with our proposal to remove the option to obtain an ECN from the Exchange for certain exemptions.

Next, we propose to add paragraph §155.615(c)(2) to align with the 3-year time frame requirement proposed in §155.605(d)(3). We propose that if the hardship-qualifying event or circumstance in §155.605(d)(1) began more than 3 years from the date the exemption application was submitted, and if the event or circumstance continued beyond the initial 3-year period, the

Exchange must verify the applicant continued to experience the hardship to which he or she is attesting during a period that is within 3 years from the date of the exemption application submitted under §155.605(d)(1). We believe that this requirement places minimum burden on the applicant while ensuring that the Exchange appropriately meets the requirements in paragraph (c)(1) of this section under the proposed 3-year time frame in §155.605(d)(3). We seek comment on this proposal.

e. Options for Conducting Eligibility Determinations for Exemptions (§155.625)

We propose to amend §155.625(a)(2) and (b) to remove the deadline after which a State Exchange was to be required to process exemption applications for residents of the State by the start of open enrollment for 2016, and to permit an Exchange to adopt an exemption eligibility determination made by HHS indefinitely. Based on HHS's operation of this service to date, we have determined that the HHS exemption option is an efficient process for State Exchanges that has minimized confusion for consumers. This proposed rule follows an FAQ published on July 28, 2015 in which HHS stated that it will not take any enforcement action against State Exchanges that continue to use the HHS service for exemptions beyond the start of open enrollment for 2016. Therefore, we propose to delete paragraphs (b)(1), (2) and (3). We seek comment on this proposal.

8. Exchange Functions: Small Business Health Options Program (SHOP)

a. Functions of a SHOP (§155.705)

Sections 155.705(b)(2) and (3) set forth regulations related to employer choice in SHOPS. We are proposing to add new paragraphs (b)(3)(viii) and (ix) to specify that the FF-SHOPS would provide additional options for employer choice for plan years beginning on or after January 1, 2017.

For plan years beginning in 2015, employers offering coverage in certain FF-SHOP States have two options for providing coverage: they can offer a single plan or they can offer “horizontal” choice, in which an employer selects a single actuarial value coverage level and makes all plans at that coverage level available to the qualified employees. These same two options are available to participating employers in all FF-SHOP States for plan years beginning on or after January 1, 2016. For plan years beginning on or after January 1, 2017, we propose to add paragraphs (b)(3)(viii) and (ix) to this section to add an additional employer choice option available to consumers participating in FF-SHOPs. We are proposing to add a “vertical choice” option for QHPs and SADPs under which employers will be able to offer qualified employees a choice of all plans across all available levels of coverage from a single issuer, for plan years beginning on or after January 1, 2017. We anticipate that this “vertical choice” option would be appealing to employers because it gives employees greater flexibility across coverage levels, and that it may encourage more issuers to participate in SHOPs because issuers would be able to offer all of their plans to employees. Issuers may also prefer this option because it minimizes the risk of adverse selection by limiting choices to their own plans. By offering multiple plans to an employer, the issuer may be more likely to enroll a greater share of the employer’s group than if multiple issuers offering coverage in a single coverage level were vying for members of the group. By doing so, the issuer would be likely to enroll a more diverse risk pool from the employer’s group, minimizing the risk of adverse selection. We note that existing SHOP regulations at §155.705(b)(3)(i)(B) and (b)(3)(ii)(B) provide State-based SHOPs with the flexibility to provide employers with vertical choice or other options for providing employer choice in addition to “horizontal” choice, and these amendments would not affect State-based SHOPs’ flexibility in this regard.

We are also seeking comment on whether the FF-SHOPs should make other employer choice options available. For example, we are considering allowing participating employers to select an actuarial value level of coverage, after which employees could choose from plans available at that level and at the level above it. We also seek comment on whether to give the State in which the FF-SHOP is operating an opportunity to recommend whether the FF-SHOP in that State should implement any additional model of employer choice. Under this approach, a State regulatory agency, such as the State Department of Insurance, could submit a letter to the Secretary with a recommendation for the employer choice models that should be offered in their State, based on the additional models of employer choice the FF-SHOP has made available. The FF-SHOP would then evaluate the State's recommendation and determine whether to make the additional models of employer choice available in the State. In all States, the FF-SHOPs would continue to give employers the option of offering a single QHP (or SADP) as well as the option of offering a choice of all QHPs (or SADPs) at a single actuarial value level of coverage, and States would not be given an opportunity to recommend that these options not be implemented in their State.

We also propose adding a new §155.705(b)(3)(x) to provide that the employer choice models that would be available for SBE-FPs utilizing the Federal platform for SHOP enrollment functions would be the ones that are available through the FF-SHOP platform, because employer choice is an integral part of the FF-SHOP platform's enrollment functionality and system build. If we finalize an approach under which States with an FF-SHOP would be given an opportunity to recommend whether the FF-SHOP in that State should implement any additional models of employer choice that would ultimately be finalized as a result of these proposals, the same opportunity would be made available to a State with an SBE-FP.

We propose to amend paragraph (b)(4)(ii)(B) to specify the timeline under which qualified employers in a FF-SHOP must make initial premium payments. Specifically, we are proposing to add paragraph (b)(4)(ii)(B)(1) to specify that in the FF- SHOPs, payment for the group's first month of coverage must be received by the premium aggregation services vendor on or before the 20th day of the month prior to the month that coverage begins. This means electronic payments must be completed or the premium aggregation services vendor must have receipt of any hard copy check on or before the 20th day of the month prior to the month that coverage would begin. HHS currently advises employers participating in FF-SHOPs to submit initial premium payments electronically by the 15th of the month prior to the coverage effective date to ensure that there is sufficient time for the payment to be cleared. Selecting the 20th of the month provides sufficient time to cancel coverage prior to the effective date. Under this proposal, if an initial premium payment is not received by the premium aggregation services vendor on or before the 20th day of the month prior to the month that coverage would begin, coverage would not be effectuated. If this happens, the employer could apply to purchase coverage that would be effective at the beginning of another month during the year, as coverage would not have been effectuated. The group would not need to submit a new application, but would need to select a new coverage effective date. Therefore, the grace period and reinstatement opportunities under §155.735(c)(2) that are provided to groups that do not make timely payments after coverage has taken effect are not relevant in this context, and we are proposing amendments to the introductory language of §155.735(c)(2) to reflect this.

In circumstances where an FF-SHOPs would be retroactively effectuating coverage for qualified employer groups, the FF-SHOP would need to receive payment prior to effectuating coverage. We seek comment on the timing of when premium payment must be received by an

FF-SHOP when coverage is effectuated retroactively. We are considering a policy under which payments for the first month's coverage and all months of the retroactive coverage would have to be received and processed no later than 30 days after the event that triggers the eligibility for retroactive coverage. We believe 30 days would provide sufficient time for groups to make these payments.

In paragraph (b)(4)(ii)(C)(2) of this section, we propose to correct a cross reference to §155.705(b)(4)(ii)(B)(*I*) that should have been updated to cross-reference §155.705(b)(4)(ii)(C)(*I*) when §155.705(b)(4)(ii)(A) was added in the 2016 Payment Notice.

We also propose amendments to §155.705(b)(11)(ii), which governs employer contributions to premiums in FF-SHOPs and applies to both medical and dental plans. Section 155.705(b)(11)(ii) currently states that the FF-SHOP “must use” the reference plan contribution methodology currently set forth at §155.705(b)(11)(ii). We propose to amend this provision to provide for FF-SHOPs to use a “fixed contribution methodology,” in addition to the reference plan methodology set forth in the current regulation. The amendments would specify that when an employer decides to offer a single plan to qualified employees, the employer would be required to use the fixed contribution methodology. Specifically, when offering a single plan, the employer would contribute a fixed percentage of the plan's premium for each qualified employee, and (if applicable) for each dependent of a qualified employee. This policy for employers offering a single plan is consistent with what was described in the preamble to the Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program rulemaking (78 FR 33233), in which we explained that when a choice of plans is not available to the employee, the single QHP offered by the employer would be the reference plan under the reference plan methodology described in the

current regulation. See 78 FR 33236. While the proposed methodology would be consistent with our interpretation of the current regulation in circumstances where a choice of plans is not offered, we are proposing to codify how the contribution methodology would be handled operationally in those circumstances. Additionally, we propose to permit employers to choose between the reference plan contribution methodology set forth in the current regulation and the proposed fixed contribution methodology when offering a choice of plans. When offering a choice of plans, an employer opting for the fixed percentage contribution methodology would contribute a fixed percentage of the premiums across all plans in which any qualified employee and, if applicable, any dependent of a qualified employee, is enrolled. The dollar amount of the fixed percentage contribution would vary from enrollee to enrollee based on their age and the plan they choose. We believe that offering these two employer contribution methodologies to employers offering a choice of plans would provide employers with flexibility to contribute to their qualified employees' plans in a manner that is appropriate for the group. We are also proposing to add language to §155.705(b)(11)(ii) explaining that a tobacco surcharge, if applicable, would be added to the monthly premium after the employer contribution is applied to the premium so that the financial impact of the surcharge is borne by the tobacco user, as opposed to being shared with the employer or other enrollees. We also propose to streamline the discussion of the reference plan contribution methodology described in §155.705(b)(11)(ii), and propose removing §155.705(b)(11)(ii)(D) because the FF-SHOPs are currently not able to support basing employer contributions on calculated composite premiums.

We seek comment on these proposals.

b. Eligibility Determination Process for SHOP (§155.715)

We propose to amend §155.715(g)(1), which sets forth what a SHOP must do if a qualified employer withdraws from the SHOP, to distinguish between terminations of enrollment and terminations of coverage. This regulation currently provides that, if an employer ceases to purchase coverage through a SHOP, the SHOP must ensure that each QHP terminates the coverage of the qualified employee who is enrolled in the QHP through the SHOP. Consistent with guaranteed availability and guaranteed renewability, coverage purchased through a SHOP might in many circumstances continue outside a SHOP in a manner no longer considered to be enrollment through the SHOP. Therefore, we propose to specify that the termination described in this paragraph would be a termination of the employer group's enrollment through the SHOP, rather than a termination of the group's coverage. For example, in many circumstances, an employer may offer to continue the same coverage outside of the SHOP, in which case the issuer should not terminate the coverage.

We seek comment on this proposal.

c. Enrollment Periods under SHOP (§155.725)

Section 155.725(c) discusses the annual employer election period. We are proposing to delete paragraph (c)(1) because it is outdated, redesignate current paragraph (c)(2) as (c) introductory text and redesignate the remaining paragraphs to reflect the new structure of paragraph (c).

We propose to redesignate §155.725(e) as §155.725(e)(1) and add paragraph (e)(2). To provide adequate time for qualified employees in FF-SHOPs to make coverage selections during their annual open enrollment period, we propose adding paragraph (e)(2) to specify that qualified employers in the FF-SHOP must provide qualified employees an annual open enrollment period

of at least one week. This proposed amendment, like all of §155.725(e), would apply only with respect to renewals.

We are also proposing amendments to §155.725(h)(2) to specify that the event that triggers a group's coverage effective date in a FF-SHOP is not the plan selections of the individual enrollees, but the employer's submission of all plan selections for the group (which we call the group enrollment), and to allow employers to opt for a coverage effective date later than the standard dates provided for under the rule. The proposed amendments would permit qualified employers to set enrollment periods for their qualified employees that could include plan selections both before and after the 15th of a month, and would also permit employers to select a coverage effective date later than the standard dates provided for under the rule.

Employers would be able to select a coverage effective date up to 2 months in advance, provided that small group market rates are available for the quarter in which the employer would like coverage to take effect. This would allow employers to maximize their enrollment periods so that they could begin the SHOP enrollment process as soon as small group market rates are available for the quarter in which they would like coverage to take effect. Under the proposed amendments, if an employer submits its group enrollment by the 15th day of any month, the FF-SHOP would ensure a coverage effective date of the first day of the following month, unless the employer opts for a later effective date for which rates are available. If an employer submits its group enrollment between the 16th day of the month and the last day of the month, we propose that the FF-SHOP must ensure a coverage effective date of the first day of the second following month, unless the employer opts for a later effective date for which rates are available.

We propose to amend §155.725(i)(1), which currently provides that if a qualified employee enrolled in a QHP through a SHOP remains eligible for coverage, that qualified

employee will remain in the QHP selected the previous year, unless certain exceptions apply. We propose to provide that a SHOP be permitted to, but need not, provide for auto-renewals of qualified employees, and also propose to revise the language of the provision for consistency with our interpretation of guaranteed renewability. If a SHOP does not provide for auto-renewals for qualified employees, qualified employees would have to review and provide a response to the employer's renewal offer of coverage. If auto-renewal is available, qualified employees need not take any action to continue in the prior year's coverage through the SHOP. We are proposing this amendment to reflect current operational capabilities in the FF-SHOPs.

Additionally, we propose to amend paragraph (j)(2)(i) of this section to remove a reference to §155.420(d)(10), which was deleted in the 2016 Payment Notice. We also propose to amend the paragraph to specify that there would not be a SHOP special enrollment period when a qualified employee or dependent of a qualified employee experiences an event described in §155.420(d)(1)(ii), which provides for a special enrollment period for individuals enrolled in a non-calendar-year group health plan.

We seek comment on these proposals.

d. Termination of SHOP enrollment or coverage (§155.735)

For the reasons discussed above in the preamble discussion of our proposed amendments to §155.705(b)(4), we are proposing to modify the introductory language of §155.735(c)(2) to specify that the provisions related to termination of employer group health coverage for non-payment of premiums in FF-SHOPs under paragraph (c)(2) would not apply to premium payments for the first month of coverage.

We are also proposing amendments to §155.735(d). Under existing regulations at §155.735(d)(2), terminations of FF-SHOP coverage or enrollment are effective on the last day of

the month in which the FF-SHOP receives notice for enrollees that change from one QHP to another during the employer's annual open enrollment period or during a special enrollment period. We propose that if an enrollee changes from one QHP to another during the annual open enrollment period or during a special enrollment period, the last day of coverage would be the day before the effective date of coverage in the enrollee's new QHP. We believe that this would prevent any instances of double coverage as well as avoid a gap in coverage.

We also propose to require at §155.735(d)(2)(iii) that the FF-SHOPs send advance notices to qualified employees before their dependents age off of their plan. This notice would be sent 90 days in advance of the date when the child dependent enrollee is no longer eligible for coverage under the plan the employer purchased through the FF-SHOP because he or she has reached the maximum child dependent age for the plan. The notice would include information about the plan the dependent is currently enrolled in, the date the dependent would age off the plan, and information about next steps. In the FF-SHOPs, consistent with current §155.735(d)(2) and proposed §155.735(d)(2)(i), a dependent aging off of the plan loses eligibility for dependent coverage at the end of the month of the dependent's 26th birthday or at the end of the month in which the issuer has set the maximum dependent age limit (but in some cases might have the option to keep the coverage for a period of time after that date under applicable continuation coverage laws). This notice is intended to be a courtesy notice as enrollees would still receive a termination notice when their coverage through the SHOP is terminating.

e. SHOP Employer and Employee Eligibility Appeals Requirements (§155.740)

In §155.740, we make certain proposals relating to SHOP appeals. We propose to amend paragraphs (c)(2) and (d)(2) to provide that employers and employees may file an appeal not

only if a SHOP fails to provide an eligibility determination in a timely manner but also if a SHOP fails to provide timely notice of an eligibility determination, in accordance with §155.715(e) and (f). We propose these amendments in order to better align the SHOP appeals provisions with individual market Exchange appeals. We note that the FF-SHOPs provide the notice of eligibility automatically when an application is submitted. For the FF-SHOPs, the date of eligibility determination and eligibility notice are generally the same date.

We also propose to amend paragraph (l)(3) to allow employers and employees who successfully appeal a denial of SHOP eligibility to select whether the effective date of coverage or enrollment through the SHOP under their appeal decision will be retroactive to the effective date of coverage or enrollment through the SHOP that the employer or employee would have had if they had correctly been determined eligible, or prospective from the first day of the month following the date of the notice of the appeal decision. The current version of paragraph (l)(3) requires all SHOP appeal decisions to be retroactive to the date the incorrect eligibility determination was made. This proposed change would grant employers and employees added flexibility regarding the effective date of coverage or enrollment through the SHOP under their appeal decision and would be better aligned with current and proposed policy for individual market Exchange appeals. For example, an employer or employee would have flexibility under this proposal to opt for a prospective effective date because he or she did not want to pay retrospective premiums. We also propose to revise paragraph (l)(3) to specify that if eligibility is denied under an appeal decision, the effective date of the coverage or enrollment through the SHOP under the appeal decision would be the first day of the month following the date of the notice of the appeal decision. We seek comment on these proposals.

9. Exchange Functions: Certification of Qualified Health Plans

a. Certification Standards for QHPs (§155.1000)

In the first few years of FFE operations, HHS has generally used an “open market” approach to QHP certification, accepting plans that met the minimum QHP certification criteria. As the new QHP market developed, it has been valuable to maintain predictability for issuers, and that remains an important consideration. For example, elsewhere in this rulemaking, we propose codifying and making transparent standards related to network adequacy. At the same time we are exploring the most useful tools to ensure that QHPs offer consumers a quality product. In this section, we seek comment on a means of improving product value by using the authority to deny certification to QHP applications.

1. Denial of Certification

Section 1311(e)(1)(B) of the Affordable Care Act states that Exchanges may certify a health plan as a QHP if “(A) such health plan meets the requirements for certification as promulgated by the Secretary...and (B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers.” Section 1311(e)(1)(B) thereby affords Exchanges the discretion to deny certification of QHPs that meet minimum QHP certification standards, but are not ultimately in the interests of qualified individuals and qualified employers. We interpret the “interest” standard to mean QHPs should provide quality coverage to consumers to meet the Affordable Care Act’s goals.

Section 155.1000 provides Exchanges with broad discretion to certify health plans that otherwise meet the QHP certification standards specified in part 156. HHS will continue to focus denials of certification in the FFEs based on the “interest of the qualified individuals and qualified employers” standard to cases involving the integrity of the FFEs and the plans offered through them. Examples of issues that could result in non-certification of a plan include

concerns related to an issuer's material non-compliance with applicable requirements, an issuer's financial insolvency, or data errors related to QHP applications and data submissions. Under this approach, HHS could consider an assessment of past performance, including with respect to oversight concerns raised through compliance reviews and consumer complaints received and the frequency and extent of any data submission errors. HHS would adopt a measured approach in exercising this authority that would take into consideration several factors, including available market competition and the availability of operational resources.

As we consider this approach, we anticipate seeking more specific comment. We seek comment on this proposal generally, and on these and any other factors HHS should consider when evaluating QHPs to determine if they meet the interests of consumers and businesses. HHS would also ensure any future policy changes do not interfere with State activities. We seek comments, specifically from States and other stakeholders, on this aspect of the proposal.

We note that the OPM has the sole discretion for contracting with multi-State plans and as such retains the authority to selectively contract with multi-State plans.

G. Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

1. Standardized Options

a. Standardized Option Definition (§156.20)

The Affordable Care Act gives Exchanges considerable flexibility in certification and oversight of QHPs. An excessive number of health plan options makes consumers less likely to make any plan selection, more likely to make a selection that does not match their health needs, and more likely to make a selection that leaves them less satisfied. In studies of consumer behavior in Medicare Part D, Medicare Advantage, and Medigap, a choice of 15 or fewer plans

was associated with higher enrollment rates, while a choice of 30 or more plans led to a decline in enrollment rates.³¹ In 2015, across the 37 Exchanges using the HealthCare.gov platform, the number of health plan choices available per county varied from 2 to 54 plans at the bronze level, 2 to 73 plans at the silver level, and 1 to 43 plans at the gold level.³² Our experience in the first two open enrollment periods suggests that many consumers, particularly those with a high number of health plan options, find the large variety of cost-sharing structures available on the Exchanges difficult to navigate.

We believe that standardized options will provide these consumers the opportunity to make simpler comparisons of plans offered by different issuers within a metal level. Consumers will be able to focus their decision making on the providers in the plan networks, premiums, benefits, and quality, and will not be required to make complex tradeoffs among cost-sharing differences among a large number of plans. Taken together, standardized options, EHB, AV, and QHP certification standards can significantly simplify consumers' ability to compare plans and make informed choices.

To simplify the consumer plan selection process, HHS is proposing to establish "standardized options" in the individual market FFEs. These plans would have standardized cost sharing for a key set of EHB that comprise a large percentage of the total allowable costs for an average enrollee. We propose that issuers would not be required to offer standardized options in 2017 and would retain the flexibility to offer non-standardized plans, but we are considering

³¹ Chao Zhou and Yuting Zhang, "The Vast Majority Of Medicare Part D Beneficiaries Still Don't Choose The Cheapest Plans That Meet Their Medication Needs." *Health Affairs*, 31, no.10 (2012):2259-2265

³² The average number of plans available per county in 2015 were: 12 bronze plans, 15 silver plans, and 9 gold plans. Available at: <https://www.cms.gov/ccio/resources/data-resources/marketplace-puf.html>

ways that standardized options, when certified by an FFE, could be displayed on HealthCare.gov in a manner that makes it easier for consumers to find and identify them, including distinguishing them from non-standardized plans.

We propose cost-sharing structures for standardized options at the bronze, silver (and associated silver cost-sharing reduction plan variations), and gold levels of coverage. At §156.20, we propose adding a definition for standardized option. A standardized option would be defined as a QHP with a standardized cost-sharing structure specified by HHS and that is offered for sale through an individual market FFE (see Table 9 for proposed models). We envision standardized options to include a single provider tier, a fixed in-network deductible, a fixed annual limitation on cost sharing, and standardized copayments and coinsurance for a key set of EHB that comprise a large percentage of the total allowable costs for an average enrollee. We seek comment on this proposal.

b. Standardized Option Design Principles

We have designed one bronze standardized option, one silver standardized option, one standardized option for each silver CSR plan variation, and one gold standardized option. We are not proposing a platinum standardized option because only a small proportion of QHP issuers in the FFEs offered platinum plans in 2015. Silver plans are the most common and popular plans in the FFEs.³³ As such, we encourage issuers to offer at least one standardized option at the silver level of coverage (along with the associated standardized silver CSR plan variations) to

³³ In 2015, across the FFEs, there were a total of: 263 catastrophic, 1864 bronze, 2500 silver, 1774 gold, and 551 platinum plans. Available at: <https://www.cms.gov/ccio/resources/data-resources/marketplace-puf.html>

simplify the consumer shopping experience for the greatest number of enrollees. We intend to propose standardized option changes annually. We seek comment on these proposals.

c. General Features of the Standardized Options.

To minimize market disruption, we have designed the standardized options to be as similar as possible to the most popular 2015 FFE QHPs (based on enrollment), and we have sought a cost-sharing structure that would generally not raise premiums. In arriving at these standardized option designs, we also consulted the standardized option designs offered in the SBEs that have provided standardized plans since the 2014 plan year (California, Connecticut, Massachusetts, New York, Oregon, and Vermont).

i. Drug Formularies.

We propose that standardized options have the four drug tiers currently utilized in our consumer-facing applications at this time — generic, preferred brand, non-preferred brand, and specialty drug tiers. However, we propose to allow issuers to offer additional lower-cost tiers if desired. Slightly more than half (56 percent) of the proposed 2016 FFE QHPs have more than four drug tiers. We seek comment on this design element.

ii. Provider tiers.

We propose that standardized options have no more than one in-network provider tier. Varying cost sharing by provider tier affects the actuarial value of a plan, making it difficult to standardize a cost-sharing structure. Further, only 14 percent of FFE enrollees are currently enrolled in QHPs with more than one in-network tier, and only 6 percent of enrollees are covered by an issuer that does not offer a single-tier plan in addition to a multi-tier plan in the same county. We seek comment on this design element.

iii. Deductible-exempt services.

In designing the standardized options, we seek to exempt from the deductible certain routine services, such as primary care, specialist visits (at the silver and gold metal levels), and generic drugs, to ensure that access to coverage translates into access to care for routine and chronic conditions and that enrollees receive some up-front value for their premium dollars. Again, in terms of this feature, we designed the standardized options to be as similar as possible to the most popular 2015 FFE QHPs (based on enrollment). Among those 2015 FFE QHPs, over 85 percent of silver plan enrollees and over 50 percent of bronze plan enrollees selected plans that cover certain services prior to application of the deductible. (The figure for gold plan enrollees was over 90 percent. However, many gold plans have a \$0 deductible, for which the concept of deductible-exempt services would not be meaningful.) Primary care and generic drugs are the services most likely to be covered without a deductible at all three metal levels. Other services that are also likely to be covered prior to the deductible, particularly by silver and gold plans, include specialist visits and mental/behavioral health and substance use disorder outpatient services. We seek comment on this design element.

iv. Copayment vs. coinsurance.

We sought to balance consumer preference for copayments over coinsurance with the potential impact on premiums. Research shows that consumers often prefer copayments to coinsurance because the former are more transparent and make it easier for consumers to predict their out-of-pocket costs. On the other hand, setting fixed copayments on a national level could lead to disparate premium effects due to regional and issuer-specific cost differences. We seek comment on this design element.

d. Specific Standardized Option Designs

The proposed 2017 bronze standardized option closely resembles a catastrophic plan, with a few key exceptions. The plan has a \$6,650 deductible, an annual limitation on cost sharing equal to the maximum allowable annual limitation on cost sharing for 2017 (proposed to be \$7,150), and 50 percent coinsurance. Primary care visits (for the first three visits) and mental health/substance use outpatient services are exempt from the deductible, and have a copayment of \$45. Generic drugs are also exempt from the deductible and have a copayment of \$35. Note that for all standardized options, cost-sharing rules for preventive services under §147.130 apply (we do not list this benefit category in Table 9).

The proposed 2017 silver standardized option has a \$3,500 deductible, an annual limitation on cost sharing equal to the maximum allowable annual limitation on sharing for 2017, and a 20 percent enrollee coinsurance rate. Primary care visits, mental health/substance use outpatient services, specialist visits, urgent care visits, and all drug benefits are exempt from the deductible, and all of the deductible-exempt benefits have copayments instead of co-insurance, except for specialty drugs, which are subject to a 40 percent coinsurance rate. Emergency room services are subject to the deductible, with a \$400 copayment applicable after the deductible.

The proposed 2017 silver cost-sharing reduction standardized options reduce all cost sharing parameters successively to meet the 73 percent, 87 percent, and 94 percent AV requirements. Where possible, the cost-sharing reduction standardized options and the non-cost-sharing reduction standardized silver option maintain similar differentials between the cost sharing for certain benefits like primary care and specialty visits.

The proposed 2017 gold standardized option has a \$1,250 deductible, a \$4,750 annual limitation on cost sharing, and a 20 percent enrollee coinsurance rate. Primary care visits, mental health and substance use outpatient services, specialist visits, urgent care visits, and all drug

benefits are not subject to the deductible. All of the benefits not subject to the deductible have copayments except for specialty drugs. We seek comment on these designs, in particular with respect to whether particular cost-sharing elements, such as deductibles or copayments for particular services, should be modified.

TABLE 9— Proposed 2017 Standardized Options

	Bronze	Silver	Silver 73% Actuarial Value Variation	Silver 87% Actuarial Value Variation	Silver 94% Actuarial Value Variation	Gold
Actuarial Value (%)	61.8	71.00	73.55	87.47	94.3	79.98
Deductible	\$6,650	\$3,500	\$3,000	\$700	\$250	\$1,250
Annual Limitation on Cost Sharing	\$7,150	\$7,150	\$5,700	\$2,000	\$1,250	\$4,750
Emergency Room Services	50%	\$400 (copay applies only after deductible)	\$300 (copay applies only after deductible)	\$150 (copay applies only after deductible)	\$100 (copay applies only after deductible)	\$250 (copay applies only after deductible)
Urgent Care	50%	\$75 (*)	\$75 (*)	\$40 (*)	\$25 (*)	\$65 (*)
Inpatient Hospital Services	50%	20%	20%	20%	5%	20%
Primary Care Visit	\$45 (* first 3 visits, then subject to deductible and 50% coinsurance)	\$30 (*)	\$30 (*)	\$10 (*)	\$5 (*)	\$20 (*)
Specialist Visit	50%	\$65 (*)	\$65 (*)	\$25 (*)	\$15 (*)	\$50 (*)
Mental Health/ Substance Use Disorder Outpatient Services	\$45 (*)	\$30 (*)	\$30 (*)	\$10 (*)	\$5 (*)	\$20 (*)
Imaging (CT/PET Scans, MRIs)	50%	20%	20%	20%	5%	20%
Rehabilitative Speech Therapy	50%	20%	20%	20%	5%	20%
Rehabilitative OT/PT	50%	20%	20%	20%	5%	20%
Laboratory Services	50%	20%	20%	20%	5%	20%
X-rays	50%	20%	20%	20%	5%	20%
Skilled Nursing Facility	50%	20%	20%	20%	5%	20%
Outpatient Facility Fee	50%	20%	20%	20%	5%	20%
Outpatient Surgery Physician/Surgical	50%	20%	20%	20%	5%	20%
Generic Drugs	\$35 (*)	\$10 (*)	\$10 (*)	\$5 (*)	\$3 (*)	\$10 (*)
Preferred Brand	50%	\$50 (*)	\$50 (*)	\$25 (*)	\$5 (*)	\$30 (*)

Drugs						
Non-Preferred Brand Drugs	50%	\$100 (*)	\$100 (*)	\$50 (*)	\$10 (*)	\$75 (*)
Specialty Drugs	50%	40% (*)	40% (*)	30% (*)	25% (*)	30% (*)

(*) = not subject to the deductible.

We propose that an issuer may offer multiple plans through an FFE for each standardized option within a service area when the plans are meaningfully different, such as offering an HMO standardized option and a PPO standardized option at a certain metal level. We seek comment on this proposal.

To reduce operational complexity, we do not propose to vary the standardized options by State or region. Instead, we propose one set of standardized options for all FFEs, including those in which States perform plan management functions. We recognize that some States regulate the level of cost sharing applied to certain benefits, such as emergency room services and specialty drugs. We invite comment from States and other stakeholders on the proposed standardized options, and how they may interact with State-specific cost-sharing laws or regulations, as well as any potential options for incorporating State cost-sharing requirements into the standardized option framework.

We do not propose to limit the number of non-standardized options that an issuer may offer through an FFE; however, meaningful difference standards at §156.298 and other QHP certification standards still apply. There is currently no such cap on the number of plans that an issuer offering a QHP through an FFE can offer, or on the number of issuers that can offer coverage at each metal level in an FFE. In this proposed rule, we do not propose to limit the total number of QHPs that may be sold through an FFE in a rating area or county. However, we may consider limiting the number of plan options in future plan years, to further simplify the health plan shopping experience for consumers. We seek comment as to whether we should limit the number of non-standardized options an issuer may offer through an FFE in future years.

We are considering making modifications to our consumer-facing plan comparison features to readily allow consumers to identify standardized options, and seek comment on how we should do so. We intend to conduct consumer testing to help us make this determination. We also anticipate providing information to explain the standardized option concept to consumers. We expect to provide information about specific design features through issuer testing of plan data and other fora. We seek comment on these proposals, including whether there should be a requirement on QHP issuers or web-brokers to differentially display standardized options when a non-FFE website is used to facilitate enrollment in an FFE. Multi-State plan issuers may use the standardized options noted above. OPM, at its discretion, may design additional standardized options applicable only to multi-State plan issuers, though we would not display these OPM options in a differential manner in order to preserve consistency in the standardized options identified on the FFE.

2. FFE User Fee for the 2017 Benefit Year (§156.50)

Section 1311(d)(5)(A) of the Affordable Care Act permits an Exchange to charge assessments or user fees on participating health insurance issuers as a means of generating funding to support its operations. In addition, 31 U.S.C. 9701 permits a Federal agency to establish a charge for a service provided by the agency. If a State does not elect to operate an Exchange or does not have an approved Exchange, section 1321(c)(1) of the Affordable Care Act directs HHS to operate an Exchange within the State. Accordingly, at §156.50(c), we specify that a participating issuer offering a plan through an FFE must remit a user fee to HHS each month that is equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for FFEs for the applicable benefit year and the

monthly premium charged by the issuer for each policy under the plan where enrollment is through an FFE.

OMB Circular No. A-25R establishes Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. As in benefit years 2014 to 2016, issuers seeking to participate in an FFE in benefit year 2017 will receive two special benefits not available to the general public: (1) the certification of their plans as QHPs; and (2) the ability to sell health insurance coverage through an FFE to individuals determined eligible for enrollment in a QHP. These special benefits are provided to participating issuers through the following Federal activities in connection with the operation of FFEs:

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

OMB Circular No. A-25R further states that user fee charges should generally be set at a level so that they are sufficient to recover the full cost to the Federal government of providing the service when the government is acting in its capacity as sovereign (as is the case when HHS operates an FFE). Accordingly, we propose to set the 2017 user fee rate for all participating FFE

issuers at 3.5 percent. This user fee rate assessed on FFE issuers is the same as the 2014 to 2016 user fee rate. In addition, we intend to seek an exception from OMB Circular No. A-25R, which requires that the user fee charge be sufficient to recover the full cost to the Federal government of providing the special benefit. We seek this exception to ensure that the FFE can support many of the goals of the Affordable Care Act, including improving the health of the population, reducing health care costs, and providing access to health coverage, in cases where user fee collections do not cover the full cost of the special benefit. We seek comments on this proposal.

Additionally, we have proposed under §§155.106(c) and 155.200(f) to allow State Exchanges to enter into a Federal platform agreement with HHS so that the State Exchange may rely on the Federal platform for certain Exchange functions to enhance efficiency and coordination between State and Federal programs, and to leverage the systems established by the FFE to perform certain Exchange functions. We propose in §156.50(c)(2) to charge SBE-FP issuers a user fee for the services and benefits to the issuers provided by HHS. For 2017, these functions will include the Federal Exchange information technology and call center infrastructure used in connection with eligibility determinations for enrollment in QHPs and other applicable State health subsidy programs, as defined at section 1413(e) of the Affordable Care Act and enrollment in QHPs under §155.400. As previously discussed, OMB Circular No. A-25R establishes Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. If our proposals under §§155.106(c) and 155.200(f) are finalized, issuers seeking to participate in an SBE-FP in benefit year 2017 will receive special benefits not available to the general public: the ability to sell health insurance coverage through a State Exchange that realizes efficiencies by relying on the Federal platform

to enroll individuals determined eligible for enrollment in a QHP, including individuals who may be eligible for insurance affordability programs that may support premiums paid to issuers offering plans through the State Exchange by way of the Federal platform (HealthCare.gov), and the ability to sell health insurance coverage to small employers eligible to purchase QHPs for its employees through a SHOP exchange. Other services that will be provided to issuers offering plans through State Exchanges on the Federal platform include the Federal Exchange information technology and call center infrastructure used in connection with eligibility determinations for enrollment in QHPs and other applicable State health subsidy programs. We propose to charge issuers offering QHPs through an SBE-FP a user fee rate of 3.0 percent of the monthly premium charged by the issuer for each policy under a plan offered through an SBE-FP. This fee will recover funding to support FFE operations incurred by the Federal government associated with providing the services described above.

The proposed user fee rate was calculated based on the proportion of FFE costs that are associated with the FFE information technology infrastructure, the consumer call center, and eligibility and enrollment services, and allocating a share of those costs to issuers in the relevant SBE-FPs. A significant portion of expenditures for FFE services are associated with the information technology, call center infrastructure, and personnel who conduct eligibility determinations for enrollment in QHPs and other applicable State health subsidy programs as defined at section 1413(e) of the Affordable Care Act, and who perform the functions set forth in §155.400 to facilitate enrollment in QHPs. We intend to review the costs incurred to provide these special benefits each year, and revise the user fee rate for issuers in SBE-FPs accordingly in the annual HHS notice of benefit and payment parameters. Additional guidance on user fee collection processes will be provided in the future.

While a user fee rate of 3.0 percent is reflective of HHS's actual costs, we recognize that States that are currently using the Federal platform may find the abrupt change of the proposed user fee in 2017 challenging for their health insurance markets. Therefore, HHS is also considering reducing for the 2017 benefit year the user fee rate by one half or one third (that is, to 1.5 or 2.0 percent) for the issuers in State Exchanges utilizing the Federal platform, to provide these States additional time to integrate this user fee rate. In future years, issuers in SBE-FPs would be charged the full user fee rate for SBE-FPs to cover their full share of costs incurred by the FFE for those services. We seek comment on this proposal and this possible reduction.

Additionally, to ease administrative burdens on issuers and States, at the request of SBE-FPs, pursuant to the authority under the Intergovernmental Cooperation Act of 1968 (IGCA), HHS will seek to offer States the option to have HHS collect an additional user fee from issuers at a rate specified by the State to cover costs incurred by the State-based Exchange for the functions the State retains. If HHS grants requests to provide such services, States may be required to reimburse HHS any additional costs that are associated with HHS's provision of such service. This coordination between the State and Federal programs will reduce administrative burden on issuers as well as the SBEs-FP.

3. Single Risk Pool (§156.80)

In the small group market, an issuer may update rates on a quarterly basis, provided that any changes to rates have effective dates of January 1, April 1, July 1, or October 1. In the preamble to the second Program Integrity Rule (78 FR 65067), we explained that any new rates set by an issuer would apply for new or renewing coverage on or after the rate effective date, and would apply for the entire the plan year. We propose to codify this policy in §156.80(d)(3)(ii),

and to make non-substantive changes to the wording of that paragraph, including to delete an outdated reference to when quarterly rate changes could first be implemented.

For all issuers, we also reiterate that §156.80(d)(2) permits a health insurance issuer to vary the plan-adjusted index rate for a particular plan from its market-wide index rate adjusting only for the explicitly stated factors. Any plan level adjustment not specifically stated, including adjusting for morbidity of plan enrollees, is not permissible.

4. Essential Health Benefits Package

a. Prescription Drug Benefits (§156.122)

Current §156.122(c) requires plans providing EHB to have procedures in place that allow an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request and gain access to clinically appropriate drugs not covered by the plan. Such procedures must include a process to request an expedited review based on exigent circumstances. Under the expedited process, the issuer must make its coverage determination no later than 24 hours after it receives the request. This requirement, commonly referred to as the "exceptions process," applies to drugs that are not included on the plan's formulary drug list. For plan years beginning in 2016, these processes must also include certain processes and timeframes for the standard review process, and have an external review process if the internal review request is denied. The costs of the non-formulary drug provided through the exceptions process count towards the annual limitation on cost sharing and AV of the plan.

As discussed in the 2016 Payment Notice (80 FR 10750), the exceptions process established in this section is distinct from the coverage appeals process established under §147.136. Specifically, the drug exceptions process applies to drugs that are not included on the plan's formulary drug list, while the coverage appeals regulations apply if an enrollee receives an

adverse benefit determination for a drug that is included on the plan's formulary drug list. Because these two processes serve different purposes, we believe they are not duplicative and we do not propose to change these definitions. However, we also clarified in the 2016 Payment Notice that "nothing under this policy (§156.122(c)) precludes a State from requiring stricter standards in this area."

Since finalizing the rule, we have received additional comment regarding States' coverage appeals laws and regulations and non-formulary drugs. For example, if a State is subjecting non-formulary drugs to the standards under §147.136 as opposed to §156.122(c), the State's coverage appeals laws or regulations would provide the enrollee with a different process for review, and as a result a different process for obtaining coverage of the non-formulary drug. Specifically, §147.136 has separate requirements for its external review process. Also, §147.136(b)(ii)(G) allows for a secondary level of internal review before the final internal review determination for group plans. Therefore, if the State is subjecting non-formulary drugs to §147.136 and the issuers are also required to comply §156.122(c), the issuer may have to satisfy two standards for non-formulary drugs.

We are considering amending the rule to establish that a plan, in a State that has coverage appeals laws or regulations that are more stringent than or are in conflict with our exceptions process under §156.122(c), and that include reviews for non-formulary drugs, satisfies §156.122(c) if it complies with the State's coverage appeals laws or regulations. The purpose of §156.122(c) is to ensure that an enrollee has the ability to request and gain access to clinically appropriate drugs not covered by the plan. Regardless of whether a State's coverage appeals laws or regulations are satisfying §156.122(c) or if the issuer is meeting §156.122(c) through its exception process, we would expect that an enrollee would retain the ability to request and gain

access to clinically appropriate drugs not covered by the plan. Therefore, we solicit comments on the scope of application of State appeals laws or regulations that are allowing determinations for non-formulary drugs for this purpose, especially under medical necessity provisions and whether these provisions would allow the enrollee the ability to request and gain access to clinically appropriate drugs not covered by the plan in all cases through a State's coverage appeals laws or regulations. As the State is the primary enforcer of the EHB requirements, the State would determine whether its coverage appeals laws or regulations would satisfy §156.122(c) and therefore, would allow the issuers in the State to defer to the States' coverage laws or regulations. We note that we consider multi-State plans that comply with OPM's coverage appeals requirements to satisfy §156.122(c), and we are considering codifying this interpretation.

We are also considering amending the process at §156.122(c) to allow for a second level of internal review. For example, we are considering using the same timelines as the first level of internal review, 72 hours for the standard review request and 24 hours for the expedited review request. We seek comments on all of these proposals.

Lastly, opioid abuse has become a public health crisis in recent years. In 2013, nearly 2 million Americans abused prescription painkillers, and each day, nearly 7,000 people receive emergency department care for misusing these drugs. We recognize that medication-assisted treatments for substance use disorders might not be available to all consumers as an essential health benefit. Therefore, we seek comment on whether the substance use disorder requirement in essential health benefits needs additional clarification with regard to medication-assisted treatment for opioid addiction.

b. Premium Adjustment Percentage (§156.130)

Section 1302(c)(4) of the Affordable Care Act directs the Secretary to determine an annual premium adjustment percentage, which is used to set the rate of increase for three parameters detailed in the Affordable Care Act: the maximum annual limitation on cost sharing (defined at §156.130(a)), the required contribution percentage by individuals for minimum essential coverage the Secretary may use to determine eligibility for hardship exemptions under section 5000A of the Code, and the assessable payment amounts under section 4980H(a) and (b) of the Code. Section 156.130(e) provides that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013, and that this percentage will be published annually in the HHS notice of benefit and payment parameters.

Under the methodology established in the 2015 Payment Notice and amended in the 2015 Market Standards Rule for estimating average per capita premium for purposes of calculating the premium adjustment percentage, the premium adjustment percentage is calculated based on the projections of average per enrollee employer-sponsored insurance premiums from the NHEA, which is calculated by the Office of the Actuary. Accordingly, using the employer-sponsored insurance data, the premium adjustment percentage for 2017 is the percentage (if any) by which the most recent NHEA projection of per enrollee employer-sponsored insurance premiums for 2016 (\$6,076) exceeds the most recent NHEA projection of per enrollee employer-sponsored insurance premiums for 2013 (\$5,365).³⁴ Using this formula, the proposed premium adjustment

³⁴ See <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf>, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf>.

percentage for 2017 is 13.25256291 percent. We note that the 2013 premium used for this calculation has been updated to reflect the latest NHEA data. Based on the proposed 2017 premium adjustment percentage, we propose the following cost-sharing parameters for calendar year 2017.

Maximum Annual Limitation on Cost Sharing for Calendar Year 2017. Under §156.130(a)(2), for the 2017 calendar year, cost sharing for self-only coverage may not exceed the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage for 2017, and for other than self-only coverage, the limit is twice the dollar limit for self-only coverage. Under §156.130(d), these amounts must be rounded down to the next lowest multiple of 50. Using the premium adjustment percentage of 13.25256291 percent for 2017 we established above, and the 2014 maximum annual limitation on cost sharing of \$6,350 for self-only coverage, which was published by the IRS on May 2, 2013,³⁵ we propose that the 2017 maximum annual limitation on cost sharing would be \$7,150 for self-only coverage and \$14,300 for other than self-only coverage.

c. Reduced Maximum Annual Limitation on Cost Sharing (§156.130)

Sections 1402(a) through (c) of the Affordable Care Act direct issuers to reduce cost sharing for EHBs for eligible individuals enrolled in a silver level QHP. In the 2014 Payment Notice, we established standards related to the provision of these cost-sharing reductions. Specifically, in 45 CFR part 156, subpart E, we specified that QHP issuers must provide cost-

Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology2012.pdf and Table 17 (located in the NHE Projections 2014-2024 – Tables link) found here <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html> in <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2012.pdf> for additional information.

³⁵ See <http://www.irs.gov/pub/irs-drop/rp-13-25.pdf>.

sharing reductions by developing plan variations, which are separate cost-sharing structures for each eligibility category that change how the cost sharing required under the QHP is to be shared between the enrollee and the Federal government. At §156.420(a), we detailed the structure of these plan variations and specified that QHP issuers must ensure that each silver plan variation has an annual limitation on cost sharing no greater than the applicable reduced maximum annual limitation on cost sharing specified in the annual HHS notice of benefit and payment parameters. Although the amount of the reduction in the maximum annual limitation on cost sharing is specified in section 1402(c)(1)(A) of the Affordable Care Act, section 1402(c)(1)(B)(ii) of the Affordable Care Act states that the Secretary may adjust the cost-sharing limits to ensure that the resulting limits do not cause the AVs of the health plans to exceed the levels specified in section 1402(c)(1)(B)(i) of the Affordable Care Act (that is, 73 percent, 87 percent, or 94 percent, depending on the income of the enrollee). Accordingly, we propose to use a method we established in the 2014 Payment Notice for determining the appropriate reductions in the maximum annual limitation on cost sharing for cost-sharing plan variations. As we proposed above, the 2017 maximum annual limitation on cost sharing would be \$7,150 for self-only coverage and \$14,300 for other than self-only group coverage. We analyzed the effect on AV of the reductions in the maximum annual limitation on cost sharing described in the statute to determine whether to adjust the reductions so that the AV of a silver plan variation will not exceed the AV specified in the statute. Below, we describe our analysis for the 2017 benefit year and our proposed results.

Consistent with our analysis in the 2014, 2015, and 2016 Payment Notices, we developed three test silver level QHPs, and analyzed the impact on AV of the reductions described in the Affordable Care Act to the estimated 2017 maximum annual limitation on cost sharing for self-

only coverage (\$7,150). The test plan designs are based on data collected for 2016 plan year QHP certification to ensure that they represent a range of plan designs that we expect issuers to offer at the silver level of coverage through the Exchanges. For 2017, the test silver level QHPs included a PPO with typical cost-sharing structure (\$7,150 annual limitation on cost sharing, \$2,175 deductible, and 20 percent in-network coinsurance rate), a PPO with a lower annual limitation on cost sharing (\$4,800 annual limitation on cost sharing, \$2,775 deductible, and 20 percent in-network coinsurance rate), and an HMO (\$7,150 annual limitation on cost sharing, \$3,000 deductible, 20 percent in-network coinsurance rate, and the following services with copayments that are not subject to the deductible or coinsurance: \$500 inpatient stay per day, \$350 emergency department visit, \$25 primary care office visit, and \$50 specialist office visit). All three test QHPs meet the AV requirements for silver level health plans.

We then entered these test plans into the proposed 2017 AV Calculator developed by HHS and observed how the reductions in the maximum annual limitation on cost sharing specified in the Affordable Care Act affected the AVs of the plans. We found that the reduction in the maximum annual limitation on cost sharing specified in the Affordable Care Act for enrollees with a household income between 100 and 150 percent of the Federal poverty line (FPL) (2/3 reduction in the maximum annual limitation on cost sharing), and 150 and 200 percent of the FPL (2/3 reduction), would not cause the AV of any of the model QHPs to exceed the statutorily specified AV level (94 and 87 percent, respectively). In contrast, the reduction in the maximum annual limitation on cost sharing specified in the Affordable Care Act for enrollees with a household income between 200 and 250 percent of FPL (1/2 reduction), would cause the AVs of two of the test QHPs to exceed the specified AV level of 73 percent. As a result, we propose that the maximum annual limitation on cost sharing for enrollees in the 2017 benefit

year with a household income between 200 and 250 percent of FPL be reduced by approximately 1/5, rather than 1/2. We further propose that the maximum annual limitation on cost sharing for enrollees with a household income between 100 and 200 percent of the FPL be reduced by approximately 2/3, as specified in the statute, and as shown in Table 10. These proposed reductions in the maximum annual limitation on cost sharing should adequately account for unique plan designs that may not be captured by our three model QHPs. We also note that selecting a reduction for the maximum annual limitation on cost sharing that is less than the reduction specified in the statute would not reduce the benefit afforded to enrollees in aggregate because QHP issuers are required to further reduce their annual limitation on cost sharing, or reduce other types of cost sharing, if the required reduction does not cause the AV of the QHP to meet the specified level. We welcome comment on this analysis and the proposed reductions in the maximum annual limitation on cost sharing for 2017.

We note that for 2017, as described in §156.135(d), States are permitted to submit for approval by HHS State-specific data sets for use as the standard population to calculate AV. No State submitted a data set by the September 1 deadline.

TABLE 10: Reductions in Maximum Annual Limitation on Cost Sharing for 2017

Eligibility Category	Reduced Maximum Annual Limitation on Cost Sharing for Self-only Coverage for 2017	Reduced Maximum Annual Limitation on Cost Sharing for Other than Self-only Coverage for 2017
Individuals eligible for cost-sharing reductions under §155.305(g)(2)(i) (that is, 100-150 percent of FPL)	\$2,350	\$4,700
Individuals eligible for cost-sharing reductions under §155.305(g)(2)(ii) (that is, 150-200 percent of FPL)	\$2,350	\$4,700

Eligibility Category	Reduced Maximum Annual Limitation on Cost Sharing for Self-only Coverage for 2017	Reduced Maximum Annual Limitation on Cost Sharing for Other than Self-only Coverage for 2017
Individuals eligible for cost-sharing reductions under §155.305(g)(2)(iii) (that is, 200-250 percent of FPL)	\$5,700	\$11,400

d. AV Calculation for Determining Level of Coverage (§156.135)

Section 2707(a) of the PHS Act and section 1302 of the Affordable Care Act direct issuers of non-grandfathered health insurance in the individual and small group markets, including QHPs, to ensure that plans meet a level of coverage specified in section 1302(d)(1) of the Affordable Care Act and codified at §156.140(b). On February 25, 2013, HHS published the EHB Rule (78 FR 12833) implementing section 1302(d) of the Affordable Care Act that required that, to determine the level of coverage for a given metal tier level, the calculation of AV be based upon the provision of EHB to a standard population. Section 156.135(a) establishes that AV is generally to be calculated using the AV Calculator developed and made available by HHS for a given benefit year. In the 2015 Payment Notice (79 FR 13743), we established at §156.135(g) provisions for updating the AV Calculator in future plan years and provided an overview of how we would consider each of these updates and our approach towards making these updates.

As discussed in the 2015 Payment Notice, we recognize the importance of balancing the interests of ensuring that the AV Calculator accurately reflects the current market and that changes to the AV Calculator minimize disruption to current plan designs through keeping AVs stable. In considering updates to the AV Calculator under the factors established under §156.135(g), we found the need for greater flexibility than provided for under current regulations to better ensure updates to the AV Calculator achieve these objectives.

For example, in the preamble of the 2015 Payment Notice, we established our methodology for developing the trend factor. We stated that “when updating the trending factor in the AV Calculator, we will use two sources of data, one to reflect the individual market and one to reflect the small group market, to develop a single trend factor that could be applied to the AV Calculator.”³⁶ However, in considering options for updating the trend factor annually under this policy, we found that this policy unduly limits our options. For instance, costs for specific services, such as specialty drugs, are currently increasing at a significantly different rate than other medical services. Trending costs based on each service type could capture those different rates of cost growth more accurately and better ensure that the trend adjustments in the AV Calculator reflect the actual market.

We propose to revise §156.135(g) to allow for additional flexibility in our approach and options for updating of the AV Calculator in the future. We propose that HHS will update the AV Calculator annually for material changes that may include costs, plan designs, the standard population, developments in the function and operation of the AV Calculator and other actuarially relevant factors. Specifically, we would not be required to make each of these changes each year, but we could include these types of material changes in our annual updating of the AV Calculator. Under this proposed policy, we will continue to make updates to the AV Calculator, as we have in previous years, including updates to the trend factor, algorithms changes and user interface changes. We will also update the claim data and demographic distribution being used in the AV Calculator as needed and continue to update the AV Calculator’s annual limitation on cost sharing based on a projected estimate to allow for

³⁶ 79 FR 13811. Col 1. [March 11, 2014]

compliance with §156.130(a). The major difference under the proposed §156.135(g) will be that the methodology, data sources, and trigger for making updates in the AV Calculator would be more flexible than the current §156.135(g). For instance, we propose that specific timelines and materiality thresholds for updating the continuance tables to reflect more current enrollment and claims data will no longer be specified by the regulation. This will allow us more options in considering approaches to making changes in the AV Calculator, particularly as the health insurance market and the AV Calculator evolve, new methodological approaches are developed, and new data becomes available. In developing the annual updates to the AV Calculator, we will continue to take into consideration stakeholder feedback on needed changes to the AV Calculator (through actuarialvalue@cms.hhs.gov) and to publicly release a draft version of the AV Calculator and the AV Calculator Methodology for comment before releasing the final AV Calculator. We also understand the importance for issuers and States to have time to use the final version of the AV Calculator to develop and adjust plan designs and we hope that by providing the additional flexibility under proposed §156.135(g), we will have more options that could allow us to release the AV Calculator sooner. We solicit comments on the proposed §156.135(g).

e. Application to Stand-alone Dental Plans inside the Exchange (§156.150)

In §156.150, we propose revisions to increase the annual limitation on cost sharing for SADPs. In the 2015 Payment Notice, we established that the annual limitation on cost sharing for an SADP covering the pediatric dental EHB under §155.1065 in any Exchange may not exceed \$350 for one covered child and \$700 for two or more covered children.

To make adjustments to the annual limitation on cost sharing in subsequent years to keep pace with inflation, we propose in paragraph (a)(1) that for a plan year beginning after 2016, the

dollar limit applicable to a SADP for one covered child be increased by an amount equal to the product of that amount and the quotient of consumer price index for dental services for the year 2 years prior to the benefit year, divided by the consumer price index for dental services for 2016. In paragraph (a)(2), we propose that the dollar limit for two or more covered children be twice the dollar limit for one child described in paragraph (a)(1) of this section.

We considered using the premium adjustment percentage defined in §156.130(e), but ultimately decided that the dental CPI would be a more appropriate adjuster for the annual limitation on cost sharing as it is based on dental services. The annual limitation on cost sharing should increase over time to keep pace with inflation and moderate potential increases in premium. This is similar to the approach for medical QHPs. We seek comment on whether the premium adjustment percentage defined in §156.130(e) should be used instead. We would propose and finalize the annual increase to the dental annual limitation on cost sharing in the annual Payment Notice.

In paragraph (c), we propose to define the dental CPI, which is a sub-component of the U.S. Department of Labor's Bureau of Labor Statistics Consumer Price Index specific to dental services. We would use the annual dental CPI published by the Department of Labor.

In paragraph (d), we propose that increases in the annual dollar limits for one child that do not result in a multiple of \$25 will be rounded down, to the next lowest multiple of \$25. We believe this provision will result in stability in SADPs, making changes in annual limits that are based on round figures in moderate increments.

We seek comment on these proposals.

5. Qualified Health Plan Minimum Certification Standards
 - a. Network Adequacy Standards (§156.230)

At §156.230, we established the minimum criteria for network adequacy that health and dental plan issuers must meet to be certified as QHPs, including SADPs, in accordance with the Secretary's authority in section 1311(c)(1)(B) of the Affordable Care Act. Section 156.230(a)(2) requires all issuers to maintain a network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay. Section 156.230(b) sets forth standards for access to provider directories requiring issuers to publish an up-to-date, accurate, and complete provider directory for plan years beginning on or after January 1, 2016 and §156.230(c) requires QHPs in the FFE to make this provider directory data available on its website in an HHS specified format and also submit this information to HHS in a format and manner and at times determined by HHS.

i. State Selection of Minimum Network Adequacy Standards.

The National Association of Insurance Commissioners' (NAIC's) Network Adequacy Model Review Subgroup has been doing significant work in the area of network adequacy, which includes work towards development of a Network Adequacy Model Act that States could adopt in whole or in part. We will continue to monitor the NAIC work and look forward to partnering with States and the NAIC in developing and promulgating network adequacy protections. In the interest of furthering this work, we are proposing standards related to network adequacy below, but will take into consideration the NAIC's final recommendation as we assess these policies.

In recognition of the traditional roles States have in developing and enforcing network adequacy standards, we propose that FFEs would rely on State reviews for network adequacy in States in which an FFE is operating, provided that HHS determines that the State uses an

acceptable quantifiable network adequacy metric commonly used in the health insurance industry to measure network adequacy, approved by HHS.

We anticipate that HHS would determine that a State's network adequacy assessment methodology meets the standard above if the State selects one or more standards from a list of metrics provided by HHS and applies them prospectively to the QHP issuers in the State. HHS intends to detail the specific criteria and process for meeting the standard in each annual Letter to Issuers, but we anticipate including at least the following metrics:

- Prospective time and distance standards at least as stringent as the FFE standard.
- Prospective minimum provider-covered person ratios for the specialties with the highest utilization rate for its State.

HHS would discuss with States their selection in advance of the start of the certification cycle to determine whether the State's network adequacy standard would be acceptable under the standard above. We would thereafter notify issuers via subregulatory guidance whether the State standards or Federal default standards apply.

If HHS determines that a State's network adequacy standard is acceptable under the standard above, the State would certify to the FFE which plans meet the network adequacy standard, and the FFE in that State would rely on the State's review for purposes of determining whether a QHP meets the requirements under §156.230(a)(2), although those issuers would still be required to submit to HHS provider data, attest to the HHS network adequacy certification requirements, and meet other applicable HHS standards, including the other standards under §156.230.

We welcome comments on this proposal, including suggestions for additional State network adequacy methodologies that the FFEs could rely on, and other factors we might consider.

In States that do not review for network adequacy, or do not select a standard as described above, the FFE would conduct an independent review under a Federal default standard. We propose the Federal default standard at §156.230(d) to be a time and distance standard. For the certification cycle for plan years beginning in 2017, we anticipate evaluating the QHP issuer networks under this standard based on the numbers and types of providers, in addition to their general geographic location. In particular, we propose to calculate a time and distance standard at the county level. We are considering using standards similar to those used in Medicare Advantage, utilizing the National Provider Identifier database, and focusing on the specialties that enrollees most generally use. HHS is also carefully considering other network standards, including those of individual States, accrediting entities, and Federal health care programs, as it develops the time and distance standards for the FFEs. We solicit comments on whether these proposed standards are appropriate. We also seek comment specifically on whether they are appropriate for SADPs, and, if not, what standards for SADPs would be more appropriate, and the basis for any deviation.

The county-specific time and distance parameters that plans will be required to meet, including specifications for specific provider and facility types, would be detailed annually in conjunction with the Letter to Issuers.

We also propose that issuers that are unable to meet the specified standards would be able to submit a justification to account for any variances, and that the FFE would review the

justification to determine whether the variance is reasonable based on circumstances, such as the availability of providers and variables reflected in local patterns of care.

It is not our intent in establishing these default standards to prohibit certification of plans with narrow networks or otherwise impede innovation in plan design. Instead, we intend to establish a minimum floor consistent with the levels generally maintained in the market today, so that generally a very small number of plans would be identified as having networks deemed inadequate. The Federal default standard would provide issuers with more transparency regarding our certification processes and will be designed and implemented to achieve results similar to those yielded by the reviews conducted by the FFEs in prior certification cycles. We believe this will promote predictability for issuers in the course of certification. We note that multi-State plan options will be considered to meet the network adequacy requirements under §156.230(a)(2) if they meet network adequacy standards established by OPM.

We seek comments on this proposal, including how we might develop time and distance standards appropriate for the FFEs, the use of Medicare Advantage or other standards and other factors we should examine in measuring network adequacy, and suggestions of other models we might consider.

ii. Additional Network Adequacy Standards.

We also propose other additional network-related standards under §156.230(e) and (f).

In the new §156.230(e)(1), we propose to require QHP issuers in all FFEs to notify enrollees about a discontinuation in their network coverage of a contracted provider. We believe that it is important for enrollees to be notified of changes to the network on a timely basis. Consumers need accurate information about which providers are in-network to ensure that they can optimize their health insurance coverage and make cost effective choices. Therefore, we

propose that a QHP in an FFE be required to make a good faith effort to provide written notice of a discontinued provider, 30 days prior to the effective date of the change or otherwise as soon as practicable, to all enrollees who are patients seen on a regular basis by the provider or receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal. We propose that a discontinued provider includes cases of where the provider is being removed and where the provider is leaving the network. We solicit comments on this proposed provision, including the timeframe for notification and whether separate timeframe requirements are needed for primary care providers versus other types of providers that a patient sees on a regular basis. We also solicit comments on an appropriate definition of “regular basis,” or whether the implementation of that phrase should be left to the good faith interpretation of the issuer. For instance, we considered whether we should define regular basis if the enrollee has seen the provider within the last 3 months, 6 months or 12 months. To satisfy this requirement, we expect the issuer to try to work with the provider to obtain the list of affected patients or to use their claims data system to identify enrollees who see the affected providers. As part of the notice, we encourage issuers to notify the enrollee of other comparable in-network providers in the enrollee’s service area, provide information on how an enrollee could access the plan’s continuity of care coverage, and encourage the enrollee to contact the plan with any questions.

In developing the proposed notification standard under §156.230(e)(1), we considered Medicaid Managed Care and Medicare Advantage’s notification requirements and considered the work by the NAIC’s Network Adequacy Model Review Subgroup. For instance, Medicare Advantage’s notification requirements are similar to the proposed §156.230(e)(1), and require that the Medicare Advantage organization make a good faith effort to provide written notice of a

termination of a contracted provider at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Medicare Advantage also requires that when a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional must be notified.³⁷ Medicaid Managed Care, on the other hand, requires the Managed Care Organization, the Prepaid Inpatient Health Plan, and, when appropriate, the Prepaid Ambulatory Health Plan or Primary Care Case Manager, to make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by the terminated provider.³⁸ We seek comments on other standards for notifying enrollees about their network coverage in cases of discontinuation, including States' standards and whether exceptions should be allowed for States' that already require notification to enrollees when a provider leaves the network.

We are also proposing in §156.230(e)(2) a provision for QHP issuers in all FFEs to ensure continuity of care for enrollees in cases where a provider is terminated without cause. Specifically, we propose to require the issuer, in cases where the provider is terminated without cause, to allow an enrollee in active treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates. Additionally, in proposed paragraph (e)(2), we propose a definition of active treatment as meaning: (1) an

³⁷ 42 CFR 422.111(e).

³⁸ 42 CFR 438.10(f)(5).

ongoing course of treatment for a life-threatening condition; (2) an ongoing course of treatment for a serious acute condition; (3) the second or third trimester of pregnancy; or (4) an ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes. Under the proposed definition of active treatment, an ongoing course of treatment would include treatments for mental health and substance use disorders that fall within the proposed definition. For the purposes of the active treatment definition, we propose to interpret a life-threatening condition as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; and a serious acute condition as a disease or condition requiring complex on-going care which the covered person is currently receiving, such as chemotherapy, post-operative visits, or radiation therapy. Finally, under paragraph (e)(2)(ii), we propose that any decisions made for a request for continuity of care be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable State or Federal law or regulations. We solicit comments on this proposed section of the regulation, including the definitions of "active treatment," "life-threatening condition," and "serious acute condition" and whether exceptions should be allowed for States' standards that already require coverage of continuity of care for enrollees. We also solicit comments about whether enrollees in their second or third trimester of pregnancy should be allowed to extend obstetric care through the postpartum period, which could require the continuity of care standard to extend beyond 90 days. If these enrollees were allowed to extend obstetric care through the postpartum period, we solicit comment on the definition of the postpartum period, such as for 6 weeks after birth, and whether the allowance of care through the postpartum period should apply for broader types of care than

for obstetric care. We also solicit comments on proposed §156.230(e)(1) and (2) on the distinction between a termination with or without cause versus when a provider leaves the network because the provider's contract is non-renewed. Specifically, we solicit comments on whether §156.230(e)(2) should incorporate cases where the provider's contract is non-renewed or whether we should consider a non-renewal of the provider's contract as a termination without cause under §156.230(e)(1) and (2). Lastly, we seek comments about what other possible provisions may be needed to protect an enrollee when a provider contract is terminated and can be implemented with limited burden on issuers.

In general, our network adequacy rules for QHPs require that a network plan maintain a network sufficient to assure that all services will be accessible without unreasonable delay. However, there may be occasions when an enrollee obtains an EHB outside the QHP's network because the enrollee unknowingly receives out-of-network care. An enrollee may have made reasonable efforts to stay within the QHP's network when obtaining an EHB service, but then unknowingly received care from an out-of-network provider in an in-network setting (for example, an anesthesiologist or pathologist). To address these circumstances, we propose to add a new §156.230(f).

In that paragraph, we propose to require, notwithstanding §156.130(c) of the subpart, for a network to be deemed adequate, each QHP that uses a provider network must count cost sharing paid by an enrollee for an EHB provided by an out-of-network provider in an in-network setting under certain circumstances towards the enrollee's annual limitation on cost sharing. That is, if an enrollee received an EHB in an in-network setting, such as an in-network hospital, but as part of the provision of the EHB the enrollee was charged out-of-network cost-sharing for an EHB provided by an out-of-network provider (such as anesthesiology or pathology services,

for example), that cost-sharing would apply towards the annual limitation on cost-sharing. The enrollee could still be responsible for out-of-network cost sharing, and balance billing, for other benefits received from an out-of-network provider at any time, but not for cost sharing for a covered EHB provided in-network or out-of-network in a circumstance described in this paragraph after the annual limitation is met.

Alternatively, the plan could provide a written notice to the enrollee at least 10 business days before the provision of the benefit that additional costs may be incurred for EHB provided by an out-of-network provider in an in-network setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing. Such notice could be provided during preauthorization. If the plan provides such notice, this rule would not require the plan to apply the out-of-network cost sharing towards the enrollee's annual limit on cost sharing or to be responsible for covering out-of-network cost sharing above the annual limit. This alternative would not be available if fewer than 10 business days' notice is provided, including in cases where that amount of time is not available (for example, in urgent but non-emergency care situations).

We believe that this proposal balances financial protection for consumers against surprise out-of-network cost sharing, while maintaining the larger part of the QHP's cost-sharing structure. The 10 business days' advance notice provision is intended to allow the enrollee to arrange for an in-network provider to provide the EHB; we solicit comments on whether this time frame should be shorter or longer. We would expect the issuer would provide this notification to the enrollee at the time it notifies the provider with any pre-authorization documents. The issuer would also be permitted to send a "form" document—that is, one that is

not customized to the particular situation at issue—but it could not rely on a blanket notification through its website or provided at enrollment, for example. We seek comment on this proposal and if we should instead require the issuer to provide customized information to the consumer including information on potential in-network providers.

We acknowledge that some States and issuers may offer consumers in these scenarios protections which go beyond what we are proposing here for QHPs. Several States have enacted laws that similarly provide consumers financial protection from the high out-of-pocket expenditures associated with receiving out-of-network care. States, relying on their authority to regulate both providers and issuers, generally impose requirements on both, whereas our proposal focuses on QHP issuers. States have generally included in their laws mechanisms to address the level of reimbursement an issuer must pay an out-of-network provider. For example, States have required payment of all charges, set the rate at a percentage of a fee schedule, and set forth a process through which providers and issuers must resolve disputes about charges. Some States have also prohibited balance billing consumers for certain out-of-network services, ranging from only emergency services to any covered service. This proposal is not intended to preempt any State laws that would be more consumer protective. We note that this proposal would apply to QHPs in all Exchanges. We seek comment on these proposals.

We are also soliciting comments regarding other network adequacy standards that may be appropriate to apply to QHPs in an FFE in future years, including standards included in the work being done by the NAIC's Network Adequacy Model Review Subgroup. One policy we are considering is whether a QHP in an FFE should have a network resilience policy for disaster preparedness. Network resilience refers to the provider network's capacity to withstand and recover from natural or man-made disasters that may threaten enrollees' continuous access to

quality care. Disasters may negatively impact an issuer's network and can result in delay in services. Therefore, issuers who have a network resilience policy will be better prepared to ensure that their network can provide reasonable access under adverse circumstances. Some examples of appropriate network resilience policies might include business continuity planning, consideration of temporary policy changes in the event of a disaster, and/or disclosure or communication plans. We solicit comments on this possible future policy and the examples provided, including thoughts on what type of policy would be reasonable and operationally feasible.

In addition, certain States measure network adequacy based on enrollee wait times for scheduled appointments. As a result, we are interested in comments on the variation in wait times depending on the type of provider, such as for primary care or non-primary care services. Additionally, we also solicit comments as to whether we should add a wait time standard as an option under the proposed permissible State standards mentioned in this preamble, or if we should apply a broad wait time standard across QHPs in the FFEs.

We are also soliciting comments on whether an issuer should be required to survey all of its contracted providers on a regular basis to determine if a sufficient number of network providers are accepting new patients. Additionally, we solicit comments on transparency of issuers' standards for selecting and tiering of participating providers for QHPs in an FFE and whether issuers should be required to make available their selecting and tiering criteria for review and approval by HHS and the State upon request. We are proposing §156.230(e) as a requirement for QHPs in the FFEs and §156.230(f) as a requirement for QHPs in all Exchanges. However, we solicit comments on whether these provisions should apply to all QHPs or only QHPs in the FFEs. We also solicit comments on applying §156.230(e) and (f) to SADPs and

whether other standards should be provided for these provisions for stand-alone dental plans.

We note that §156.230(f) applies to cost sharing incurred in connection with EHB, and, of dental benefits, only pediatric dental is EHB.

In addition to the policies above, we are also considering providing on HealthCare.gov a rating of each QHP's relative network coverage. This rating or classification could be made available to a consumer when making a plan selection. We believe that such a rating would help an enrollee select the plan that best meets his or her needs, and we anticipate that this analysis would compare the breadth of the QHP network at the plan level as compared to the breadth of the other plan networks for plans available in the same geographic area.

We anticipate analyzing the QHP network by calculating the number of specific providers that are accessible within specified time and distance standards. We would then classify the QHP networks into three categories. We are considering performing the calculation based on the provider information submitted by all QHP issuers in the existing network adequacy FFE QHP certification template, but comments on potential additional data collections are welcome.

This network breadth rating would allow an enrollee to better understand plans' design, and, like other consumer tools, could help improve plan satisfaction. We anticipate providing additional details about how we would classify networks in the Letter to Issuers and in the QHP certification instructions, and solicit comments on what types of methods should be used to identify each network's breadth, what specific specialties should be included in the analysis, what sorts of adjustments should be made to address provider shortages, and other possible data sources to obtain information about available providers in the area. We welcome comments on

the best way to make this information available to consumers, and any other comments related to this topic.

b. Essential Community Providers (§156.235)

On June 5, 2015, we proposed through a Paperwork Reduction Act notice a provider petition process to update the ECP list against which issuer compliance with the ECP standard is measured. We expect that this data collection for the 2017 benefit year should be completed by the end of 2015, although HHS will provide additional opportunities for ECPs to submit provider data to HHS for benefit years beyond 2017. If the degree of provider participation in this data collection effort through the ECP petition allows HHS to assemble a more complete listing of ECPs, we believe the proposals described below would strengthen the ECP standard.

We propose that, for the 2017 QHP certification cycle, HHS will continue to credit a health plan seeking certification to be offered through an FFE with multiple providers at a single location counting as a single ECP toward both the available ECPs in the plan's service area and the issuer's satisfaction of the ECP participation standard. For QHP certification cycles beginning with the 2018 benefit year, we solicit public comment on crediting issuers for multiple contracted full-time equivalent (FTE) practitioners at a single location, up to the number of available FTE practitioners reported to HHS by the ECP facility through the provider petition process and published on the HHS ECP list. HHS would apply this credit in the numerator of an issuer's percentage satisfaction of the general ECP standard described in paragraphs (a)(1) and (2) of this section. The denominator of an issuer's percentage satisfaction of the ECP standard would reflect the number of available FTE practitioners reported to HHS by each ECP facility that appears on the HHS ECP list located in the issuer's plan service area. Once we have collected this FTE practitioner data through the provider petition process, we believe that

crediting an issuer for multiple contracted FTE practitioners at a single location would more accurately reflect the issuer's ECP participation in its network. Therefore, we propose for QHP certification cycles beginning with the 2018 benefit year to revise §156.235(a)(2)(i) to credit an issuer for multiple contracted FTE practitioners at a single location, up to the number of available FTE practitioners reported to HHS by the ECP facility and reflected on the HHS ECP list, toward the issuer's satisfaction of the ECP participation standard.

In the final 2016 Payment Notice, we stated that we would consider disaggregating certain ECP categories to ensure better access to a wider variety of health care services. However, our analysis of the available ECPs in each of the additional categories considered for disaggregation (that is, children's hospitals, rural health clinics, free-standing cancer centers, community mental health centers, and hemophilia treatment centers) does not support further ECP category disaggregation at this time. We believe there are too few ECPs within each of these additional categories appearing on our HHS ECP list to afford issuers sufficient flexibility in their contracting. We may revisit this consideration in the future and encourage QHP issuers to include in their networks these additional providers to best meet the needs of the populations they serve.

For the same reasons described for our proposal to revise §156.235(a)(2)(i), we propose in §156.235(b)(2)(i) that issuers that qualify for the alternate ECP standard described in §156.235(a)(5) that seek certification to be offered through an FFE (or SBE-FP) be credited for multiple contracted FTE practitioners at a single location toward the issuer's satisfaction of the alternate ECP standard described in paragraphs (b)(1) and (2) of this section, beginning with the 2018 benefit year. We propose that for the 2017 benefit year, HHS will continue to credit an issuer that qualifies for the alternate ECP standard and is seeking certification to be offered

through an FFE with multiple providers at a single location counting as a single ECP toward both the available ECPs in the plan's service area and the issuer's satisfaction of the ECP participation standard. We seek comment on these proposals.

c. Enrollment Process for Qualified Individuals (§156.265)

Under §156.265(b)(2), if an applicant initiates enrollment directly with the QHP issuer for enrollment through the Exchange (direct enrollment through an issuer), the QHP issuer must redirect an applicant to go directly to the Exchange website to complete the application and receive an eligibility determination. HHS is considering options under which an applicant could remain on the QHP issuer's website to complete the application and enroll in coverage, and the QHP issuer's website can obtain eligibility information from the Exchange in order to support the consumer in selecting and enrolling in a QHP with Exchange financial assistance. The intent is to have this information exchange occur through an Exchange-approved web service, as described in §155.220, enhancing the current direct enrollment process. This option would provide Exchanges offering direct enrollment and QHP issuers more operational flexibility to expand front-end, consumer-facing channels for enrollment through a more seamless consumer experience.

For a discussion of the options we are considering in the direct enrollment scenario, see the discussion regarding direct enrollment by web-brokers in our discussion of changes to §155.220. We seek comment on these options, and whether standards should differ for a web-broker compared to a QHP issuer, and how to maintain privacy and security.

Accordingly, we propose to revise §156.265(b)(2)(ii) to ensure that an applicant who initiates enrollment directly with the QHP issuer for enrollment through the Exchange receives an eligibility determination for coverage through the Exchange through the Exchange website or

through an Exchange-approved web service via the FFE single streamline application. This maintains the role of the Exchange in determining eligibility. We seek comment on this proposal.

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

We propose to amend §156.270(d) to specify that a QHP issuer must provide a 3-month grace period to an enrollee who, upon failing to timely pay his or her premiums, is receiving advance payments of the premium tax credit. Because we believe that changing the length of an enrollee's grace period during the middle of such a grace period would be confusing to enrollees and could result in otherwise avoidable terminations for failure to pay premium, enrollees receiving APTC who enter a grace period for failing to timely pay premiums and who lose their eligibility for APTC during the grace period would be able to complete the remaining portion of the grace period as though the loss of eligibility for APTC did not occur. The proposed amendment to §156.270(d) also eliminates language limiting the 3-month grace period for enrollees who are receiving APTC to only those enrollees who made a payment during the benefit year. This would permit enrollees renewing coverage that does not require a binder payment who fail to pay January premiums in full (or fail to pay within an issuer's premium payment threshold policy, if applicable) to receive the full grace period of 3 months. This change would align more closely with our interpretation of the interaction between grace periods, guaranteed availability and renewability, and the binder payment requirement, that a binder payment is not necessary when an enrollee enrolls, either actively or passively, in a plan within the same insurance product, and would prevent enrollees who re-enroll in the same plan or product from unfairly losing their right to a grace period because they do not make a payment for January coverage. Finally, we propose to codify with regard to the grace period standards our policy described in the preamble for §155.400 of this part that if an enrollee receiving advance

payments of the premium tax credit can satisfy the requirement to pay all outstanding premiums, or if the enrollee satisfies an issuer's premium payment threshold implemented under §155.400(g), if applicable, the QHP issuer must not terminate for non-payment of premium the enrollee's enrollment through the Exchange. This change to the rule would reflect the extension of the premium threshold policy to enrollees who are in a grace period for non-payment of premium.

e. Additional Standards Specific to SHOP (§156.285)

Sections 155.720(g) and 156.285(c)(5) currently provide that SHOPs and QHP issuers must reconcile enrollment information on no less than a monthly basis. We propose to amend §156.285(c)(5) to specify additional details about how a QHP issuer offering a QHP through a FF- SHOP should reconcile enrollment files with the FF- SHOP. Specifically, the proposed amendments would provide that the issuer must send enrollment reconciliation files on at least a monthly basis according to a process and timeline established by the FF-SHOP, and in a file format specified by the FF-SHOP.

We are also proposing to delete §156.285(d)(2) consistent with our interpretation of guaranteed availability and renewability. If a qualified employer withdraws from a SHOP, the SHOP, not the issuer, should terminate the group's enrollment through the SHOP, and coverage might in many circumstances continue outside the SHOP.

f. Meaningful Difference Standard for Qualified Health Plans in the Federally-facilitated Exchanges (§156.298)

At §156.298, we propose modifications to the meaningful difference standard for QHPs in the FFEs. We propose to remove the criterion in paragraph (b)(5) that otherwise identical plans would be considered meaningfully different on the basis of one QHP being health savings

account eligible. A QHP's health savings account eligibility is a cost-sharing status that may be assessed by examining the QHP's cost sharing, which is included at paragraph (b)(1). This criterion is therefore redundant.

We also propose to delete "self-only" and "non-self-only" from paragraph (b)(6). Self-only (that is, individual) plans do not allow any dependent relationships, while non-self-only (that is, enrollee group) plans allow at least one dependent relationship type. An individual can enroll in individual and enrollee group plans. The allowance of dependents is the only difference between two plans if they are identified as individual or enrollee group only. We have determined that these statuses alone are not indicative of meaningful differences among QHPs. We will maintain the "child-only" versus non-child-only status. We further propose to redesignate paragraph (b)(6) as paragraph (b)(5) and add the word "or" to paragraph (b)(4). We seek comment on the proposed changes.

g. Other Considerations

We remind issuers that certain other Federal civil rights laws impose non-discrimination requirements. Issuers that receive Federal financial assistance, including in connection with offering a QHP on an Exchange, are subject to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, section 504 of the Rehabilitation Act of 1973, and section 1557 of the Affordable Care Act. The Office for Civil Rights (OCR), which enforces these statutes, published a notice of proposed rulemaking on September 9, 2015 (80 FR 54172) on the requirements of section 1557. Issuers that intend to seek certification of one or more QHPs are directed to that proposed rule and to <http://www.hhs.gov/ocr/civilrights> for additional information.

We also seek to foster market-driven programs that can improve the management of costs and care. We note that innovative issuer, provider, and local programs or strategies may be successful in promoting and managing care, potentially resulting in better health outcomes and lower rates while creating important differentiation opportunities for market participants. We seek comment on ways in which we can facilitate such innovation, and in particular on whether there are regulations or policies in place that we should modify in order to foster this innovation.

6. Standards for Qualified Health Plan Issuers on Federally-Facilitated Exchanges and State-Based Exchanges on the Federal Platform.

To make it operationally feasible for a State-based Exchange to rely on the Federal platform for eligibility and enrollment functions, issuers and plans offered on the SBE-FP must comply with rules, as interpreted and implemented in policy and guidance related to the Federal eligibility and enrollment infrastructure. These would be the same requirements related to eligibility and enrollment that are applicable to QHP issuers and plans on FFEs. For example, SBE-FP special enrollment periods must be administered within the guidelines of the FFE special enrollment periods, as it is not possible at this time for the FFE to accommodate State customization in policy or operations, such as State-specific SEPs, application questions, display elements in plan compare, or data analysis. Additionally, if the FFE is to perform eligibility and enrollment functions, the FFE would also need to provide for certain consumer tools (plan compare, premium estimator, second-lowest cost silver plan tool, etc.) to support those functions. Thus, the FFE would need SBE-FP QHP plan data by the dates specified in the annual Letter to Issuers to provide for enough time for adequate testing and loading of the data into the various consumer tools the FFE offers. Issuers must also comply with certain FFE enrollment policies and operations (for example, premium payment and grace period rules, effective date logic,

acceptable transaction codes, and reconciliation rules) for the FFE to successfully process 834 transactions with issuers and minimize any data discrepancies for reconciliation.

Therefore, we propose to add §156.350 to address eligibility and enrollment standards for QHP issuers participating on an SBE-FP. In paragraph (a) of new §156.350, we would require QHP issuers participating in an SBE-FP to comply with HHS regulations, and guidance related to the eligibility and enrollment functions for which the State-based Exchange relies on the Federal platform. For example, those issuers would be required to comply with operational standards in the Federally-facilitated Marketplace and Federally-facilitated Small Business Health Options Program Enrollment Manual. We provide in paragraph (a) a list of provisions with which QHP issuers participating in an SBE-FP would be required to comply. These provisions relate to eligibility and enrollment functions directly, or are critical to enabling HHS to assess compliance with eligibility and enrollment functions. For example, we would require QHP issuers to comply with the requirements regarding compliance reviews of QHP issuers to the extent relating directly to applicable eligibility and enrollment functions. Without this requirement, we would be severely limited in our ability to determine whether an issuer is complying with the requirements related directly to the Federal platform's eligibility and enrollment functions. In paragraph (b), we propose to permit these issuers to directly enroll applicants in a manner that is considered to be through the Exchange, under §156.1230, just as QHP issuers on FFEs are permitted.

In paragraph (c), we propose that if an SBE-FP does not substantially enforce the eligibility and enrollment standards described in paragraph (a), then HHS may enforce against the issuer or plan using the enforcement remedies and processes described in subpart I of part 156. We also propose that the administrative review process in subpart J of part 156 would

apply to enforcement actions taken against QHP issuers or plans under proposed §156.350.

Because timely compliance with paragraph (a) is vital to the smooth functioning of the Federal platform and because the Federal platform would apply a uniform compliance and enforcement regime for reasons of efficiency and speed, we believe it is appropriate that HHS have this authority in this circumstance.

Because this proposal would insert a section applicable to SBE-FPs in subpart D, which currently describes only standards for QHP issuers on the FFEs, we propose to amend the title of subpart D to read Standards for Qualified Health Plan Issuers on Federally-Facilitated Exchange and State-Based Exchanges on the Federal Platform.

We seek comment on this proposal.

7. Enforcement Remedies in Federally-Facilitated Exchanges (§§156.800, 156.805, 156.810, and 156.815)

We propose to revise paragraph §156.805(d). We believe paragraph (d) provides insufficient information on the effect of appealing a CMP. In the interest of aligning our CMP and decertification regulations, we propose to rename paragraph (d) “Request for hearing.” Next, we propose to revise paragraph (d)(1) to state affirmatively the issuer’s right to file a request for hearing on the assessment of a CMP. Finally, we propose to add paragraph (d)(2), stating that the request for hearing will suspend the assessment of CMP until a final administrative decision on the appeal. A similar provision exists in the decertification regulation at §156.810.

We propose to amend §156.810 by revising paragraph (e) to present the appeal rights of QHP issuers and the impact of an appeal more clearly. Specifically, we propose to provide for the issuer’s appeal right in paragraph (e). Then in paragraph (e)(1) and its paragraphs, we

propose to explain how an appeal will affect the effective date of a decertification depending on whether the decertification is standard or expedited.

Previously, we finalized §156.800(c), in which we stated that sanctions will not be imposed on a QHP issuer on an FFE if it has made good faith efforts to comply with applicable requirements for calendar years 2014 and 2015. We are not proposing to extend this policy. Starting in the 2016 calendar year and beyond, sanctions may be imposed if a QHP issuer on an FFE fails to comply with applicable standards, even if the QHP issuer has made good faith efforts to comply with these requirements.

Section 156.810 contains bases for decertification of a QHP. One of the bases for decertification, §156.810(a)(5), authorizes decertification if a QHP issuer is hindering the efficient and effective operation of a Federally-facilitated Exchange. We interpret the efficient and effective operation of the FFEs to include displaying plans that will provide coverage to enrollees who purchase coverage under that plan. Where an issuer has informed HHS that it cannot continue to provide coverage under a QHP, HHS will interpret this information to mean that the efficient and effective operation of the FFE will be hindered because it will incorrectly display plans on the FFE platform. In such a case, HHS may take all necessary steps to suppress and/or decertify the QHP.

We propose to add new bases for decertification to §156.810 to address situations where a QHP issuer is the subject of a pending or existing State enforcement action, including a consent order, or where HHS has reasonably determined that an issuer lacks the funds to continue providing coverage to its consumers for the remainder of the plan year. Under its obligation to determine that making a plan available on the FFEs is in the interest of qualified individuals and

employers, HHS is proposing to adopt these decertification bases as a consumer protection measure.

We welcome comments on these proposals.

8. Quality Standards

a. Patient Safety Standards for QHP Issuers (§156.1110)

In §156.1110, we established the first phase of patient safety standards, beginning on January 1, 2015, for QHP issuers to verify that certain contracted hospitals meet Medicare Hospital Conditions of Participation requirements regarding a quality assessment and performance improvement program and a discharge planning process. We propose to strengthen QHP patient safety standards in accordance with section 1311(h) of the Affordable Care Act for plan years beginning on or after January 1, 2017. In addition to hospital requirements to meet certain quality and patient safety standards delineated in the Medicare Conditions of Participation, HHS has engaged with several initiatives such as the Patient Safety Organization (PSO) program, Hospital Engagement Networks and the Quality Improvement Organizations, to broaden the national impact on reducing patient harm. By leveraging the successful work already being done at national, regional, and local hospital systems for health care quality improvement and harm reduction, we believe that alignment of the QHP issuer standards with effective patient safety interventions will achieve greater impact. Therefore, we propose amending §156.1110 to capture the current patient safety standards that continue to apply for plan years beginning before January 1, 2017 in new paragraph (a)(1). We also propose to add new paragraph (a)(2)(i)(A) to specify that for plan years beginning on or after January 1, 2017, a QHP issuer that contracts with a hospital with greater than 50 beds must verify that the hospital uses a patient safety evaluation system as defined in 42 CFR 3.20. The patient safety evaluation

system is defined in the PHS Act as the collection, management, or analysis of information for reporting to or by a Patient Safety Organization.³⁹ We propose in §156.1110(a)(2)(i)(B) to require that a QHP issuer that contracts with a hospital with greater than 50 beds must ensure that the hospital implemented a comprehensive person-centered discharge program to improve care coordination and health care quality for each patient. We believe that use of a data-driven approach, analytic feedback, and shared learning to advance patient safety, such as working with a PSO, are essential to implementing meaningful interventions to improve patient health care quality.

In accordance with the flexibility provided to the Secretary under section 1311(h)(2) of the Affordable Care Act to establish reasonable exceptions to the QHP issuer patient safety requirements, we propose in §156.1110(a)(2)(ii), that the hospital may implement evidence-based initiatives to reduce all cause preventable harm,⁴⁰ prevent hospital readmission, improve care coordination and improve health care quality through the collection, management and analysis of patient safety events by a means other than reporting of such information to or by a PSO. For example, a QHP issuer may comply with the proposed patient safety standards if the applicable QHP issuer-contracted hospital participates through the Partnership for Patients initiative as part of a Hospital Engagement Network.⁴¹ We believe this would allow for flexibility and promote alignment for hospitals that already engage in effective national, State,

³⁹ See, 42 U.S.C. 299b-21(6); and <http://www.pso.ahrq.gov/regulations/fnlrule01.pdf>.

⁴⁰ All cause preventable harm or all adverse events-any event during the care process that results in harm to a patient, regardless of cause (<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-19.pdf>)

⁴¹ <http://partnershipforpatients.cms.gov/about-the-partnership/aboutthepartnershipforpatients.html>

public and private patient safety programs. Although hospital patient safety programs are diverse, we believe that promoting a common goal of preventing the risk of patient harm in an effective, sustainable way is important. We also believe it is important to recognize the core components of a hospital patient safety program, including development of comprehensive patient safety systems to identify, report and analyze data; tracking of process and outcome measures; encouraging a culture of safety with leadership and health care provider support and expertise; and engaging patients and families in quality improvement and action plans. Over time, as PSO activities continue to expand in scope, maturity and effectiveness to advance efforts to ensure patient safety, we anticipate continuing to reassess the reasonable exceptions to the QHP issuer patient safety requirements outlined in §156.1110(a)(2)(ii). We expect that QHP-issuer contracted hospitals with more than 50 beds will contract with a PSO and implement a comprehensive person-centered discharge program to improve care coordination and health care quality for each patient. HHS will continue to monitor the status of the PSO program and other patient safety initiatives and will develop additional requirements or guidance, if needed, to support effective patient safety strategies and harmonization of evidence-based standards and requirements under §156.1110.

In addition, HHS strongly supports hospital tracking of patient safety events using the Agency for Healthcare Research and Quality Common Formats,⁴² which are a useful tool for a hospital regardless of what patient safety interventions are implemented for ongoing, data-driven quality assessment. The Agency for Healthcare Research and Quality anticipates releasing version 2.0 of the Common Formats for Event Reporting – Hospitals, which would define a

⁴² <https://www.pso.ahrq.gov/common>

systematic process for reporting adverse events, near misses and unsafe conditions, and allow a hospital to report harm from all causes. We believe that use of Common Formats, and aligning with existing HHS recommendations for hospitals,⁴³ is integral whether a hospital chooses to work with a PSO to comply with the proposed requirement in §156.1110(a)(2)(i) or implements the alternative approach under the reasonable exception provision as proposed in §156.1110(a)(2)(ii).

We believe these proposed amendments to QHP issuer patient safety requirements would support these common aspects and goal, and also align with the established requirements in §156.1130 for a QHP quality improvement strategy, specifically the outlined quality improvement strategy topic areas from section 1311(g) of the Affordable Care Act, including implementation of activities to prevent hospital readmissions and implementation of activities to improve patient safety and reduce medical errors.

We propose in §156.1110(b) to amend the documentation requirement to specify that, for plan years beginning on or after January 1, 2017, a QHP issuer to collect information from each of its contracted hospitals with greater than 50 beds to demonstrate that those hospitals meet the patient safety standards required in paragraph (a)(2) of this section. Such information could include a copy of the current agreement to partner with a PSO, a Hospital Engagement Network, or a Quality Improvement Organization. The documentation should reflect implementation of PSO activities, such as PSOs and hospitals working together to collect, report and analyze patient safety events, and implementation of a comprehensive person-centered hospital discharge program to demonstrate compliance with the proposed requirements in §156.1110(a)(2)(i); or

⁴³ <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-19.pdf>.

implementation of other patient safety initiatives to reduce all cause preventable harm, prevent hospital readmission, improve care coordination and improve health care quality through the collection, management and analysis of patient safety events to demonstrate compliance with the reasonable exception provision proposed to be captured in §156.1110(a)(2)(ii). We also propose to remove paragraph (d) from section §156.1110 because it is no longer needed given the clarifying proposed effective date language within paragraphs (a) and (b). We clarify that, at this time, HHS does not intend to amend the number of hospital beds threshold authorized by section 1311(h)(3) of the Affordable Care Act and does not intend to begin implementing the provisions in section 1311(h)(1)(B) regarding non-hospital health care providers.

We seek comment on the proposed amendments to paragraphs (a) and (b), and the proposed deletion of paragraph (d). We seek comment specifically on the proposals to require that a QHP issuer that contracts with a hospital with greater than 50 beds must verify that the hospital uses a patient safety evaluation system and implements a comprehensive person-centered discharge program to improve care coordination and health care quality for each patient. We also seek comment on the reasonable exception provision under which the QHP issuer-contracted hospital with greater than 50 beds may implement evidence-based initiatives other than working with a PSO to reduce all cause preventable harm, prevent hospital readmission, improve care coordination and improve health care quality through the collection, management and analysis of patient safety events. We are considering providing that QHP issuers must ensure that their contracted hospitals as described in section 1311(h) are standardizing reporting of patient safety events with the use of the Agency for Healthcare Research and Quality Common Formats, and we seek comment regarding this potential requirement. We seek comment on the types of information, such as hospital agreements with PSOs, HENs or QIOs,

that may be submitted to a QHP issuer to comply with the proposed standard in §156.1110(b)(2). We also seek comment on the proposed documentation standard, including the burden and costs, to require a QHP issuer to track information and demonstrate compliance with meeting the new patient safety standards described in paragraph (a)(2).

9. Qualified Health Plan Issuer Responsibilities

a. Payment and Collections Processes (§156.1215)

In the 2015 Payment Notice, HHS established a monthly payment and collections cycle for insurance affordability programs, user fees, and premium stabilization programs. In 2017, as discussed elsewhere in this document, we are proposing to charge issuers in State-based Exchanges that utilize the Federal platform for eligibility and enrollment services a user fee for the use of the platform. To streamline our payment and collections process, we propose that, for 2017 and later years, for purposes of the netting process, the reference to FFE user fees in §156.1215(b) would be interpreted to include any fees for issuers in State-based Exchanges using the Federal platform, as well as user fees that HHS collects on behalf of the State-based Exchange using the Federal platform.

In the 2015 Payment Notice, we established in §156.1215(c) that any amount owed to the Federal government by an issuer and its affiliates is the basis for calculating a debt owed to the Federal government. Similarly, we propose that, for 2015 and later years, for purposes of calculating the debt owed to the Federal government, we would interpret the reference to FFE user fees to include any fees for issuers in State-based Exchanges using the Federal platform, as well as user fees that HHS collects on behalf of the State-based Exchange using the Federal platform.

We solicit comments on these proposals, including whether the current regulations should be amended to reflect this interpretation.

b. Administrative Appeals (§156.1220)

In the 2015 Payment Notice (79 FR 13818), we established an administrative appeals process for issuers. We established a three-tiered appeals process: a request for reconsideration under §156.1220(a); a request for an informal hearing before a CMS hearing officer under §156.1220(b); and a request for review by the Administrator of CMS under §156.1220(c). We note that should we finalize our proposal around SBE-FPs, we would interpret this administrative appeals process to apply to user fee payments that we collect from SBE-FP QHP issuers that offer plans on an SBE-FP.

Under §156.1220(a), an issuer may only file a request for reconsideration based on the following: a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error. For example, an issuer may file a request for reconsideration that challenges the assessment of a default risk adjustment charge if the issuer believes the default charge was assessed because HHS incorrectly applied its methodology regarding data quantity and data sufficiency standards; however, the issuer may not file a request for reconsideration to challenge the methodology itself. We note that we are seeking comment on the proposed requirements related to the data quantity and data sufficiency methodology for the reinsurance and risk adjustments programs elsewhere in this proposed rule. We also clarify that an issuer may not file a request for reconsideration regarding issues arising from the issuer's failure to load complete and accurate data to its dedicated distributed data environment within the data submission window. Errors by the issuer are not appealable.

We seek to clarify these grounds for appeal for the risk adjustment and reinsurance programs, as follows. In line with our proposal to delete §153.710(d), we propose to make conforming amendments to modify §156.1220 to remove cross-references to the interim discrepancy reporting process. Under §156.1220(a)(4)(ii), a reconsideration relating to risk adjustment or reinsurance may only be requested if, to the extent the issue could have been previously identified by the issuer to HHS under the final discrepancy reporting process proposed to be redesignated at §153.710(d)(2), it was so identified and remains unresolved. As proposed to be redesignated, § 153.710(d)(2) states that an issuer must identify to HHS any discrepancies it identified in the final distributed data environment reports. We clarify that issuers may identify issues during the discrepancy reporting process under newly designated §153.710(d)(2) that are not subject to appeal; issuers may identify issues that are not processing errors by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical errors. We clarify that, in contrast, an issuer may only request a reconsideration of unresolved issues that were identified under the final discrepancy reporting process proposed to be redesignated at §153.710(d)(2), if contesting a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error. The existence of an unresolved discrepancy is not alone a sufficient basis on which to request a reconsideration.

We also seek to clarify the grounds for appeal for the risk corridors program. An issuer may not file a request for reconsideration to challenge the standards for the risk corridors program, including those established in §§153.500 through 153.540 and in guidance issued by HHS. In addition, appeals related to data for programs other than risk corridors covered in §156.1220(a) cannot be grounds for risk corridors appeals.

We also propose to shorten the deadline for filing a request for reconsideration in §156.1220(a)(3) from 60 to 30 calendar days. This proposal will permit HHS to resolve administrative appeals, calculate final payments and charges, and make payments in a more expedited manner. Additionally, we propose to clarify that an issuer must pay the full amount owed to HHS as set forth in the applicable notification, even if the issuer files a request for reconsideration under §156.1220. Failure to pay an amount owed will result in interest accruing after the applicable payment deadline. Therefore, if an appeal is unsuccessful, and the issuer has not already remitted the charge amount owed, the issuer would owe the debt plus the interest, and administrative fees which accrue from delayed payment. If an appeal is successful, HHS will refund the amount paid in accordance with the final appeal decision.

Therefore, we propose that the request for reconsideration must be filed in accordance with the following timeframes: (i) for the premium tax credit and cost-sharing reduction portions of the advance payments, or FFE user fee charges, within 30 calendar days after the date of the final reconsideration notification specifying the aggregate amount of such advance payments or user fees for the applicable benefit year; (ii) for a risk adjustment payment or charge, including an assessment of risk adjustment user fees, within 30 calendar days of the date of the notification under §153.310(e); (iii) for a reinsurance payment, within 30 calendar days of the date of the notification provided under §153.240(b)(1)(ii); (iv) for a default risk adjustment charge, within 30 calendar days of the date of the notification of such charge; (v) for reconciliation of the cost-sharing reduction portion of the advance payments, within 30 calendar days of the date of the notification of such payment or charge; and (vi) for a risk corridors payment or charge, within 30 calendar days of the date of the notification of such payment or charge for the purposes of §153.510(d). We propose to clarify that the last submission of data to which the issuer has

attested serves as the notification for purposes of §153.510(d). We seek comment on this proposal.

c. Third Party Payment of Qualified Health Plan Premiums (§156.1250)

On March 19, 2014, we published in the **Federal Register** an interim final rule (IFR) with comment period titled, Patient Protection and Affordable Care Act; Third Party Payment of Qualified Health Plan Premiums (79 FR 15240). The IFR requires individual market QHP issuers, including SADP issuers, to accept premium and cost-sharing payments made on behalf of enrollees by: the Ryan White HIV/AIDS Program; other Federal and State government programs that provide premium and cost sharing support for specific individuals; and Indian tribes, tribal organizations, and urban Indian organizations. The IFR applies the requirements at §156.1250 to all individual market QHPs and SADPs, regardless of whether they are offered through an FFE, an SBE, or outside of an Exchange.

The IFR also amended §156.805 to ensure that §156.1250 could be enforced. Specifically, the IFR amended §156.805(a)(1) to: provide that §156.805 targets violations of issuer standards and requirements of part 153 that are applicable to issuers; clarify that substantial non-compliance with any Exchange standard or requirement applicable to issuers in the FFE is grounds for imposing CMPs; and explicitly reference part 156 to clarify that substantial non-compliance with the Exchange standards applicable to issuers offering QHPs in the FFEs under part 156, including new §156.1250, may be a basis for the imposition of CMPs under §156.805.

Prior to publishing the IFR, HHS issued two “Frequently Asked Questions” documents regarding premium and cost-sharing payments made by third parties on behalf of QHP enrollees. In an FAQ issued on November 4, 2013 (the November FAQ), HHS encouraged QHP issuers not

to accept third-party payments made on behalf of enrollees by hospitals, other healthcare providers, and other commercial entities due to concerns that such practices could skew the insurance risk pool and create an uneven field in the Exchanges.⁴⁴ On February 7, 2014, HHS issued another FAQ (the February FAQ) clarifying that the November FAQ did not apply to third party premium and cost-sharing payments made on behalf of enrollees by Indian tribes, tribal organizations, and urban Indian organizations; State and Federal government programs (such as the Ryan White HIV/AIDS Program); or private, not-for-profit foundations that base eligibility on financial status, do not consider enrollees' health status, and provide assistance for an entire year.⁴⁵ In the February FAQ, HHS affirmatively encouraged QHP issuers to accept such payments given that Federal or State law or policy specifically envisions third party payment of premium and cost-sharing amounts by these entities.

We received 174 comments in response to the March 19, 2014 IFR. The comments ranged from general support of or opposition to the IFR's provisions to very specific questions or comments. Based on these comments, we propose to make some modifications to the policy finalized in the IFR.

Several commenters requested that final regulations clarify that "Federal and State government programs" include programs administered by a State's political sub-divisions (for example, counties and municipalities). Several other commenters expressed confusion regarding the definition of "State and Federal government programs," particularly in the case where an entity is both a (Federal or State) government program as well as a health care provider. These

⁴⁴ <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf>.

⁴⁵ <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-payments-of-premiums-for-qualified-health-plans-in-the-marketplaces-2-7-14.pdf>.

commenters expressed concern that §156.1250 does not make a distinction between government programs (such as Ryan White HIV/AIDS programs) and programs that involve Federal grantees receiving considerable public funding. Other commenters expressed concern that the category of Federal and State government programs is too broad, and does not provide adequate notice of which payments must be accepted.

We propose to amend §156.1250 to clarify that a Federal or State government program includes programs of the political subdivisions of the State, namely counties and municipalities, which we refer to as “local governments.” Including this clarification in regulations will ensure that States have the flexibility to distribute care and Exchange financial assistance to their vulnerable populations through local governments, consistent with their statutory and regulatory authority.

In terms of the distinction between programs sponsored and operated by the government (such as the Ryan White HIV/AIDS programs) and programs that involve Federal grantees that receive considerable public funding, we acknowledge that programs such as the Ryan White HIV/AIDS program operate by working with cities, States, and local community-based organizations to provide services in line with their statutory authority. Sections 2604(c)(3)(F), 2612(c)(3)(F), and 2651(c)(3)(F) of the PHS Act authorize Ryan White HIV/AIDS program grantees and sub-grantees to use program funds for premium and cost-sharing assistance. These grantees and sub-grantees must provide the assistance through third-party payments as they are prohibited from making payments directly to patients. Though many Ryan White HIV/AIDS program grantees are State and local governments, not all are; similarly, many of the State and local government grantees administer funds through sub-grantees that are not government entities. We propose to distinguish government programs from government grantees such that

the requirement at §156.1250 applies to government programs, but not necessarily to entities that are government grantees, unless specifically authorized and funded by the Federal, State, or local government program to make the payments on behalf of the program, consistent with the government programs' statutory and regulatory authority to provide premium and cost-sharing assistance through grants and grantees. In other words, if such Federal, State, and local governments are authorized to administer their premium and cost-sharing assistance through grantees or sub-grantees, the payments may not be rejected on the grounds that they did not come directly from the government programs. In such cases, the source of the Exchange financial assistance is the government program, and administration or distribution of that assistance through grants and grantees is authorized under statute or regulation. We seek comment on this proposal and also on whether final regulations should list out the specific entities that qualify as government programs for purposes of this provision.

We also propose to require entities that make third party payments of premiums under this section to notify HHS, in a format and timeline specified in guidance. We propose that the notification must reflect the entity's intent to make payments of premiums under this section and the number of consumers for whom it intends to make payments. We seek comment on this requirement, and on what information entities should provide as part of this notification.

We also propose to clarify that while issuers offering individual market QHPs, including SADPs, generally do not collect cost-sharing payments, they are required to accept third party cost-sharing payments on behalf of enrollees in circumstances where the issuer or the issuer's downstream entity accepts cost-sharing payments from plan enrollees. Although generally cost-sharing payments are made to providers, rather than to issuers, there are certain contractual circumstances where an issuer's non-provider downstream entity engages in activities on behalf

of the issuer, including the collection of cost-sharing payments. For example, an issuer's pharmacy benefits manager may collect cost-sharing payments from the issuer's plan enrollees for prescription drugs. We propose to clarify that in such situations, the rules at §156.1250 regarding third-party payments would apply to cost sharing. We seek comment on these proposals.

We received a number of comments requesting that final regulations require issuers to accept third-party payments from not-for-profit, charitable organizations. Several comments stated that requiring QHP issuers to accept third party payments from Ryan White HIV/AIDS programs but not from other disease-specific programs is unfair to those individuals with other diseases or conditions. Several other commenters expressed that many not-for-profit foundations and charitable organizations offer premium and cost-sharing assistance to individuals based on both financial status and diagnosis of a particular condition or disease.

We are considering whether we should expand the list of entities from whom issuers are required to accept payment under §156.1250 to include not-for-profit charitable organizations organizations in future years. If we did include not-for-profit charitable organizations, we would intend to include guardrails intended to minimize risk pool impacts, such as limiting assistance to individuals not eligible for other MEC and requiring assistance until the end of the calendar year. In making this determination, we intend to carefully review data provided by entities currently making third party premium payments and data related to the overall risk pool to better understand the impact of these payments.

d. Other Notices (§156.1256)

We propose to add a new §156.1256, which would add a requirement for issuers, in the case of a plan or benefit display error included in §155.420(d)(4), to notify their enrollees within

30 calendar days after the error is identified, if directed to do so by the FFE. We believe that enrollees should be made aware of any error that may have impacted their QHP selection and enrollment and any associated monthly or annual costs. Therefore, we are proposing a requirement for issuers to notify their enrollees of such error, should such error occur, as well as the availability of a special enrollment period, under §155.420(d)(4), for the enrollee to select a different QHP, if desired. We seek comment on this proposal.

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

1. Definitions (§158.103)

To ensure consistency in the definitions of “large employer” and “small employer” between the MLR regulation and the market reform requirements, and to reflect the recent amendments to section 2791(e) of the PHS Act and section 1304(b) of the Affordable Care Act that were made by the Protecting Affordable Coverage for Employees Act (Pub. L. 114-60), we propose to revise the regulatory definitions of “large employer” and “small employer” in §158.103 to cross-reference the definitions of those terms in §144.103.

2. Reporting of Incurred Claims (§§158.103 and 158.140(a))

The MLR December 1, 2010 interim final rule (75 FR 74864) and the May 16, 2012 technical corrections thereto (77 FR 28788) direct issuers to report incurred claims with a 3-month run-out period, and define unpaid claim reserves to mean reserves and liabilities established to account for claims that were incurred during the MLR reporting year but had not been paid within 3 months of the end of the MLR reporting year. The run-out period improves the accuracy of reported incurred claims by using the actual claims payments that take place during the run-out period, instead of the estimated claims liabilities and reserves, in the calculation of claims incurred in the reporting year.

Prior to the 2014 MLR reporting year, the deadline for submitting MLR reports to the Secretary was June 1 of the year following the reporting year. The 2014 Payment Notice (78 FR 15410) moved the reporting deadline from June 1 to July 31 of the year following the reporting year to accommodate inclusion of the transitional reinsurance and risk adjustment amounts, which HHS generally publishes by June 30, in the MLR and risk corridors calculations.

Because the MLR reporting deadline applicable to the 2014 and later reporting years occurs later in the year, the incurred claims valuation can also occur later in the year. Therefore, we propose to amend the definition of unpaid claims reserves in §158.103 and the requirements for reporting incurred claims in §158.140(a) to utilize a 6-month, rather than a 3-month run-out period beginning with the 2015 reporting year. This proposed amendment would require incurred claims to be calculated as of June 30, rather than March 31, of the year following the reporting year. We note that this approach is consistent with the proposal outlined in section III.D.3.a. of this preamble regarding the treatment of incurred but not received claims for the risk corridors program. We seek comment on this proposal.

Finally, we are inviting comment on whether we should modify the treatment of a health insurance issuer's investments in fraud prevention activities for MLR reporting purposes in the final rule. We are considering amending the MLR regulation to permit the counting of a health insurance issuer's investments in fraud prevention activities among those expenses attributable to incurred claims. We solicit comments on this approach, including whether safeguards against potential abuse should be included (for example, an upper limit on this allowance, such as a percentage based on the ratio of issuers' fraud reduction expenses reported under §158.140(b)(iv) and issuers' earned premium as defined in §158.130); whether we should collect fraud prevention activity expense data as an informational item on the MLR Annual Reporting

Form before amending the regulation; as well as on potential alternative treatment of these expenses for MLR reporting or rebate calculation purposes. We seek comment on this issue from all stakeholders, and specific actual data, if available, including with respect to the additional incentives that would result for health plan investments of this sort.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. This proposed rule contains information collection requirements (ICRs) that are subject to review by OMB. A description of these provisions is given in the following paragraphs with an estimate of the annual burden, summarized in Table 11. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 (PRA) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this proposed rule that contain ICRs. We generally used data from the Bureau of Labor Statistics

to derive average labor costs (including a 35 percent increase for fringe benefits and overhead) for estimating the burden associated with the ICRs.⁴⁶

A. ICRs Regarding Submission of Risk Corridors Data (§153.530)

We are proposing to amend the risk corridors program requirements at §153.530 to require issuers to true-up claims liabilities and reserves used to determine the allowable costs reported for the preceding benefit year to reflect the actual claims payments made through June 30 of the year following the benefit year. Although this proposal would require issuers to submit data indicating the difference between their incurred liability estimated as of March 31 and June 30, we believe that issuers will be recording these amounts as part of their normal business practices, and that there will be no new data elements and no additional burden as a result of this proposal. Therefore, in accordance with the implementing regulations of the PRA at 5 CFR 1320.3(b)(2), we believe the burden associated with this requirement would be exempt as it associated with a usual and customary business practice.

B. ICRs Regarding Submission of Rate Filing Justification (§154.215)

This proposed rule would require health insurance issuers to submit a Unified Rate Review Template for all single risk pool coverage regardless of whether there is a plan within a product that experiences a rate increase. The existing information collection requirement is approved under OMB Control Number 0938–1141. This includes the unified rate review template and instructions for rate filing documentation that issuers currently use to submit rate information to HHS for rate increases of any size for single risk pool coverage and rate increases that meet or exceed the subject to review threshold for non-single risk pool coverage. As

⁴⁶ See May 2014 Bureau of Labor Statistics, Occupational Employment Statistics, National Occupational Employment and Wage Estimates at http://www.bls.gov/oes/current/oes_nat.htm

detailed in the accompanying preamble discussion, we believe most issuers already report this information. Therefore, we do not expect issuers to incur a burden associated with this proposed regulation. Prior to the deadline for the submission of rate information to CMS for rates for single risk pool coverage effective on or after January 1, 2017, HHS intends to solicit public comment on and seek OMB approval for revisions to the information collection template and instructions approved under OMB Control Number 0938–1141.

C. ICRs Regarding Election to Operate an Exchange after 2014 (§155.106)

This proposed rule would modify the dates for application submission and approval for States seeking to operate an SBE, and have an approved or conditionally-approved Exchange Blueprint application and operational readiness assessment. HHS does not propose modifying the documents that States already must submit as part of the required Exchange Blueprint application. Therefore, HHS does not anticipate any additional impact to the administrative burden associated with the proposed regulatory changes to §155.106. HHS proposes utilizing the existing PRA package approved under OMB Control Number 0938-1172 for the Exchange Blueprint application.

D. ICRs Regarding Standards for Certified Application Counselors (§155.225(b)(1)(iii))

Section 155.225(b)(1)(ii) requires certified application counselor designated organizations to maintain a registration process and methodology to track the performance of certified application counselors. This proposed rule would add a new §155.225(b)(1)(iii) requiring certified application counselor designated organizations to provide the Exchange with information and data regarding the performance of the organization's certified application counselors, and the consumer assistance they provide. Although the current requirement at §155.225(b)(1)(ii) does not specify the type of performance information that must be tracked, or

require that the information be provided to the Exchange, we expect that certified application counselor designated organizations already have a tracking process in place to collect performance information from individual certified application counselors, and that individual certified application counselors are already recording and submitting this required information to their organization. Therefore, we expect this proposal to have minimal impact on individual certified application counselors and on certified application counselor designated organizations.

The proposed §155.225(b)(1)(iii) would add a new burden of compiling the performance information and submitting it to the Exchanges. In States with FFEs, HHS anticipates that, beginning in January 2017, it would collect three performance data points each month from certified application counselor designated organizations: the number of individuals who have been certified by the organization; the total number of consumers who received application and enrollment assistance from the organization; and of that number, the number of consumers who received assistance applying for and selecting a QHP, enrolling in a QHP, or applying for Medicaid or CHIP. We anticipate that this data would be reported to FFEs electronically, through HIOS or another electronic submission vehicle. For the purpose of estimating costs and burdens, we assume that State Exchanges will collect the same information with the same frequency, although our proposal gives Exchanges the flexibility to determine which data to collect and the form and manner of the collection. We estimate that certified application counselor designated organizations will have a mid-level health policy analyst prepare the reports and a senior manager will review each monthly report. HHS expects that a mid-level health policy analyst (at an hourly wage rate of \$40.64) will spend 2 hours each month to provide the required monthly submissions and a senior manager (at an hourly wage rate of \$91.31) will spend 3/8 hour to review the submissions. Therefore, we estimate each monthly report will

require 2.375 hours and a cost burden of \$115.52 per month per organization, or 28.50 hours with a cost (12 monthly reports) of \$1,386.25 annually per certified application counselor designated organization. Nationwide, we estimate there are 5,000 certified application counselor designated organizations, resulting in an annual cost burden of \$6,931,200 and 142,500 hours for certified application counselor designated organizations.

Under proposed §155.225(b)(1)(iii), if an Exchange requests these certified application counselor reports, the Exchange would also need to review the reports. We assume that all Exchanges will require monthly reports and will utilize in-house staff to review them. We assume that an employee earning a wage that is equivalent to a mid-level GS-11 employee would review monthly report submissions from certified application counselor designated organizations.⁴⁷ We estimate that a mid-level employee (at an hourly wage rate of \$43.13) will spend 10 minutes reviewing each monthly report for a cost burden of approximately \$7.19 per monthly report per certified application counselor designated organization. For State Exchanges, we estimate that there are 1,500 certified application counselor designated organizations resulting in a cost burden of 3,000 hours and approximately \$129,390 annually. Costs to the FFEs are estimated separately in the Regulatory Impact Analysis section of this proposed rule.

E. ICRs Regarding Network Adequacy Standards (§156.230(e) and (f))

Proposed §156.230(e) would require that QHP issuers make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued,

⁴⁷ Federal wage rates are available at https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2015/GS_h.pdf

irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal. This is a third-party disclosure requirement. We estimate that a total of 475 issuers participate in the FFE and would be required to comply with the proposed standard. We propose an estimate of 5 percent of providers discontinue contracts per year and that an issuer in the FFE covers 7,500 National Provider Identifiers, which means that we estimate an issuer would have 375 provider discontinuations in a year. For each provider discontinuation, we propose an estimate that it will take a database administrator 30 minutes for data analysis to produce the list of affected enrollees at \$55.37 an hour and an administrative assistant 30 minutes to develop the notification and send the notification to the affected enrollees, at \$29.93 an hour. The total costs per an issuer would be \$15,993.75. The total annual costs estimate would be \$7,597,031. Because we are already collecting information regarding network classifications as part of the existing QHP certification process, we do not believe that this proposal described in the preamble will result in additional information collection requirements for issuers.

Proposed §156.230(f) would require QHP issuers to provide a notice to enrollees of the possibility of out-of-network charges from an out-of-network provider in an in-network setting at least 10 business days prior to the benefit being provided to avoid counting the out-of-network costs against to the annual limitation on cost sharing. This provision would apply to all QHPs, which includes 575 issuers. We estimate it would take an issuer's mid-level health policy analyst (at an hourly wage rate of \$ 54.87) approximately 6 minutes to create a notification and send the proposed information. We estimate that approximately 2 notices would be sent for every 100 enrollees. Assuming approximately 9 million enrollees in QHPs 2017, we estimate

QHPs would send approximately 180,000 total notices, for a total hours of 18,000, with a total cost of \$987,660.

F. ICR Regarding Monthly SHOP Enrollment Reconciliation Files Submitted by Issuers (156.285(c)(5))

Proposed amendments to §156.285(c)(5) would specify that issuers in a Federally-facilitated SHOP would send monthly enrollment reconciliation files to the SHOP according to a process, timeline and file format established by the FF-SHOP. CMS anticipates that it would require FF- SHOP issuers to submit a standard file with specific data elements and submit their files in a process set out by the SHOP, no less frequently than on a monthly basis.

Issuers of QHPs available through the SHOP are already required under the current version of §156.285(c)(5) “to reconcile enrollment files with the SHOP at least monthly.”

Therefore, we expect this proposal to have minimal impact on SHOP issuers.

G. ICR Regarding Patient Safety Standards (§156. 1110)

In §156.1110(a)(2), we propose that for plan years beginning on or after January 1, 2017, a QHP issuer that contracts with a hospital with greater than 50 beds must verify that the hospital uses a patient safety evaluation system and implements a mechanism for comprehensive person-centered hospital discharge to improve care coordination and health care quality for each patient. We also propose in §156.1100(a)(2)(ii) to establish reasonable exceptions to these new QHP issuer patient safety requirements such that the hospital may implement evidence-based initiatives to reduce all cause preventable harm, prevent hospital readmission, improve care coordination and improve health care quality through the collection, management and analysis of patient safety events (rather than requiring reporting of such information to or by a Patient Safety Organization). The burden estimate associated with the information collection, recordkeeping,

and disclosure requirements to demonstrate compliance with these standards includes the time and effort required for QHP issuers to maintain and submit to the applicable Exchanges, documentation including but not limited to, hospital agreements to partner with a Patient Safety Organization, a Hospital Engagement Network, or a Quality Improvement Organization that demonstrate that each of its contracted hospitals with greater than 50 beds meets the patient safety standards required in §156.1110(a)(2) for plan years beginning on or after January 1, 2017. QHP issuers may not already be collecting such network provider information; therefore, we estimate the cost and burden to collect this administrative information as follows: For a total of 600 QHP issuers, offering 15 plans as potential QHPs, we estimate each issuer would require one senior manager an average of 3 hours to collect and maintain the hospital agreements or other information necessary to demonstrate compliance as required in §156.1110(a)(2) for their QHPs offered on Exchanges for plan years beginning on or after January 1, 2017. For a senior manager (at an hourly wage rate of \$91.31), we estimate the total annual cost for a QHP issuer to be \$273.93. Therefore, we estimate a total annual burden of 1,800 hours, resulting in an annual cost of \$164,358.

H. ICR Regarding Third Party Payment of Qualified Health Plan Premiums (§156.1250)

We are proposing to require entities that make third party payments of premiums under this section to notify HHS, in a format and timeline specified in guidance. We expect that the notification would reflect the entity's intent to make payments of premiums under this section and the number of consumers for whom it intends to make payments. We estimate it would take approximately four hours to analyze the number of consumers the entity intends to make payments of premiums on behalf of, draft a notification and send the proposed information by a mid-level health policy analyst (at an hourly wage rate of \$ 54.87). Assuming 500 entities exist

that make third party payments and each would send one notice, we estimate a total burden of 2,000 hours resulting in an annual cost of \$109,740.

I. ICRs Regarding Other Notices (§156.1256)

We are proposing to add a new section at §156.1256 to require that, in the event of a plan or benefit display error, QHP issuers notify their enrollees within 30 calendar days after the error is identified, both of the plan or benefit display error and of the opportunity to enroll in a new QHP under a special enrollment period at §155.420(d)(4), if directed to do so by the FFE. This provision would apply to all QHPs in the FFEs, which includes 475 issuers. We estimate it would take approximately 30 minutes to amend a form notice, add SEP language provided by the FFE, and send the proposed information by an issuer's mid-level health policy analyst (at an hourly wage rate of \$54.87). We estimate that approximately 4 percent of enrollees would receive such a notice. Assuming approximately 7 million FFE enrollees, we estimate QHPs in the FFEs would send approximately 280,000 total notices, for a total hours of 140,000, with a total cost of \$7,681,800.

However, although this proposal would require issuers to send notices for the specified situation, sending these notices is already part of normal issuer business practices and issuers are already working with the FFE to include language in their notices about special enrollment periods, as applicable and appropriate. Therefore, there will be no additional information required by issuers and no new administrative burden as a result of this proposal. In accordance with the implementing regulations of the PRA at 5 CFR 1320.3(b)(2), we believe the burden associated with this requirement would be exempt as it associated with a usual and customary business practice.

TABLE 11: Annual Reporting, Recordkeeping and Disclosure Burden

Regulation Section	OMB Control Number	Number of respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting (\$)	Total Labor Cost of Reporting (\$)	Total Cost (\$)
§155.225 (b)(1)(iii)-certified application counselor organizations	0938-1172	5,000	60,000	2.375	142,500	48.64	6,931,200	6,931,200
§155.225 (b)(1)(iii)-State Exchange	0938-1172	1,500	1,500	0.167	3,000	\$43.13	129,390	129,390
§156.230(e)	0938-NEW	475	178,125	1	375	42.65	7,597,031	7,597,031
§156.230(f)	0938-NEW	575	180,000	0.1	18,000	54.87	987,660	987,660
§156.1110	0938-1249	600	9,000	0.2	1,800	91.31	164,358	164,358
§156.1250	0938-NEW	500	500	4	2,000	54.87	109,740	109,740
§156.1256	0938-NEW	475	280,000	0.5	140,000	54.87	7,681,800	7,681,800
Total		6,100	----	-----	334,675	----	23,601,179	23,601,179

Note: There are no capital/maintenance costs associated with the information collection requirements contained in this rule; therefore, we have removed the associated column from Table 11.

Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection requirements. These requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' website at <http://www.cms.hhs.gov/PaperworkReductionActof1995>; email your request, including your address, phone number, OMB control number, and CMS document identifier, to Paperwork@cms.hhs.gov; or call the Reports Clearance Office at 410-786-1326.

We invite public comments on these potential information collection requirements. If you comment on these information collection and recordkeeping requirements, please submit your comments electronically as specified in the ADDRESSES section of this proposed rule.

Please include “CMS-9937-P,” the ICR’s OMB control number, and the CMS document ID number in your comment.

PRA-specific comments must be received by [**INSERT DATE 60 DAYS AFTER THE DATE OF PUBLICATION IN THE FEDERAL REGISTER**].

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this proposed rule, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

A. Statement of Need

This rule proposes standards related to the premium stabilization programs (risk adjustment, reinsurance, and risk corridors) for the 2017 benefit year, as well as certain modifications to these programs that will protect issuers from the potential effects of adverse selection and protect consumers from increases in premiums due to issuer uncertainty. The Premium Stabilization Rule and previous Payment Notices provided detail on the implementation of these programs, including the specific parameters for the 2014, 2015, and 2016 benefit years applicable to these programs. This rule proposes additional standards related to essential health benefits, meaningful access in the Exchange, consumer assistance tools and programs of an Exchange, Navigators, non-Navigator assistance personnel, agents and brokers registered with the Federally-facilitated Exchange, certified application counselors, cost-sharing parameters and cost-sharing reduction notices, essential community providers, qualified health

plans, network adequacy, stand-alone dental plans, acceptance of third-party payments by QHP issuers, patient safety standards for issuers of qualified health plans participating in Exchanges, guaranteed availability and guaranteed renewability, minimum essential coverage, the rate review program, the medical loss ratio program, the Small Business Health Options Program, and FFE user fees.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects (\$100 million or more in any 1 year).

OMB has determined that this proposed rule is “economically significant” within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of \$100 million in any 1 year. Accordingly, we have prepared an RIA that presents the costs and benefits of this proposed rule.

Although it is difficult to discuss the wide-ranging effects of these provisions in isolation, the overarching goal of the premium stabilization, market standards, and Exchange-related provisions and policies in the Affordable Care Act is to make affordable health insurance available to individuals who do not have access to affordable employer-sponsored coverage. The provisions within this proposed rule are integral to the goal of expanding coverage. For example, the premium stabilization programs help prevent risk selection and decrease the risk of financial loss that health insurance issuers might otherwise expect in 2017 and Exchange financial assistance assists low- and moderate-income consumers and American Indians/Alaska Natives in purchasing health insurance. The combined impacts of these provisions affect the private sector, issuers, and consumers, through increased access to health care services including preventive services, decreased uncompensated care, lower premiums, establishment of the next phase of patient safety standards, and increased plan transparency. Through the reduction in financial uncertainty for issuers and increased affordability for consumers, these provisions are expected to increase access to affordable health coverage.

HHS anticipates that the provisions of this proposed rule will help further the Department's goal of ensuring that all consumers have access to quality and affordable health care and are able to make informed choices, that Exchanges operate smoothly, that premium stabilization programs work as intended, that SHOPs are provided flexibility, and that employers and consumers are protected from fraudulent and criminal activities. Affected entities such as QHP issuers would incur costs to comply with the proposed provisions, including administrative costs related to notices, new patient safety requirements, training and recertification requirements, and establishing a larger provider network. In accordance with Executive Order 12866, HHS believes that the benefits of this regulatory action justify the costs.

C. Impact Estimates of the Payment Notice Provisions and Accounting Table

In accordance with OMB Circular A-4, Table 12 depicts an accounting statement summarizing HHS's assessment of the benefits, costs, and transfers associated with this regulatory action.

This proposed rule implements standards for programs that will have numerous effects, including providing consumers with affordable health insurance coverage, reducing the impact of adverse selection, and stabilizing premiums in the individual and small group health insurance markets and in an Exchange. We are unable to quantify certain benefits of this proposed rule – such as improved health outcomes and longevity due to continuous quality improvement, improved patient safety and increased insurance enrollment – and certain costs – such as the cost of providing additional medical services to newly-enrolled individuals. The effects in Table 12 reflect qualitative impacts and estimated direct monetary costs and transfers resulting from the provisions of this proposed rule for health insurance issuers. The annualized monetized costs described in Table 12 reflect direct administrative costs to health insurance issuers as a result of the proposed provisions, and include administrative costs related to notices, new patient safety requirements, and training and recertification requirements that are estimated in the Collection of Information section of this proposed rule. The annual monetized transfers described in Table 12 include costs associated with FFE user fees, the risk adjustment user fee paid to HHS by issuers, changes in the overall transfer amount for the risk corridors program for fiscal years 2017 through 2018, and an increase in MLR rebates to consumers. We are proposing to collect a total of \$52 million in risk adjustment user fees or \$1.80 per enrollee per year from risk adjustment issuers, which is slightly more than the \$50 million generated in benefit year 2016 when we established a \$1.75 per-enrollee-per-year risk adjustment user fee amount. As in 2016, the risk

adjustment user fee contract costs for 2017 include additional costs for risk adjustment data validation; however, we expect increased enrollment in 2017 HHS risk adjustment covered plans, which decreases the per enrollee amount. Also, the increase in FFE user fee collections is the result of expected growth in enrollment in the FFEs rather than an increase in the user fee rate, which at 3.5 percent remains the same from 2016 to 2017. Beginning in 2017, we are also proposing to charge a user fee for SBEs that utilize the Federal platform for eligibility and enrollment services. This user fee rate would be set at 3.0 percent for benefit year 2017.

TABLE 12: Accounting Table

Benefits:				
Qualitative:				
<ul style="list-style-type: none"> ● Increased enrollment in the individual market leading to improved access to health care for the previously uninsured, especially individuals with medical conditions, which will result in improved health and protection from the risk of catastrophic medical expenditures ● Continuous quality improvement among QHP issuers to reduce patient harm and improve health outcomes at lower costs ● More informed Exchanges QHP certification decisions ● Increased coverage options for small businesses and employees with minimal adverse selection 				
Costs:	Estimate	Year Dollar	Discount Rate	Period Covered
	\$ 23.91	2015	7 percent	2016-2020
Annualized Monetized (\$/year)	\$ 23.91	2015	3 percent	2016-2020
Quantitative:				
<ul style="list-style-type: none"> ● Costs incurred by issuers to comply with provisions in the proposed rule 				
Transfers:	Estimate	Year Dollar	Discount Rate	Period Covered
	\$ 21.73	2015	7 percent	2016-2020
Annualized Monetized (\$/year)	\$ 21.84	2015	3 percent	2016-2020
<ul style="list-style-type: none"> ● Transfers reflect an additional \$2 million annual cost of risk adjustment user fees (the total risk adjustment user fee amount for 2015 was \$50 million), which are transfers from health insurance issuers to the Federal government. Transfers also reflect an additional \$31 million in rebates from entities subject to medical loss ratio (MLR) requirements to consumers, an increase of \$105 million in the amount of user fees collected from State-based Exchanges that use the Federal platform for eligibility and enrollment, which are transfers from issuers to the Federal government, and a total decrease of \$112 million in the amount of risk corridors transfers between issuers of qualified health plans (QHPs) ● Unquantified: Lower premium rates in the individual market due to the improved risk profile of the insured, competition, and pooling 				

This RIA expands upon the impact analyses of previous rules and utilizes the Congressional Budget Office's (CBO) analysis of the Affordable Care Act's impact on Federal spending, revenue collection, and insurance enrollment. The Affordable Care Act ends the temporary risk corridors program and, in this rulemaking, we propose to end the transitional

reinsurance program after the benefit year 2016. Therefore, the costs associated with those programs are not included in Tables 12 or 13 for fiscal years 2019-2020. Table 13 summarizes the effects of the risk adjustment program on the Federal budget from fiscal years 2016 through 2020, with the additional, societal effects of this proposed rule discussed in this RIA. We do not expect the provisions of this proposed rule to significantly alter CBO's estimates of the budget impact of the premium stabilization programs that are described in Table 13. We estimate that the proposal to true up claims liabilities and reserves used to determine allowable costs for the risk corridors program will reduce the overall risk corridors transfer amount by \$112 million in each of fiscal years 2017 and 2018. We note that transfers associated with the risk adjustment and reinsurance programs were previously estimated in the Premium Stabilization Rule; therefore, to avoid double-counting, we do not include them in the accounting statement for this proposed rule (Table 12).

In addition to utilizing CBO projections, HHS conducted an internal analysis of the effects of its regulations on enrollment and premiums. Based on these internal analyses, we anticipate that the quantitative effects of the provisions proposed in this rule are consistent with our previous estimates in the 2016 Payment Notice for the impacts associated with the advance payments of cost-sharing reductions and premium tax credits, the premium stabilization programs, and FFE user fee requirements.

TABLE 13: Estimated Federal Government Outlays and Receipts for the Risk Adjustment, Reinsurance, and Risk Corridors Programs from Fiscal Year 2016-2020, in billions of dollars

Year	2016	2017	2018	2019	2020	2016-2020
Risk Adjustment, Reinsurance, and Risk Corridors Program Payments	16.5	19.5	13	15	16	80
Risk Adjustment, Reinsurance, and Risk Corridors Program Collections*	15.5	18.5	13	15	16	78

Note 1 : Risk adjustment program payments and receipts lag by one quarter. Receipt will fully offset payments over time.

Note 2: The CBO score reflects an additional \$2 million in collections in FY 2015 that are outlayed in the FY 2016-FY 2020 timeframe. CBO does not expect a shortfall in these programs.

Source: Congressional Budget Office. Insurance Coverage Provisions of the Affordable Care Act—CBO’s March 2015 Baseline Table
<https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf>

1. Fair Health Insurance Premiums

The proposed regulations would permit an additional principal business address to be identified for a small employer that is within the service area of an issuer’s network plan, in instances where the issuer is rating based on geography and the employer’s principal business address is not within that service area. This would ensure that the network plan can be appropriately rated for sale to the group policyholder, benefitting both issuers and employers.

2. Guaranteed Availability

This proposed rule would codify certain exceptions to guaranteed availability. Because we believe this codification is consistent with current industry practice under current standards, we do not believe this change will have a material impact on issuers or enrollees.

2. Student Health Insurance Coverage

This proposed rule would subject student health insurance coverage to the index rating methodology under the single risk pool regulation, but specify that issuers may establish one or more separate risk pools for each institution of higher education, provided they are based on a bona fide school-related classification and not related to health status. The proposed rule would also eliminate the requirement that issuers of student health insurance coverage provide coverage comprised of the specific metal levels, and instead require such issuers to provide insurance policies that provide at least 60 percent AV. This would provide flexibility for colleges and universities to offer student health insurance plans that are more generous than the standard metal levels. This would affect an estimated 41 issuers that offer student health insurance

coverage nationwide and approximately 1.3 million students and dependents enrolled in such plans.⁴⁸

3. Risk Adjustment

The risk adjustment program is a permanent program created by the Affordable Care Act that transfers funds from lower risk, non-grandfathered plans to higher risk, non-grandfathered plans in the individual and small group markets, inside and outside the Exchanges. We established standards for the administration of the risk adjustment program, in subparts D and G of part 45 of the CFR.

A State approved or conditionally approved by the Secretary to operate an Exchange may establish a risk adjustment program, or have HHS do so on its behalf. As described in the 2014, 2015, and 2016 Payment Notices, if HHS operates risk adjustment on behalf of a State, it will fund its risk adjustment program operations by assessing a risk adjustment user fee on issuers of risk adjustment covered plans. For the 2017 benefit year, we estimate that the total cost for HHS to operate the risk adjustment program on behalf of States for 2017 will be approximately \$52 million, slightly more than in 2016, and that the risk adjustment user fee would be approximately \$1.80 per enrollee per year. This user fee reflects both increased contract costs to support the risk adjustment data validation process in 2017 and an expected increase in enrollment in risk adjustment covered QHPs.

4. Risk Corridors

The Federally operated temporary risk corridors program ends in benefit year 2016 as required by statute. Because risk corridors charges are collected in the year following the

⁴⁸ Source: Data from Medical Loss Ratio submissions for 2013 reporting year.

applicable benefit year, and risk corridors payments lag receipt of collections by one quarter, we estimate that risk corridors transfers will continue through fiscal year 2018. We are proposing that for the 2015 and later benefit years, the issuer must true up claims liabilities and reserves used to determine the allowable costs reported for the preceding benefit year to reflect the actual claims payments made through June 30 of the year following the benefit year. This proposed amendment would provide for a more accurate risk corridors calculation by substituting actual experience in place of estimates. Some issuers overestimate their claims and liabilities, while others underestimate them. Based on the 2014 MLR and risk corridors data, we estimate that this proposed amendment will result in a combined total reduction of approximately \$315 million in risk corridors payments or increase in risk corridors charges for some issuers; and a combined total increase of approximately \$203 million in risk corridors payments or decrease in risk corridors charges for other issuers. The estimated net impact of the proposed amendment would thus be a reduction of approximately \$112 million in total transfers between issuers.

5. Rate Review

In §154.215, we propose to amend the criteria for submission of the Unified Rate Review Template for single risk pool coverage to HHS. We estimated the burden associated with the rate filing process in the Supporting Statement approved under OMB Control Number 0938–1141. We intend to revise the information collection currently approved under OMB Control Number 0938–1141 to clarify instructions related to completing the template for single risk pool coverage that has a rate decrease, no rate change and for new plans.

6. Additional Required Benefits

In §155.170, we propose to amend the requirement for coverage of benefits in addition to the essential health benefits. Specifically, we propose to reword §155.170(a)(2) to make clear

that a benefit required by the State through action taking place on or before December 31, 2011 is considered an EHB and one required by the State through action taking place after December 31, 2011 is considered in addition to EHB. As we see this as a clarification, we do not anticipate an additional burden on States or issuers. At §155.170(a)(3), we currently require the Exchange to identify which additional State-required benefits, if any, are in excess of EHB. We propose to amend paragraph (a)(3) to designate the State, rather than the Exchange, as the entity that identifies which State-required benefits are not EHB. Because Exchanges have generally been relying upon State Departments of Insurance in determining what constitutes an essential health benefit, we do not anticipate any additional burden to States because of this modification.

7. Standards for Navigators and certain Non-Navigator Assistance Personnel

This proposed rule would amend some of the standards for consumer assistance functions under §155.205(d) and (e), as well as for the activities of Navigators and non-Navigator assistance personnel subject to §155.215. The proposed changes include ensuring consumers have access to skilled assistance with Exchange-related issues beyond applying for and enrolling in coverage. Such post enrollment and other assistance would include assisting consumers with applying for exemptions from the individual shared responsibility payment that are granted through the Exchange, with the process of filing Exchange appeals, and with understanding basic concepts related to health coverage and how to use it. The proposed rule would also require Navigators to provide targeted assistance to serve underserved and/or vulnerable populations, as identified by each Exchange. Our proposals would also specify that any individual or entity carrying out consumer assistance functions under §155.205(d) and (e) or §155.210 must complete training prior to performing any assister duties, including conducting outreach and education activities.

Our proposal to amend §§155.205(d) and 155.215(b)(1)(i) related to completing training for Navigators and certain non-Navigator assistance personnel only applies to the timing of the training and does not have any impact on the training itself. Therefore, it would not affect the burden or cost for entities already subject to training requirements. Because under existing §155.215(b)(2), Navigators in FFEs must already be trained on the tax implications of enrollment decisions, the individual responsibility to have health coverage, eligibility appeals, and rights and processes for QHP appeals and grievances, we expect our amendments to §155.210(b)(2)(v) through (viii) to have minimal impact on FFE training. If any SBEs do not already provide training on these topics, we expect they would incur minimal costs in developing and implementing this training. Our proposal requiring Navigators to serve underserved and vulnerable populations will have an increased benefit for consumers, especially hard to reach populations. All costs associated with reaching these consumers in FFEs would be considered allowable costs that would be covered by the Navigator grants for the FFEs and that may be drawn down as the grantee incurs such costs. Additionally, §155.210(b)(2)(i) already requires Navigators in all States to receive training on serving underserved and vulnerable populations.

8. Certified Application Counselors

This proposed rule would require certified application counselor organizations to submit data and information to the Exchanges regarding the performance of their certified application counselors and the consumer assistance they provide, upon request, in a form and manner specified by the Exchange. Under proposed §155.225(b)(1)(iii), if an Exchange requests these certified application counselor reports, the Exchange would also need to review them. We assume that all Exchanges will require monthly reports and will utilize in-house staff to review them. We assume that an employee earning a wage that is equivalent to a mid-level GS-11

employee would review monthly report submissions from certified application counselor designated organizations.⁴⁹ We estimate that a mid-level employee (at an hourly wage rate of \$43.13) will spend 10 minutes reviewing each monthly report for a cost burden of approximately \$7.19 per monthly report per certified application counselor designated organization. We estimate the costs of this proposal for State Exchanges in the Collection of Information Requirements section of this proposed rule. For the FFEs, we estimate there are 3,500 certified application counselor designated organizations, resulting in a total annual burden for FFEs of 7,000 hours, at a cost of \$301,910.

9. SHOP

The SHOP facilitates the enrollment of eligible employees of small employers into small group health insurance plans. A qualitative analysis of the costs and benefits of establishing a SHOP was included in the RIA published in conjunction with the Exchange Establishment Rule.⁵⁰

The proposed §155.735(d)(2)(iii) would require the FF-SHOPs to send qualified employees a notice notifying them that their child dependent(s) are no longer eligible for dependent child coverage under their plan because of age. The notice would be sent 90 days in advance of the date when the dependent enrollee loses eligibility for dependent coverage. We estimate the Federally-facilitated SHOPs will spend roughly 35 hours annually, per State, to prepare the notice, for a total cost of \$1,775, per State, to design and implement the notices proposed under §155.735(d)(2)(iii). We estimate that there will be approximately 32 States

⁴⁹ Federal wage rates are available at https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2015/GS_h.pdf

⁵⁰ Available at: <http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf>

operating under the Federally-facilitated SHOPs and all will be subject to this requirement. Therefore, we estimate a total annual cost of \$58,575 for the FF-SHOPs as a result of this requirement.

10. Standardized Options

In assessing the burden associated with implementing standardized options, as described in §156.20, we assessed the potential impact on premiums established by QHP issuers in the FFEs. Due to the many complex factors that issuers consider when setting premiums, it is impossible to fully predict how each QHP issuer would price a standardized option prior to HHS sharing the standardized option with stakeholders and soliciting feedback. We anticipate that an issuer will price a standardized option based on how similar or different the standardized option is to the issuer's current shelf (plan offerings). Because of the large variation across the country, we expect that how standardized options will be priced will vary by issuer and by State. We do not anticipate that it will significantly affect 2017 plan premiums. We expect that issuers will offer standardized options at a given metal level if the standardized options are similar to their existing plans and can be priced competitively.

The premium impact on issuers' non-standard plan offerings is difficult to estimate.

Among the six State Exchanges that standardized plans and required standardized options to be offered by QHP issuers in 2014, two (California and New York) that attempted to conduct premium impact analysis found that introduction of the requirement on issuers to offer standardized options was associated with a negligible or downward impact on premiums. However, these SBEs found it was difficult to isolate the effects of plan standardization on premiums given the many changes that occurred in the insurance market in 2014 (including the

uptake in individual market enrollment, the movement to narrow networks, and active purchasing and rate negotiation in California).

Again, we note that there is a great deal of uncertainty in how this policy will affect Exchanges due to several considerations:

- While we propose to standardize cost-sharing on key essential health benefits, there are a wide range of other benefit design parameters that we will not standardize. It is not clear how this differentiation will manifest among plans or affect consumer choice.
- There is also wide geographic variation in health care markets, including with respect to prices, plan designs, and provider networks. As such, we anticipate that the take-up of standardized options and their impacts on consumers will vary in different locations across the country.

11. User Fees

To support the operation of FFEs, we require in §156.50(c) that a participating issuer offering a plan through an FFE must remit a user fee to HHS each month equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through an FFE. In this proposed rule, for the 2017 benefit year, we propose a monthly FFE user fee rate equal to 3.5 percent and, for a State-based Exchange that relies on the Federal platform, 3.0 percent of the monthly premium. For the user fee charges assessed on issuers in the FFE and State-based Exchanges using the Federal platform, we intend to seek an exception to OMB Circular No. A-25R, which requires that the user fee charge be sufficient to recover the full cost to the Federal government of providing the special benefit. We seek this exception to ensure that the FFE can support many of the goals of

the Affordable Care Act, including improving the health of the population, reducing health care costs, and providing access to health coverage as advanced by §156.50(d).

12. Actuarial Value

The proposed §156.135(g) changes current §156.135(g) to allow for additional flexibility in our approach and options for updating of the AV Calculator in the future. Issuers may incur minor administrative costs associated with altering cost-sharing parameters of their plan designs to ensure compliance with AV requirements when utilizing the AV calculator from year-to-year. These requirements are established in the EHB Rule. Since issuers have extensive experience in offering products with various levels of cost sharing and since these modifications are expected to be relatively minor for most issuers, HHS expects that the process for computing AV with the AV Calculator will not demand many additional resources.

13. Network Adequacy

In §156.230(f), we propose to require QHPs in the FFEs to count certain out-of-network cost sharing towards the in-network annual limitation on cost sharing for enrollees who receive EHB from an out-of-network provider at an in-network setting. The premium impact will vary based on existing State laws. It is difficult to estimate a nationwide effect with precision. We seek comment on the impact of this policy.

14. Provisions Related to Cost Sharing

The Affordable Care Act provides for the reduction or elimination of cost sharing for certain eligible individuals enrolled in QHPs offered through the Exchanges. This assistance will

help many low- and moderate-income individuals and families obtain health insurance – for many people, cost sharing is a barrier to obtaining needed health care.⁵¹

We set forth in this proposed rule the reductions in the maximum annual limitation on cost sharing for silver plan variations. Consistent with our analysis in previous Payment Notices, we developed three model silver level QHPs and analyzed the impact on their AVs of the reductions described in the Affordable Care Act to the estimated 2017 maximum annual limitation on cost sharing for self only coverage (\$7,150). We do not believe these changes will result in a significant economic impact. Therefore, we do not believe the provisions related to cost-sharing reductions in this proposed rule will have an impact on the program established by and described in the 2015 and 2016 Payment Notices.

We also proposed the premium adjustment percentage for the 2017 benefit year. Section 156.130(e) provides that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. The annual premium adjustment percentage sets the rate of increase for three parameters detailed in the Affordable Care Act: the annual limitation on cost sharing (defined at §156.130(a)), the required contribution percentage by individuals for minimum essential coverage the Secretary may use to determine eligibility for hardship exemptions under section 5000A of the Code, and the assessable payments under sections 4980H(a) and 4980H(b). We believe that the proposed 2017 premium adjustment percentage of 13.25256291 percent is well within the parameters used in the

⁵¹ Brook, Robert H., John E. Ware, William H. Rogers, Emmett B. Keeler, Allyson Ross Davies, Cathy D. Sherbourne, George A. Goldberg, Kathleen N. Lohr, Patricia Camp and Joseph P. Newhouse. The Effect of Coinsurance on the Health of Adults: Results from the RAND Health Insurance Experiment. Santa Monica, CA: RAND Corporation, 1984. Available at: <http://www.rand.org/pubs/reports/R3055>.

modeling of the Affordable Care Act, and we do not expect that these proposed provisions will alter CBO's March 2015 baseline estimates of the budget impact.

15. Stand-alone Dental Plans

In §156.150, we propose increasing the annual limitation on cost sharing for stand-alone dental plans being certified by the Exchanges. We believe that the benefit of increasing the annual limit on cost sharing is that issuers would be able to offer consumers SADPs that provide preventive care without any cost sharing, similar to what is generally offered by SADPs in the large group market. This proposal may also decrease the likelihood of premium increases.

16. Meaningful Difference

In §156.298, we propose to remove health savings account eligibility and the individual coverage or enrollment group coverage criteria as options for meeting the meaningful difference standard. As we believe the health savings account eligibility criterion to overlap with cost-sharing criterion (that is, we believe that a plan that meets the meaningful difference standard for health savings account eligibility would also meet the standard under the cost-sharing criterion), we do not believe that removing this criterion will have any impact on issuers. Additionally, our records indicate that no self-only coverage plans were reviewed for meaningful difference in 2015 and none are offered for 2016 Open Enrollment. As such, we estimate that the impact of this proposed change is negligible.

17. Patient Safety Standards

The proposed next phase of patient safety standards requires QHP issuers participating in Exchanges to track hospital participation agreements with PSOs or other evidence-based patient safety initiatives. We believe this proposed requirement to verify that hospitals with greater than 50 beds use a patient safety evaluation tool and implement a comprehensive person-centered

hospital discharge program would encourage continuous quality improvement among QHP issuers by strengthening system-wide efforts to reduce patient harm in a measurable way, improve health outcomes at lower costs, allow for flexibility and innovation in patient safety interventions and practices, and encourage meaningful health care quality improvements. We discuss the administrative costs associated with submitting this information in the Collection of Information section of this proposed rule.

18. Acceptance of Certain Third Party Payments

On March 19, 2014, we published in the **Federal Register** an interim final rule (IFR) with comment period titled, Patient Protection and Affordable Care Act; Third Party Payment of Qualified Health Plan Premiums (79 FR 15240). In §156.1250, we propose to refine this rule to require individual market QHPs and SADPs to accept premium payments made by certain third parties. This rule proposes to clarify the circumstances in which individual market QHPs and SADPs must accept payments made by Ryan White HIV/AIDS program; Federal and State government programs that provide premium and cost sharing support for specific individuals; and Indian tribes, tribal organizations, and urban Indian organizations. We do not believe these actions would impose any significant new costs on issuers because we assume that most issuers already accept such payments under our interim final rule.

19. Medical Loss Ratio

In this proposed rule, we propose to amend the definition of unpaid claims reserves in §158.103 and the requirements for reporting incurred claims in §158.140(a) to utilize a 6-month, rather than a 3-month, run-out period beginning with the 2015 reporting year. This proposed amendment would require incurred claims to be calculated as of June 30, rather than March 31, of the year following the reporting year. This proposed amendment would provide for a more

accurate MLR and risk corridors calculation by reducing reliance on estimates. Some issuers overestimate their claims and liabilities, while others underestimate them. We estimate that this proposed provision would increase rebate payments from issuers to consumers by a net total of approximately \$12 million.

In addition, we are proposing to amend the risk corridors program requirements at §153.530 to require issuers to true-up claims liabilities and reserves used to determine the allowable costs reported for the preceding benefit year to reflect the actual claims payments made through June 30 of the year following the benefit year. We estimate the impact of this proposal on the risk corridors program elsewhere in this RIA. Because risk corridors payments and charges are a component of the MLR and rebate calculation, the impact of this proposed provision on risk corridors payments and charges will affect MLR rebates to consumers. We estimate that this proposed provision would increase rebate payments from issuers to consumers by an estimated net total of \$19 million for the 2015 MLR reporting year.

D. Regulatory Alternatives Considered

In developing the policies contained in this proposed rule, we considered numerous alternatives to the presented proposals. Below we discuss the key regulatory alternatives that we considered.

Regarding the 2017 required contribution percentage, which establishes the threshold for spending on minimum essential health care required for an affordability exemption from the individual responsibility requirement, we considered continuing to use the per capita gross domestic product as the measure of income growth. However, a new measure of income growth, per capita personal income, became available for the first time last year as part of the National Health Expenditure's projections, and includes not only participation in production but also

transfer payments. We believe that this broader measure of personal income more accurately reflects individual income than GDP per capita.

For proposed §155.200(f), we considered a number of alternatives. We considered not codifying the SBE-FP model, and winding down use of the Federal platform by SBEs. This would have forced SBEs to find a way to perform all required Exchange eligibility and enrollment functions themselves, including the implementation of an Exchange technology platform, or else convert to FFEs. We made the proposal we did because we believe that it is technically feasible and will permit a number of SBEs to access the Federal government's greater economies of scale. We also considered a more customized option, under which an SBE would be permitted to select from a menu of Federal services. While we are considering providing more flexibility to SBE-FPs in the future, at this point we do not have the operational ability to permit that level of customization. Finally, we considered alternatives under which issuers and other delegated and downstream entities in States with SBE-FPs would not be required to meet FFE standards, or HHS would not participate in enforcement against issuers violating those FFE rules. As discussed in this proposed rule, we believe that applying Federal standards to issuers and their downstream entities for SBE-FPs helps promote consistent minimum standards associated with HealthCare.gov.

Regarding the exemptions program, we considered maintaining the option under which individuals can receive certification of certain exemptions from the Exchange, rather than transitioning the process for obtaining those exemption types fully to the IRS. However, we believe that this approach contributes to confusion and unnecessarily creates additional hurdles for individuals claiming these exemptions. We also considered whether to cede other exemption types to the IRS, in addition to the exemptions for Indian status, members of health care sharing

ministries, and incarceration. However, to minimize potential consumer confusion, we opted only to streamline the exemptions process and not to expand the scope of exemptions that the IRS may grant.

We propose issuing hardship exemptions when a consumer shows their hardship is ongoing at the time of application. Hardship exemptions are issued for months within the current calendar year plus the next, plus the months before and after the hardship ends. When consumers approach the Exchange near the end of the calendar year, we typically can only grant them a hardship exemption for a few months. We believe the current approach may not give consumers sufficient time to seek coverage before their hardship exemption expires, and therefore proposed extending the length of the hardship exemption. Many enrollees eligible for a hardship exemption are currently facing significant life disruptions, and may need more time to find coverage.

For employer choice in the FF-SHOPs, we considered offering an additional employer choice option that would permit an employer to select an actuarial value level of coverage, after which employees could choose from plans available at that level and at the level above it. Recognizing that small group market dynamics differ by State, we decided to seek comment on, but not propose this option at this time. We also considered requiring all SHOPs to offer these additional employer choice options, but instead opted to maintain State-based SHOPs' flexibility under the current regulations, so that States can decide whether implementing additional employer choice options would be in the best interest of small group market consumers in their State.

We considered requiring QHP issuers to offer standardized options as a condition of participation in the FFEs. However, we believe that markets and Exchanges may be at different

stages of readiness for standardized options, and that the cost-sharing structure that HHS specifies may not be well tailored for all States. Similarly, we believe that some issuers may have difficulty offering standardized options in the short run because of operational constraints.

In developing proposed §156.230, we considered waiting for the NAIC's workgroup to complete its work on drafting a revised model act on network adequacy and not proposing changes to the network adequacy standard for 2017. As discussed in the preamble of the final rule for the HHS Notice of Benefit and Payment Parameters for 2016 (80 FR 10750), HHS had planned to await the results of the NAIC's workgroup to develop a revised model act before proposing significant changes to network adequacy policy. However, since the NAIC workgroup has not completed its work, we have decided to proceed with proposing some concepts from the draft versions of the NAIC model act to strengthen network adequacy requirements, particularly for QHPs being offered in the FFEs. We propose these requirements to ensure certain consumer protections and standards are being provided to enrollees in 2017. As an alternative, we also considered proposing more concepts from the NAIC's drafts of the model act in the area of network adequacy, such as requiring issuers to submit for review and approval an access plan and establishing requirements for what the access plan must include. However, we are cognizant of the burden on issuers to implement many policy changes in one year, especially when these changes affect issuers' QHP certification applications. Therefore, we will continue to monitor the NAIC's workgroup efforts to develop a model act on network adequacy, and will consider whether additional standards will be needed in future years.

In §156.230(f), regarding QHP enrollees in the FFE who receive an EHB from an out-of-network provider in an in-network setting, we considered an alternative under which all cost sharing, regardless of notification, would count towards the in-network annual limitation on cost

sharing, or to accrue at in-network rates. However, we recognize that the issuer often has a limited ability to control the use of out-of-network providers, and are wary of the impact of such a policy on premiums.

In §156.1110, we considered maintaining the current approach of aligning with Medicare hospital Conditions of Participation standards and not establishing further regulations at this time for QHP issuers to collect information, such as hospital participation agreements with PSOs, to comply with new patient safety standards for plan years beginning on or after January 1, 2017. However, we decided to propose the policy in this proposed rule because we believe that strengthening patient safety standards and aligning with current, effective patient safety interventions will achieve greater impact for consumers, in terms of health care quality improvement and harm reduction, resulting in higher quality QHPs being offered in the Exchanges. Additionally, we considered proposing an approach that did not include establishing reasonable exceptions to the requirements for a QHP issuer that contracts with a hospital with greater than 50 beds to utilize a patient safety evaluation system and implement a mechanism for comprehensive person-centered hospital discharges, as described in section 1311(h)(1) of the Affordable Care Act. However, we determined that it is important to support national patient safety efforts, promote evidence-based patient safety interventions and allow for flexibility, innovation, and minimal burden for issuers and hospitals.

E. Regulatory Flexibility Act

The Regulatory Flexibility Act, (5 U.S.C. 601, et seq.), requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the proposed rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The RFA generally defines a “small entity” as

(1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of “small entity.” HHS uses a change in revenues of more than 3 to 5 percent as its measure of significant economic impact on a substantial number of small entities.

In this proposed rule, we propose standards for the risk adjustment, reinsurance, and risk corridors programs, which are intended to stabilize premiums as insurance market reforms are implemented and Exchanges facilitate increased enrollment. Because we believe that insurance firms offering comprehensive health insurance policies generally exceed the size thresholds for “small entities” established by the SBA, we do not believe that an initial regulatory flexibility analysis is required for such firms.

For purposes of the RFA, we expect the following types of entities to be affected by this proposed rule:

- Health insurance issuers.
- Group health plans.

We believe that health insurance issuers and group health plans would be classified under the North American Industry Classification System code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of \$38.5 million or less would be considered small entities for these North American Industry Classification System codes. Issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be \$32.5 million or less.

In this proposed rule, we proposed standards for employers that choose to participate in a SHOP Exchange. The SHOPS are limited by statute to employers with at least one but not more

than 50 employees, unless a State opts to provide that employers with from 1 to 100 employees are “small employers.” For this reason, we expect that many employers who would be affected by the proposals would meet the SBA standard for small entities. We do not believe that the proposals impose requirements on employers offering health insurance through a SHOP that are more restrictive than the current requirements on small businesses offering employer sponsored insurance. We believe the processes that we have established constitute the minimum amount of requirements necessary to implement the SHOP program and accomplish our policy goals, and that no appropriate regulatory alternatives could be developed to further lessen the compliance burden.

We believe that a substantial number of sponsors of self-insured group health plans could qualify as “small entities.” This proposed rule provides HHS with the authority to audit these entities. However, we do not believe that the burden of these audits is likely to reflect more than 3 to 5 percent of such an entity’s revenues.

Some of the entities that voluntarily act as Navigators and non-Navigator assistance personnel subject to §155.215, or as designated certified application counselor organizations, might be small entities and could incur costs to comply with the provisions of this proposed rule. It should be noted that HHS, in its role as the operator of the FFEs, does not impose any fees on these entities for participating in their respective programs, nor are there fees for taking the Federally required training or completing continuing education or recertification in FFEs. The cost burden related to our proposals about reaching vulnerable and underserved populations and providing post-enrollment and other assistance would apply to Navigators in all Exchanges. The costs associated with these proposals would generally be considered an allowable cost that would be covered by the Navigator grants for the FFEs, and these grant funds may be drawn down as

the grantee incurs such costs. Depending upon applicable State law and how States with State Exchanges implement their Navigator grant programs, the same might be true in those States. Though it is very likely that many costs associated with these proposals would be covered by affected entities' and individuals' funding sources, HHS cannot guarantee that all such costs would be covered because of the possibility of budget limitations applicable to the FFEs in any given period, and because there may be variations in how State Exchanges implement their Navigator grant programs.

The costs related to the proposed reporting requirement for designated certified application counselor organizations would be borne by those organizations, which do not receive funding from Exchanges for these services. The costs incurred by designated certified application counselor organizations for the reporting of performance metrics are expected to be low.

Based on data from MLR annual report submissions for the 2014 MLR reporting year, approximately 118 out of 525 issuers of health insurance coverage nationwide had total premium revenue of \$38.5 million or less. This estimate may overstate the actual number of small health insurance companies that may be affected, since almost 80 percent of these small companies belong to larger holding groups, and many if not all of these small companies are likely to have non-health lines of business that would result in their revenues exceeding \$38.5 million. Only seven of these 118 potentially small entities, all of them part of larger holding groups, are estimated to experience an increase or decrease in the rebate amount under the proposed amendments to the MLR provisions of this proposed rule in part 158, including one entity that did not owe a rebate for the 2014 reporting year. Two additional entities may experience a small (less than 2.5 percent) change in their risk corridors payments and charges under the MLR

provisions of this proposed rule. Based on data from the 2014 MLR and risk corridors annual report submissions, 20 of these 118 potentially small entities had risk corridors payments or charges for the 2014 benefit year. Only one of these entities is estimated to experience a decrease in its risk corridors payment under the proposed provisions in §153.530(b)(2)(iv), with no impact on its rebate liability. Therefore, we do not expect the proposed provisions of this rule to affect a substantial number of small entities.

F. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a proposed rule that includes any Federal mandate that may result in expenditures in any 1 year by a State, local, or Tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In 2015, that threshold is approximately \$144 million. Although we have not been able to quantify all costs, the combined administrative cost and user fee impact on State, local, or Tribal governments and the private sector may be above the threshold. Earlier portions of this RIA constitute our UMRA analysis.

G. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications. Because States have flexibility in designing their Exchange and Exchange-related programs, State decisions will ultimately influence both administrative expenses and overall premiums. States are not required to establish an Exchange or risk adjustment or reinsurance program. For States electing to operate an Exchange, risk adjustment or reinsurance program, much of the initial cost of creating these

programs will be funded by Exchange Planning and Establishment Grants. After establishment, Exchanges will be financially self-sustaining, with revenue sources at the discretion of the State. Current State Exchanges charge user fees to issuers.

In HHS's view, while this proposed rule would not impose substantial direct requirement costs on State and local governments, this regulation has Federalism implications due to direct effects on the distribution of power and responsibilities among the State and Federal governments relating to determining standards relating to health insurance that is offered in the individual and small group markets. For example, our proposal permitting a State to elect to utilize the Federal platform for enrollment and eligibility services may make certain SBEs more economically feasible, providing more options for States seeking to exercise the right to establish and operate an Exchange. However, HHS anticipates that the Federalism implications (if any) are substantially mitigated because under the statute, States have choices regarding the structure and governance of their Exchanges and risk adjustment and reinsurance programs. Additionally, the Affordable Care Act does not require States to establish these programs; if a State elects not to establish any of these programs or is not approved to do so, HHS must establish and operate the programs in that State.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policy making discretion of the States, HHS has engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners, and consulting with State insurance officials on an individual basis.

While developing this proposed rule, HHS has attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide access to Affordable Insurance Exchanges for consumers in every State. By doing so, it is HHS's view that we have complied with the requirements of Executive Order 13132.

States will continue to license, monitor, and regulate agents and brokers, both inside and outside of Exchanges. All State laws related to agents and brokers, including State laws related to appointments, contractual relationships with issuers, licensing, marketing, conduct, and fraud will continue to apply.

H. Congressional Review Act

This proposed rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801, *et seq.*), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller for review.

List of Subjects

45 CFR Parts 144, 146, and 147

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 153

Administrative practice and procedure, Health care, Health insurance, Health records, Organization and functions (Government agencies), Reporting and recordkeeping requirements.

45 CFR Part 154

Administrative practice and procedure, Claims, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 155

Administrative practice and procedure, Health care, Health insurance, Reporting and recordkeeping requirements, State and local governments

45 CFR Part 156

Administrative practice and procedure, Advertising, American Indian/Alaska Natives, Conflict of interest, Consumer protection, Cost-sharing reductions, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Individuals with disabilities, Loan programs-health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, Youth.

45 CFR Part 158

Administrative practice and procedure, Claims, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Department of Health and Human Services proposes to amend 45 CFR parts 144, 146, 147, 150, 153, 154, 155, 156, and 158 as set forth below.

PART 144 – REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

1. The authority citation for part 144 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92.

2. Section 144.103 is amended by revising paragraph (1) of the definition of “Excepted benefits” and revising the definitions of “Large employer” and “Small employer” to read as follows:

§144.103 Definitions.

* * * * *

Excepted benefits * * *

(1) Group market provisions in 45 CFR part 146, subpart D, is defined in 45 CFR 146.145(b); and

* * * * *

Large employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. A State may elect to define large employer by substituting “101 employees” for “51 employees.” In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a large employer is

based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

* * * * *

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. A State may elect to define small employer by substituting “100 employees” for “50 employees.” In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

* * * * *

PART 146 – REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

3. The authority citation for part 146 continues to read as follows:

Authority: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg-1 through 300gg-5, 300gg-11 through 300gg-23, 300gg-91, and 300gg-92).

4. Section 146.150 is amended by--

a. In paragraph (a) introductory text, removing the reference “paragraphs (c) through (f)” and adding in its place the reference “paragraphs (c) through (g)”.

b. Adding paragraph (g).

The addition reads as follows:

§146.150 Guaranteed availability of coverage for employers in the small group market.

* * * * *

(g) Exception for discontinuing a particular product or all coverage. (1) If an issuer decides to discontinue offering a particular product or all coverage in the small group market in accordance with §146.152, the issuer may between the time of providing the relevant notice and discontinuing the coverage --

(i) Deny health insurance coverage in that product when the exception to guaranteed renewability of coverage related to discontinuing the particular product under §146.152(c) applies.

(ii) Deny health insurance coverage in the small group market when the exception to guaranteed renewability of coverage related to discontinuing all coverage under §146.152(d) applies.

(2) An issuer that denies coverage under this paragraph (g) must apply paragraph (g)(1) of this section uniformly to all small employers in the State consistent with applicable State law and without regard to the claims experience or any health-status related factor relating to those employers and their employees (or their respective dependents).

(3) Nothing in this paragraph (g) relieves an issuer of its obligations with respect to existing policyholders, such as enrolling dependents under an applicable special enrollment period.

* * * * *

PART 147 – HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

5. The authority citation for part 147 continues to read as follows:

Authority: Secs 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 USC 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

6. Section 147.102 is amended by revising paragraph (a)(1)(ii) to read as follows:

§147.102 Fair health insurance premiums.

(a) * * *

(1) * * *

(ii) Rating area, as established in accordance with paragraph (b) of this section. For purposes of this paragraph (a), rating area is determined—

(A) In the individual market, using the primary policyholder's address.

(B) In the small group market, using the group policyholder's principal business address.

For purposes of this paragraph, principal business address means the principal business address registered with the State or, if a principal business address is not registered with the State, or is registered solely for purposes of service of process and is not a substantial worksite for the employer's business, the business address within the State where the greatest number of employees of such employer works. If, for a network plan, the group policyholder's principal business address is not within the service area of such plan, and the policyholder has employees who live, reside, or work within the service area, the principal business address for purposes of the network plan is deemed to be the business address within the plan's service area where the greatest number of employees work as of the beginning of the plan year. If there is no such business address, the principal business address for purposes of the network plan is deemed to be an address within the rating area selected by the employer that reasonably reflects where the greatest number of employees within the plan's service area live or reside as of the beginning of the plan year.

* * * * *

7. Section 147.104 is amended by--

- a. In paragraph (a), removing the reference “paragraphs (b) through (d)” and adding in its place the reference “paragraphs (b) thorough (e)”.
- b. Redesignating paragraphs (e) through (i) as paragraphs (f) through (j), respectively.
- c. Adding paragraph (e).

The addition reads as follows:

§147.104 Guaranteed availability of coverage.

* * * * *

(e) Exception for discontinuing a particular product or all coverage. (1) If an issuer decides to discontinue offering a particular product or all coverage in the large group, small group, or individual market in accordance with §147.106, the issuer may between the time of providing the relevant notice and discontinuing the coverage--

(i) Deny health insurance coverage in that product when the exception to guaranteed renewability of coverage related to discontinuing the particular product under §147.106(c) applies.

(ii) Deny health insurance coverage in that market when the exception to guaranteed renewability of coverage related to discontinuing all coverage under §147.106(d) applies.

(2) An issuer that denies coverage under this paragraph (e) must apply paragraph (e)(1) of this section uniformly to all employers or individuals in the large group, small group, or individual market, as applicable, in the State consistent with applicable State law and without regard to the claims experience or any health-status related factor relating to those individuals or employers and their employees (or their respective dependents).

(3) Nothing in this paragraph (e) relieves an issuer from any of its obligations with respect to existing policyholders, such as enrolling dependents under an applicable special enrollment period.

* * * *

8. Section 147.145 is amended by revising paragraph (b)(3) and adding paragraph (b)(4) to read as follows:

§147.145 Student health insurance coverage.

* * * *

(b) * * *

(3) Single risk pool. For plan years beginning on or after January 1, 2017, student health insurance coverage is subject to the index rating provisions of §156.80(d) of this subchapter. For purposes of the preceding sentence, a health insurance issuer that offers student health insurance coverage may establish one or more separate risk pools for each institution of higher education, if the distinction between or among groups of students (or dependents of students) who form the risk pool is based on a bona fide school-related classification and not based on a health factor as described in §146.121 of this subchapter.

(4) Levels of coverage. The requirement to provide a specific level of coverage described in section 1302(d) of the Affordable Care Act does not apply to student health insurance coverage for plan years beginning on or after January 1, 2017. However, the benefits provided by such coverage must provide at least 60 percent actuarial value, as certified by a member of the American Academy of Actuaries using generally accepted actuarial principles.

* * * *

**PART 153 – STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND
RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT**

9. The authority citation for part 153 continues to read as follows:

Authority: Secs. 1311, 1321, 1341–1343, Pub. L. 111–148, 24 Stat. 119.

10. Section 153.405 is amended by revising paragraph (i) to read as follows:

§153.405 Calculation of reinsurance contributions.

* * * * *

(i) Audits. HHS or its designee may audit a contributing entity to assess its compliance with the requirements of this subpart. HHS or its designee may audit a third party administrator, administrative services-only contractor, or other third party who assists a contributing entity with its obligations under this subpart to assess compliance with the requirements of this subpart. A contributing entity that chooses to use a third party administrator, administrative services-only contractor, or other third party to assist with its obligations under this subpart must ensure that the third party administrator, administrative services-only contractor, or other third party cooperate with any audit under this section.

11. Section 153.510 is amended by adding paragraph (g) to read as follows:

§153.510 Risk corridors establishment and payment methodology.

* * * * *

(g) Adjustment to risk corridors payments and charges. If an issuer reported a certified estimate of 2014 cost-sharing reductions on its 2014 MLR and Risk Corridors Annual Reporting Form that is lower than the actual value of cost-sharing reductions calculated under §156.430(c) of this subchapter for the 2014 benefit year, HHS will make an adjustment to the amount of the issuer's 2015 benefit year risk corridors payment or charge measured by the full difference

between the certified estimate of 2014 cost-sharing reductions reported and the actual value of cost-sharing reductions provided as calculated under §156.430(c) for the 2014 benefit year.

12. Section 153.530 is amended by revising paragraphs (b)(2)(ii) and (iii) and adding paragraph (b)(2)(iv) to read as follows:

§153.530 Risk corridors data requirements.

* * * * *

(b) * * *

(2) * * *

(ii) Any reinsurance payments received by the issuer for the non-grandfathered health plans under the transitional reinsurance program established under subpart C of this part;

(iii) A cost-sharing reduction amount equal to the amount of cost-sharing reductions for the benefit year as calculated under §156.430(c) of this subchapter, to the extent not reimbursed to the provider furnishing the item or service.

(iv) For the 2015 and later benefit years, any difference between—

(A) The sum of unpaid claims reserves and claims incurred but not reported, as set forth in §§158.103 and 158.140(a)(2) and (3) of this subchapter, that were reported on the MLR and Risk Corridors Annual Reporting Form for the year preceding the benefit year; and

(B) The actual claims incurred during the year preceding the benefit year and paid between the valuation date of the unpaid claims reserves and liabilities described above and June 30 of the year following the benefit year.

* * * * *

13. Section 153.710 is amended by--

a. Removing paragraph (d).

- b. Redesignating paragraphs (e) and (f) as paragraphs (d) and (e), respectively.
- c. Revising newly redesignated paragraph (e).
- d. Adding paragraph (f).
- e. Revising paragraphs (g) introductory text, (g)(1) introductory text, (g)(1)(iii) and (iv), and (g)(2).
- f. Adding paragraph (g)(3).

The revisions and additions read as follows:

§153.710 Data requirements.

* * * * *

(e) Unresolved discrepancies. If a discrepancy first identified in a final dedicated distributed data environment report in accordance with paragraph (d)(2) of this section remains unresolved after the issuance of the notification of risk adjustment payments and charges or reinsurance payments under §153.310(e) or §153.240(b)(1)(ii), respectively, an issuer of a risk adjustment covered plan or reinsurance-eligible plan may make a request for reconsideration regarding such discrepancy under the process set forth in §156.1220(a) of this subchapter.

(f) Data sufficiency. If an issuer of a risk adjustment covered plan fails to provide sufficient required data, such that HHS cannot apply the applicable methodology to calculate the risk adjustment payment transfer amount for the risk adjustment covered plan in a timely or appropriate fashion, then HHS will assess a default risk adjustment charge under §153.740(b). A default charge will be assessed under this paragraph no later than the date of the notification provided by HHS under §153.310(e). If an issuer of a reinsurance eligible plan fails to provide data sufficient for HHS to calculate reinsurance payments, the issuer will forfeit reinsurance payments for claims it fails to submit.

(1) Data quantity. An issuer of a risk adjustment covered plan or a reinsurance-eligible plan must provide, in a format and on a timeline specified by HHS, data on its total enrollment and claims counts by market, which HHS may use in evaluating whether the issuer provided access in the dedicated distributed data environment to a sufficient quantity of data to meet reinsurance and risk adjustment data requirements.

(2) Data quality. If, following the deadline for submission of data specified in §153.730, HHS identifies an anomaly that would cause the data that a risk adjustment covered plan or a reinsurance-eligible plan made available through a dedicated data environment to fail HHS's data quality thresholds, the issuer may, within 10 calendar days of receiving notification of the anomaly, submit an explanation of the anomaly for HHS to consider in determining whether the issuer met the reinsurance and risk adjustment data requirements.

(g) Risk corridors and MLR reporting. Except as provided in paragraph (g)(3) of this section:

(1) Notwithstanding any discrepancy report made under paragraph (d)(2) of this section, or any request for reconsideration under §156.1220(a) of this subchapter with respect to any risk adjustment payment or charge, including an assessment of risk adjustment user fees; reinsurance payment; cost-sharing reduction payment or charge; or risk corridors payment or charge, unless the dispute has been resolved, an issuer must report, for purposes of the risk corridors and MLR programs:

* * * * *

(iii) A cost-sharing reduction amount equal to the actual amount of cost-sharing reductions for the benefit year as calculated under §156.430(c) of this subchapter, to the extent not reimbursed to the provider furnishing the item or service; and

(iv) For medical loss ratio reporting only, the risk corridors payment to be made or charge assessed by HHS under §153.510.

(2) An issuer must report any adjustment made or approved by HHS for any risk adjustment payment or charge, including an assessment of risk adjustment user fees; any reinsurance payment; any cost-sharing reduction payment or charge; or any risk corridors payment or charge; where such adjustment has not be accounted for in a prior MLR and Risk Corridor Annual Reporting Form, in the MLR and Risk Corridors Annual Reporting Form for the following reporting year.

(3) In cases where HHS reasonably determines that the reporting instructions in paragraph (g)(1) or (2) of this section would lead to unfair or misleading financial reporting, issuers must mitigate or correct their data submissions in a form and manner to be specified by HHS.

PART 154 – HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS

14. The authority citation for part 154 continues to read as follows:

Authority: Section 2794 of the Public Health Service Act (42 USC 300gg-94).

15. Section 154.200 is amended by revising paragraph (c)(2) to read as follows:

§154.200 Rate increases subject to review.

* * * * *

(c) * * *

(2) For rates filed for single risk pool coverage beginning on or after January 1, 2017, the average increase, including premium rating factors described in §147.102 of this subchapter,

for all enrollees weighted by premium volume for any plan within the product meets or exceeds the applicable threshold.

* * * *

16. Section 154.215 is amended by revising paragraphs (a) and (b) introductory text and removing and reserving paragraph (c) to read as follows:

§154.215 Submission of rate filing justification.

(a) A health insurance issuer must submit to CMS and to the applicable State (if the State accepts such submissions) the information specified below on a form and in a manner prescribed by the Secretary.

(1) For all single risk pool coverage products, including new and discontinuing products, the Unified Rate Review Template, as described in paragraph (d) of this section;

(2) For each single risk pool coverage product that includes a plan that is subject to a rate increase, regardless of the size of the increase, the Unified Rate Review Template and Actuarial Memorandum, as described in paragraph (f) of this section;

(3) For each single risk pool coverage product that includes a plan with a rate increase that is subject to review under §154.210, all parts of the Rate Filing Justification, as described in paragraph (b) of this section

(b) A Rate Filing Justification includes one or more of the following:

* * * *

(c) [Reserved]

* * * *

17. Section 154.220 is amended by revising the introductory text and paragraphs (b) introductory text and (b)(1) to read as follows:

§154.220 Timing of providing the rate filing justification.

A health insurance issuer must submit applicable sections of the Rate Filing Justification for all single risk pool coverage in the individual or small group market, as follows:

* * * * *

(b) For coverage effective on or after January 1, 2017, by the earlier of the following:

(1) The date by which the State requires submission of a rate filing; or

* * * * *

18. Section 154.230 is amended by revising paragraph (c)(2)(i) to read as follows:

§154.230 Submission and posting of Final Justifications for unreasonable rate increases.

* * * * *

(c) * * *

(2) * * *

(i) The information made available to the public by CMS and described in §154.215(h).

* * * * *

PART 155 – EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

19. The authority citation for part 155 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1332, 1334, 1402, 1411, 1412, 1413, Pub. L. 111-148, 124 Stat. 119 (42 U.S.C. 18021-18024, 18031-18033, 18041-18042, 18051, 18054, 18071, and 18081-18083).

20. Section 155.20 is amended by—

a. In the definition of “Applicant”, revising paragraph (2).

- b. Adding the definition of “Federal platform agreement” in alphabetical order.
- c. Revising the definitions of “Large employer” and “Small employer”.

The addition and revisions read as follows:

§155.20 Definitions.

* * * * *

Applicant * * *

(2) For SHOP:

(i) An employer seeking eligibility to purchase coverage through the SHOP; or

(ii) An employer, employee, or a former employee seeking eligibility for enrollment in a QHP through the SHOP for himself or herself and, if the qualified employer offers dependent coverage through the SHOP, seeking eligibility to enroll his or her dependents in a QHP through the SHOP.

* * * * *

Federal platform agreement means an agreement between a State Exchange and HHS under which a State Exchange elects to rely on the Federal platform to carry out select Exchange functions.

* * * * *

Large employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a large employer is based on the average number of employees that it is reasonably expected the employer will employ on

business days in the current calendar year. A State may elect to define large employer by substituting “101 employees” for “51 employees.” The number of employees must be determined using the method set forth in section 4980H(c)(2) of the Code.

* * * * *

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. A State may elect to define small employer by substituting “100 employees” for “50 employees.” The number of employees must be determined using the method set forth in section 4980H(c)(2) of the Code.

* * * * *

21. Section 155.106 is amended by--

- a Revising paragraphs (a) introductory text, (a)(2) and (3), and (b) introductory text.
- b. Adding paragraphs (a)(4), (a)(5), and (c).

The revisions and additions read as follows:

§155.106 Election to operate an Exchange after 2014.

(a) Election to operate an Exchange. Except as provided in paragraph (c) of this section, a State electing to seek approval of its Exchange must:

* * * * *

(2) Submit an Exchange Blueprint application for HHS approval at least 15 months prior to the date on which the Exchange proposes to begin open enrollment as a State Exchange;

(3) Have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment at least 14 months prior to the date on which the Exchange proposes to begin open enrollment as a State Exchange;

(4) Develop a plan jointly with HHS to facilitate the transition to a State Exchange; and

(5) If the open enrollment period for the year the State intends to begin operating an SBE has not been established, this deadline must be calculated based on the date open enrollment began or will begin in the year in which the State is submitting the Blueprint application.

(b) Transition process for State Exchanges that cease operations. If a State intends to cease operation of its Exchange, HHS will operate the Exchange on behalf of the State.

Therefore, a State that intends to cease operations of its Exchange must:

* * * * *

(c) Process for State Exchanges that seek to utilize the Federal platform for select functions. A State seeking approval as a State Exchange utilizing the Federal platform to support select functions through a Federal platform agreement under §155.200(f) must:

(1) If the State Exchange does not have a conditionally approved Exchange Blueprint application, submit one for HHS approval at least 3 months prior to the date on which the Exchange proposes to begin open enrollment as an SBE-FP;

(2) If the State Exchange has a conditionally approved Exchange Blueprint application, submit any significant changes to that application for HHS approval, in accordance with §155.105(e), at least 3 months prior to the date on which the Exchange proposes to begin open enrollment as an SBE-FP;

(3) Have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment at least 2 months prior to the date on which the Exchange proposes to begin open enrollment as an SBE-FP, in accordance with HHS rules, as a State Exchange utilizing the Federal platform;

(4) Upon approval, or conditional approval, of the Exchange Blueprint, execute a Federal platform agreement prior to the start of the open enrollment period for which the State Exchange desires to begin utilizing the Federal platform; and

(5) Coordinate with HHS on a transition plan to be developed jointly between HHS and the State.

22. Section 155.170 is amended by revising paragraphs (a)(2), (a)(3), and (c)(2)(iii) to read as follows:

§155.170 Additional required benefits.

(a) * * *

(2) A benefit required by State action taking place on or before December 31, 2011 is considered an EHB. A benefit required by State action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, is considered in addition to the essential health benefits.

(3) The State will identify which State-required benefits are in addition to the EHB.

* * * *

(c) * * *

(2) * * *

(iii) Reported to the State.

23. Section 155.200 is amended by revising paragraph (a) and adding paragraph (f) to read as follows:

§155.200 Functions of an Exchange.

(a) General requirements. An Exchange must perform the functions described in this subpart and in subparts D, E, F, G, H, K, M, and O of this part unless the State is approved to operate only a SHOP by HHS under §155.100(a)(2), in which case the Exchange operated by the State must perform the functions described in subpart H of this part and all applicable provisions of other subparts referenced in that subpart. In a State that is approved to operate only a SHOP, the individual market Exchange operated by HHS in that State will perform the functions described in this subpart and in subparts D, E, F, G, K, M, and O of this part.

* * * * *

(f) Requirements for State Exchanges on the Federal platform. (1) A State that receives approval or conditional approval to operate a State Exchange on the Federal platform under §155.106(c) may meet its obligations under paragraph (a) of this section by relying on Federal services that the Federal government agrees to provide under a Federal platform agreement.

(2) A State Exchange on the Federal platform must establish and oversee requirements for its issuers that are no less strict than the following requirements that are applied to Federally-facilitated Exchange issuers:

- (i) Data submission requirements under §156.122(d)(2) of this subchapter;
- (ii) Network adequacy standards under §156.230 of this subchapter;
- (iii) Essential community providers standards under §156.235 of this subchapter;
- (iv) Meaningful difference standards under §156.298 of this subchapter;
- (v) Changes of ownership of issuers requirements under §156.330 of this subchapter;

(vi) QHP issuer compliance and compliance of delegated or downstream entities requirements under §156.340(a)(4) of this subchapter; and

(vii) Casework requirements under §156.1010 of this subchapter.

(3) If a State is not substantially enforcing any requirement listed under §155.200(f)(2) of this subchapter with respect to a QHP issuer or plan in a State-based Exchange on the Federal platform, HHS may enforce that requirement directly against the issuer or plan by means of plan suppression under §156.815 of this subchapter.

24. Section 155.205 is amended by--

a. Revising paragraphs (a) and (d)(1).

b. Adding paragraph (b)(7).

The addition and revisions read as follows:

§155.205 Consumer assistance tools and programs of an Exchange.

(a) Call center. The Exchange must provide for operation of a toll-free call center that addresses the needs of consumers requesting assistance and meets the requirements outlined in paragraphs (c)(1), (c)(2)(i), and (c)(3) of this section, unless it enters into a Federal platform agreement through which it relies on HHS to carry out call center functions, in which case the Exchange must provide at a minimum a toll-free telephone hotline to respond to requests for assistance.

(b) * * *

(7) A State-based Exchange on the Federal platform must at a minimum maintain an informational Internet Web site.

* * * *

(d) * * *

(1) The Exchange must have a consumer assistance function that meets the standards in paragraph (c) of this section, including the Navigator program described in §155.210. Any individual providing such consumer assistance must be trained regarding QHP options, insurance affordability programs, eligibility, and benefits rules and regulations governing all insurance affordability programs operated in the State, as implemented in the State, prior to providing such assistance or the outreach and education activities specified in paragraph (e) of this section.

* * * * *

25. Section 155.210 is amended by--

- a. Revising paragraphs (b)(2)(iii) and (iv).
- b. Adding paragraphs (b)(2)(v), (vi), (vii), and (viii).
- c. Revising paragraph (d)(6).
- d. In paragraph (e)(7), removing the period at the end of the paragraph and adding a semicolon in its place.
- e. Adding paragraphs (e)(8) and (9).

The revisions and additions read as follows:

§155.210 Navigator program standards.

* * * * *

(b) * * *

(2) * * *

(iii) The range of QHP options and insurance affordability programs;

(iv) The privacy and security standards applicable under §155.260;

(v) The process of filing Exchange eligibility appeals;

(vi) General concepts regarding exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment, including the application process for exemptions granted through the Exchange, and IRS resources on exemptions;

(vii) The Exchange-related components of the premium tax credit reconciliation process and IRS resources on this process; and

(viii) Basic concepts related to health coverage and how to use it.

* * * * *

(d) * * *

(6) Provide to an applicant or potential enrollee gifts of any value as an inducement for enrollment. The value of gifts provided to applicants and potential enrollees for purposes other than as an inducement for enrollment must not exceed nominal value, either individually or in the aggregate, when provided to that individual during a single encounter. For purposes of this paragraph (d)(6), the term gifts includes gift items, gift cards, cash cards, cash, and promotional items that market or promote the products or services of a third party, but does not include the reimbursement of legitimate expenses incurred by a consumer in an effort to receive Exchange application assistance, such as travel or postage expenses.

* * * * *

(e) * * *

(8) Provide targeted assistance to serve underserved or vulnerable populations, as identified by the Exchange, within the Exchange service area.

(i) In a Federally-facilitated Exchange, this paragraph (e)(8) will apply beginning with the Navigator grant application process for Navigator grants awarded in 2018. The Federally-

facilitated Exchange will identify populations as vulnerable or underserved that are disproportionately without access to coverage or care, or that are at a greater risk for poor health outcomes, in the funding opportunity announcement for its Navigator grants, and applicants for those grants will have an opportunity to propose additional vulnerable or underserved populations in their applications for the Federally-facilitated Exchange's approval.

(ii) [Reserved]

(9) Provide information and assistance with—

(i) The process of filing Exchange eligibility appeals;

(ii) Understanding and applying for exemptions from the individual shared responsibility requirement that are granted through the Exchange, understanding the availability of exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment that are claimed through the tax filing process and how to apply for them, and understanding the availability of IRS resources on this topic;

(iii) Understanding the Exchange-related components of the premium tax credit reconciliation process, and the availability of IRS resources on this process;

(iv) Understanding basic concepts related to health coverage and how to use it; and

(v) Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Exchange application and enrollment process, exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility requirement, and premium tax credit reconciliations.

* * * * *

26. Section 155.215 is amended by revising paragraph (b)(1)(i) to read as follows:

§155.215 Standards applicable to Navigators and Non-Navigator Assistance Personnel carrying out consumer assistance functions under §§155.205(d) and (e) and 155.210 in a Federally-facilitated Exchange and to Non-Navigator Assistance Personnel funded through an Exchange Establishment Grant.

* * * *

(b) * *

(1) * *

(i) Obtain certification by the Exchange prior to carrying out any consumer assistance functions or outreach and education activities under §155.205(d) and (e) or §155.210;

* * * *

27. Section 155.220 is amended by--

- a. Revising paragraph (c)(1), (f)(4), (g)(2)(ii), (g)(3), and (g)(4);
- b. Adding paragraphs (g)(5), (j), (k), and (l).

The revisions and additions read as follows:

§155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

* * * *

(c) * *

(1) The agent or broker ensures the applicant's completion of an eligibility verification and enrollment application through the Exchange Internet Web site or an Exchange approved web service using the FFE single streamline application;

* * * *

(f) * *

(4) When termination of the agreement between the agent or broker and the Exchange under paragraph (d) of this section becomes effective under paragraph (f) of this section, the agent or broker will no longer be registered with the Federally-facilitated Exchanges, or be permitted to assist with or facilitate enrollment of qualified individuals, qualified employers or qualified employees in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. The agent's or broker's agreement with the Exchange under §155.260(b) will also be terminated through the termination for cause process set forth in that agreement. The agent or broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with the Federally-facilitated Exchange.

(g) * * *

(2) * * *

(ii) Any term or condition of the agreement with the Federally-facilitated Exchange required under paragraph (d) of this section, or any term or condition of the agreement with the Federally-facilitated Exchange required under §155.260(b);

* * * * *

(3) HHS will notify the agent or broker of the specific finding of noncompliance or pattern of noncompliance made under paragraph (g)(1) of this section, and after 30 days from the date of the notice, may terminate the agreement for cause if the matter is not resolved to the satisfaction of HHS.

(4) After the period in paragraph (g)(3) of this section has elapsed and the agreement under paragraph (d) of this section is terminated, the agent or broker will no longer be registered

with the Federally-facilitated Exchanges, or be permitted to assist with or facilitate enrollment of a qualified individual, qualified employer, or qualified employee in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. The agent's or broker's agreement with the Exchange under §155.260(b) will also be terminated through the process set forth in that agreement. The agent or broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with a Federally-facilitated Exchange.

(5) In cases involving potential fraud or abusive conduct —

(i)(A) If HHS reasonably suspects that an agent or broker may have engaged in fraud or abusive conduct using personally identifiable information of an Exchange enrollee or applicant, or in connection with an Exchange enrollment or application, HHS may temporarily suspend the agent's or broker's agreements required under paragraph (d) of this section and under §155.260(b) for up to 90 calendar days. The suspension will be effective starting on the date of the notice that HHS sends to the agent or broker advising of the suspension under this paragraph (g)(5)(i).

(B) The agent or broker may submit evidence in a form and manner to be specified by HHS, to rebut the allegation during this 90-day period. If the agent or broker fails to submit such evidence during the suspension period, HHS may terminate the agent's or broker's agreements required under paragraph (d) of this section and under §155.260(b) for cause under paragraph (g)(5)(ii) of this section.

(ii) If HHS reasonably confirms the credibility of an allegation that an agent or broker engaged in fraud or abusive conduct (or is notified by a State or law enforcement authority of the

State or law enforcement authority's finding or determination of fraud or behavior that would constitute abusive conduct) using personally identifiable information of Exchange enrollees or applicants, or in connection with an Exchange enrollment or application, HHS will terminate the agent's or broker's agreements required under paragraph (d) of this section and under §155.260(b) for cause. The termination will be effective starting on the date of the notice that HHS sends to the agent or broker advising of the termination of the agreements under this paragraph (g)(5)(ii).

(iii) During the suspension period under paragraph (g)(5)(i) of this section and following termination of the agreements under paragraph (g)(5)(ii) of this section, the agent or broker will not be registered with the Federally-facilitated Exchanges, or be permitted to assist with or facilitate enrollment of qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. In the case of termination under paragraph (g)(5)(ii) of this section, the agent's or broker's agreement with the Exchange under §155.260(b) will also be terminated as of the date of the notice. The agent or broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with a Federally-facilitated Exchange.

* * * * *

(j) Federally-facilitated Exchange standards of conduct. (1) An agent or broker that assists with or facilitates enrollment of qualified individuals, qualified employers, or qualified employees, in coverage in a manner that constitutes enrollment through a Federally-facilitated

Exchange, or assists individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs sold through a Federally-facilitated Exchange, must—

(i) Have executed the required agreement under paragraph §155.260(b);

(ii) Be registered with the Federally-facilitated Exchanges under paragraph (d)(1) of this section; and

(iii) Comply with the standards of conduct in paragraph (j)(2) of this section.

(2) Standards of conduct. An individual or entity described in paragraph (j)(1) of this section must –

(i) Provide consumers with correct information, without omission of material fact, regarding the Federally-facilitated Exchanges, QHPs offered through the Federally-facilitated Exchanges, and insurance affordability programs, and refrain from marketing or conduct that is misleading or coercive, or discriminates based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation;

(ii) Provide the Federally-facilitated Exchanges with correct information under section 1411(b) of the Affordable Care Act;

(iii) Obtain the consent of the individual, employer, or employee prior to assisting with or facilitating enrollment through a Federally-facilitated Exchange, or assisting the individual in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs;

(iv) Protect consumer personally identifiable information according to §155.260(b)(3) and the agreement described in §155.260(b)(2); and

(v) Comply with all applicable Federal and State laws and regulations.

(3) An agent or broker will be considered to be in compliance with paragraphs (j)(2)(i) and (ii) of this section if HHS determines that there was a reasonable cause for the failure to provide correct information and that the agent or broker acted in good faith.

(k) Penalties other than termination of the agreement with the Federally-facilitated Exchanges. (1) If HHS determines that an agent or broker has failed to comply with the requirements of this section, in addition to any other available remedies, that agent or broker—

(i) May be denied the right to enter into agreements with the Federally-facilitated Exchanges in future years; and

(ii) May be subject to civil money penalties as described in §155.285.

(2) HHS will notify the agent or broker of the proposed imposition of penalties under paragraph (k)(1)(i) of this section and, after 30 calendar days from the date of the notice, may impose the penalty if the agent or broker has not requested a reconsideration under paragraph (h) of this section. The proposed imposition of penalties under paragraph (k)(1)(ii) of this section will follow the process outlined under §155.285.

(l) Application to State-Based Exchanges using a Federal platform. An agent or broker who enrolls qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through an State-Based Exchange using a Federal platform, or assists individual market consumers with submission of applications for advance payments of the premium tax credit and cost-sharing reductions through an State-Based Exchange using a Federal platform must comply with all applicable Federally-facilitated Exchange standards in this section.

28. Section 155.222 is amended by--

a. Revising the section heading.

- b. Revising paragraphs (a)(1), (a)(2), (b)(1) through (5), and (d).
- c. Adding paragraph (b)(6).

The revisions and addition read as follows:

§155.222 Standards for HHS-approved vendors of Federally-facilitated Exchange training for agents and brokers.

(a) * * *

(1) A vendor must be approved by HHS, in a form and manner to be determined by HHS, to have its training program recognized for agents and brokers assisting with or facilitating enrollment in individual market or SHOP coverage through the Federally-facilitated Exchanges consistent with §155.220.

(2) As part of the training program, the vendor must require agents and brokers to provide identifying information and successfully complete the required curriculum.

* * * *

(b) * * *

(1) Submit a complete and accurate application by the deadline established by HHS, which includes demonstration of prior experience with successfully conducting online training, as well as providing technical support to a large customer base.

(2) Adhere to HHS specifications for content, format, and delivery of training, which includes offering continuing education units (CEUs) for at least five States in which a Federally-facilitated Exchange or State-Based Exchange using a Federal platform is operating.

(3) Collect, store, and share with HHS training completion data from agent and broker users of the vendor's training in a manner, format, and frequency specified by HHS, and protect

all data from agent and broker users of the vendor's training in accordance with applicable privacy and security requirements.

(4) Execute an agreement with HHS, in a form and manner to be determined by HHS, which requires the vendor to comply with applicable HHS guidelines for implementing the training and interfacing with HHS data systems, and the use of all data collected.

(5) Permit any individual who holds a valid State license or equivalent State authority to sell health insurance products to access the vendor's training.

(6) Provide technical support to agent and broker users of the vendor's training as specified by HHS.

* * * * *

(d) Monitoring. HHS may periodically monitor and audit vendors approved under this subpart, and their records related to the training functions described in this section, to ensure ongoing compliance with the standards in paragraph (b) of this section. If HHS determines that an HHS-approved vendor is not in compliance with the standards required in paragraph (b) of this section, the vendor may be removed from the approved list described in paragraph (c) of this section and may be required by HHS to cease performing the training functions described under this subpart.

* * * * *

29. Section 155.225 is amended by adding paragraph (b)(1)(iii) and revising paragraph (g)(4) to read as follows:

§155.225 Certified application counselors.

* * * * *

(b) * * *

(1) * * *

(iii) Provides data and information to the Exchange regarding the number and performance of its certified application counselors and regarding the consumer assistance provided by its certified application counselors, upon request, in the form and manner specified by the Exchange. Beginning in January 2017, in a Federally-facilitated Exchange, organizations designated by the Exchange must submit monthly reports that include, at a minimum, data regarding the number of individuals who have been certified by the organization; the total number of consumers who received application and enrollment assistance from the organization; and of that number, the number of consumers who received assistance in applying for and selecting a QHP, enrolling in a QHP, or applying for Medicaid or CHIP.

* * * * *

(g) * * *

(4) Provide to an applicant or potential enrollee gifts of any value as an inducement for enrollment. The value of gifts provided to applicants and potential enrollees for purposes other than as an inducement for enrollment must not exceed nominal value, either individually or in the aggregate, when provided to that individual during a single encounter. For purposes of this paragraph (g)(4), the term gifts includes gift items, gift cards, cash cards, cash, and promotional items that market or promote the products or services of a third party, but does not include the reimbursement of legitimate expenses incurred by a consumer in an effort to receive Exchange application assistance, such as travel or postage expenses.

* * * * *

30. Section 155.260 is amended by revising paragraph (a)(1) introductory text to read as follows:

§155.260 Privacy and security of personally identifiable information.

(a) * * *

(1) Where the Exchange creates or collects personally identifiable information for the purposes of determining eligibility for enrollment in a qualified health plan; determining eligibility for other insurance affordability programs, as defined in §155.300; or determining eligibility for exemptions from the individual responsibility provisions in section 5000A of the Code, the Exchange may only use or disclose such personally identifiable information to the extent such information is necessary:

* * * * *

31. Section 155.280 is amended by revising paragraph (a) to read as follows:

§155.280 Oversight and monitoring of privacy and security requirements.

(a) General. HHS will oversee and monitor the Federally-facilitated Exchanges, State-based Exchanges on the Federal platform, and non-Exchange entities required to comply with the privacy and security standards established and implemented by a Federally-facilitated Exchange pursuant to §155.260 for compliance with those standards. HHS will oversee and monitor State Exchanges for compliance with the standards State Exchanges establish and implement pursuant to §155.260. State Exchanges will oversee and monitor non-Exchange entities required to comply with the privacy and security standards established and implemented by a State Exchange in accordance to §155.260.

* * * * *

32. Section 155.302 is amended by revising paragraph (a)(1) to read as follows:

§155.302 Options for conducting eligibility determinations.

(a) * * *

(1) Directly, through contracting arrangements in accordance with §155.110(a), or as a State-based Exchange on the Federal platform through a Federal platform agreement under which HHS carries out eligibility determinations and other requirements contained within this subpart; or

* * * * *

33. Section 155.310 is amended by revising paragraphs (h) introductory text and (h)(2) to read as follows:

§155.310 Eligibility process.

* * * * *

(h) Notice of an employee's receipt of advance payments of the premium tax credit and cost-sharing reductions to an employer. The Exchange must notify an employer that an employee has been determined eligible for advance payments of the premium tax credit and cost-sharing reductions and has enrolled in a qualified health plan through the Exchange within a reasonable timeframe following a determination that the employee is eligible for advance payments of the premium tax credit and cost-sharing reductions in accordance with §155.305(g) or §155.350(a) and enrollment by the employee in a qualified health plan through the Exchange. Such notice must:

* * * * *

(2) Indicate that the employee has been determined eligible advance payments of the premium tax credit and cost-sharing reductions and has enrolled in a qualified health plan through the Exchange;

* * * * *

34. Section 155.320 is amended by--

- a. Revising paragraphs (c)(3)(vi) and (d)(3).
- b. Adding paragraph (d)(4).

The revisions and addition read as follows:

§155.320 Verification process related to eligibility for insurance affordability programs.

* * * *

(c) * * *

(3) * * *

(vi) Alternate verification process for decreases in annual household income estimates and for situations in which tax return data is unavailable. If a tax filer qualifies for an alternate verification process based on the requirements specified in paragraph (c)(3)(iv) of this section and the applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is more than a reasonable threshold below the annual household income computed in accordance with paragraph (c)(3)(ii)(A) of this section, or if data described in paragraph (c)(1)(i) of this section is unavailable, the Exchange must attempt to verify the applicant's attestation of the tax filer's projected annual household income by following the procedures specified in paragraph (c)(3)(vi)(A) through (G) of this section. For the purposes of this paragraph (c)(3)(vi), a reasonable threshold is established by the Exchange in guidance and approved by HHS, but must not be less than 10 percent, and can also include a threshold dollar amount. The Exchange's threshold is subject to approval by HHS.

* * * *

(d) * * *

(3) Verification procedures. (i) If an applicant's attestation is not reasonably compatible with the information obtained by the Exchange as specified in paragraphs (d)(2)(i)

through (iii) of this section, other information provided by the application filer, or other information in the records of the Exchange, the Exchange must follow the procedures specified in §155.315(f).

(ii) Except as specified in paragraph (d)(3)(i) or (d)(4)(i) of this section, the Exchange must accept an applicant's attestation regarding the verification specified in paragraph (d) of this section without further verification.

(4) Alternate procedures. For any benefit year for which it does not reasonably expect to obtain sufficient verification data as described in paragraphs (d)(2)(i) through (iii) of this section, the Exchange must follow the procedures specified in paragraph (d)(4)(i) of this section or, for benefit years 2016 and 2017, the Exchange may follow the procedures specified in paragraph (d)(4)(ii) of this section. For purposes of this paragraph (d)(4), the Exchange reasonably expects to obtain sufficient verification data for any benefit year when, for the benefit year, the Exchange is able to obtain data about enrollment in and eligibility for qualifying coverage in an eligible employer-sponsored plan from at least one electronic data source that is available to the Exchange and that has been approved by HHS, based on evidence showing that the data source is sufficiently current, accurate, and minimizes administrative burden, as described under paragraph (d)(2)(i) of this section.

(i) Select a statistically significant random sample of applicants for whom the Exchange does not have any of the information specified in paragraphs (d)(2)(i) through (iii) of this section and—

(A) Provide notice to the applicant indicating that the Exchange will be contacting any employer identified on the application for the applicant and the members of his or her household, as defined in 26 CFR 1.36B-1(d), to verify whether the applicant is enrolled in an eligible

employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(B) Proceed with all other elements of the eligibility determination using the applicant's attestation, and provide eligibility for enrollment in a QHP to the extent that an applicant is otherwise qualified;

(C) Ensure that advance payments of the premium tax credit and cost-sharing reductions are provided on behalf of an applicant who is otherwise qualified for such payments and reductions, as described in §155.305, if the tax filer attests to the Exchange that he or she understands that any advance payments of the premium tax credit paid on his or her behalf are subject to reconciliation;

(D) Make reasonable attempts to contact any employer identified on the application for the applicant and the members of his or her household, as defined in 26 CFR 1.36B-1(d), to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(E) If the Exchange receives any information from an employer relevant to the applicant's enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan, the Exchange must determine the applicant's eligibility based on such information and in accordance with the effective dates specified in §155.330(f), and if such information changes his or her eligibility determination, notify the applicant and his or her employer or employers of such determination in accordance with the notice requirements specified in §155.310(g) and (h);

(F) If, after a period of 90 days from the date on which the notice described in paragraph (d)(4)(i)(A) of this section is sent to the applicant, the Exchange is unable to obtain the necessary information from an employer, the Exchange must determine the applicant's eligibility based on his or her attestation regarding coverage provided by that employer.

(G) To carry out the process described in paragraph (d)(4)(i) of this section, the Exchange must only disclose an individual's information to an employer to the extent necessary for the employer to identify the employee.

(ii) Establish an alternative process approved by HHS.

* * * *

35. Section 155.335 is amended by revising paragraph (j) to read as follows:

§155.335 Annual eligibility redetermination.

* * * *

(j) Re-enrollment. If an enrollee remains eligible for enrollment in a QHP through the Exchange upon annual redetermination and—

(1) QHPs under the product under which the QHP in which he or she is enrolled remain available through the Exchange for renewal, consistent with §147.106 of this subchapter, such enrollee will have his or her enrollment through the Exchange in a QHP under that product renewed, unless he or she terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with §155.430. The Exchange will ensure that re-enrollment in coverage under this paragraph (j)(1) occurs under the same product (except as provided in paragraph (j)(1)(iii)(A) of this section) in which the enrollee was enrolled, as follows:

(i) The enrollee's coverage will be renewed in the same plan as the enrollee's current QHP, unless the current QHP is not available through the Exchange.

(ii) If the enrollee's current QHP is not available through the Exchange, the enrollee's coverage will be renewed in a QHP at the same metal level as the enrollee's current QHP within the same product.

(iii) If the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP at the same metal level as the enrollee's current QHP and--

(A) The enrollee's current QHP is a silver level plan, the enrollee will be re-enrolled in a silver level QHP under a different product offered by the same QHP issuer that is most similar to the enrollee's current product. If no such silver level QHP is available for enrollment through the Exchange, the enrollee's coverage will be renewed in a QHP that is one metal level higher or lower than the enrollee's current QHP under the same product;

(B) The enrollee's current QHP is not a silver level plan, the enrollee's coverage will be renewed in a QHP that is one metal level higher or lower than the enrollee's current QHP under the same product; or

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

(2) No plans under the product under which the QHP in which he or she is enrolled are available through the Exchange for renewal, consistent with §147.106 of this subchapter, such enrollee may be enrolled in a QHP under a different product offered by the same QHP issuer, to

the extent permitted by applicable State law, unless he or she terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with §155.430. The Exchange will ensure that re-enrollment in coverage under this paragraph (j)(2) occurs as follows:

(i) The enrollee will be re-enrolled in a QHP at the same metal level as the enrollee's current QHP in the product offered by the same issuer that is the most similar to the enrollee's current product;

(ii) If the issuer does not offer another QHP at the same metal level as the enrollee's current QHP, the enrollee will be re-enrolled in a QHP that is one metal level higher or lower than the enrollee's current QHP in the product offered by the same issuer through the Exchange that is the most similar to the enrollee's current product; or

(iii) If the issuer does not offer another QHP through the Exchange at the same metal level as, or one metal level higher or lower than the enrollee's current QHP, the enrollee will be re-enrolled in any other QHP offered by the same issuer in which the enrollee is eligible to enroll.

* * * * *

36. Section 155.400 is amended by revising paragraph (e) and adding paragraphs (g) and (h) to read as follows:

§155.400 Enrollment of qualified individuals into QHPs.

* * * * *

(e) Premium payment. Exchanges may, and the Federally-facilitated Exchange will, require payment of a binder payment to effectuate an enrollment or to add coverage retroactively

to an already effectuated enrollment. Exchanges may, and the Federally-facilitated Exchange will, establish a standard policy for setting premium payment deadlines:

(1) In a Federally-facilitated Exchange:

(i) For prospective coverage to be effectuated under regular coverage effective dates, as provided for in §§155.410(f) and 155.420(b)(1), the binder payment must consist of the first month's premium, and the deadline for making the binder payment must be no earlier than the coverage effective date, and no later than 30 calendar days from the coverage effective date;

(ii) For prospective coverage to be effectuated under special effective dates, as provided for in §155.420(b)(2), the binder payment must consist of the first month's premium, and the deadline for making the binder payment must be no earlier than the coverage effective date and no later than 30 calendar days from the date the issuer receives the enrollment transaction or the coverage effective date, whichever is later.

(iii) For coverage to be effectuated under retroactive effective dates, as provided for in §155.420(b)(2), the binder payment must consist of the premium due for all months of retroactive coverage through the first prospective month of coverage, and, the deadline for making the binder payment must be no earlier than 30 calendar days from the date the issuer receives the enrollment transaction. If only the premium for one month of coverage is paid, only prospective coverage should be effectuated, in accordance with regular effective dates.

(2) [Reserved]

* * * * *

(g) Premium payment threshold. Exchanges may, and the Federally-facilitated Exchange will, allow issuers to implement, a premium payment threshold policy under which issuers can consider enrollees to have paid all amounts due if the enrollees pay an amount sufficient to

maintain a percentage of total premium paid out of the total premium owed equal to or greater than a level prescribed by the issuer, provided that the level is reasonable and that the level and the policy are applied in a uniform manner to all enrollees. If an applicant or enrollee satisfies the premium payment threshold policy, the issuer may:

(1) Effectuate an enrollment based on payment of the binder payment under paragraph (e) of this section.

(2) Avoid triggering a grace period for non-payment of premium, as described by §156.270(d) of this subchapter or a grace period governed by State rules.

(3) Avoid terminating the enrollment for non-payment of premium as, described by §§156.270(g) of this subchapter and 155.430(b)(2)(ii)(A) and(B).

(h) Requirements. A State Exchange may rely on HHS to carry out the requirements of this section and other requirements contained within this subpart E through a Federal platform agreement.

37. Section 155.410 is amended by revising paragraphs (e)(2) and (f)(2) to read as follows:

§155.410 Initial and annual open enrollment periods.

* * * *

(e) * * *

(2) For the benefit years beginning on January 1, 2016 and on January 1, 2017, the annual open enrollment period begins on November 1 of the calendar year preceding the benefit year, and extends through January 31 of the benefit year.

(f) * * *

(2) For the benefit years beginning on January 1, 2016 and on January 1, 2017, the Exchange must ensure that coverage is effective —

(i) January 1 for QHP selections received by the Exchange on or before December 15 of the calendar year preceding the benefit year.

(ii) February 1 for QHP selections received by the Exchange from December 16 of the calendar year preceding the benefit year through January 15 of the benefit year.

(iii) March 1 for QHP selections received by the Exchange from January 16 through January 31 of the benefit year.

* * * * *

38. Section 155.430 is amended by--

- a. Adding paragraph (b)(1)(iv).
- b. Revising paragraphs (b)(2)(ii)(A).
- c. Redesignating paragraph (b)(2)(vi) as paragraph (b)(2)(vii).
- d. Adding paragraphs (b)(2)(vi) and (d)(9), (10), and (11)

The additions and revision read as follows:

§155.430 Termination of Exchange enrollment or coverage.

* * * * *

(b) * * *

(1) * * *

(iv) The Exchange must permit an enrollee to retroactively terminate or cancel his or her coverage or enrollment in a QHP in the following circumstances:

(A) The enrollee demonstrates to the Exchange that he or she attempted to terminate his or her coverage or enrollment in a QHP and experienced a technical error that did not allow the

enrollee to terminate his or her coverage or enrollment through the Exchange, and requests retroactive termination within 60 days after he or she discovered the technical error.

(B) The enrollee demonstrates to the Exchange that his or her enrollment in a QHP through the Exchange was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent, or erroneous enrollment. For purposes of this paragraph (b)(1)(iv)(B), misconduct includes the failure to comply with applicable standards under this part, part 156 of this subchapter, or other applicable Federal or State requirements as determined by the Exchange.

(C) The enrollee was enrolled in a QHP without his or her knowledge or consent due to the fraudulent activity of any third party, including third parties who have no connection with the Exchange, and requests cancellation within 60 days of discovering of the fraudulent enrollment.

(2) * * *

(ii) * * *

(A) The exhaustion of the 3-month grace period, as described in §156.270(d) and (g) of this subchapter, required for enrollees, who when first failing to timely pay premiums, are receiving advance payments of the premium tax credit;

* * * * *

(vi) The enrollee was enrolled in a QHP due to fraudulent activity, including fraudulent activity by a third party with no connection with the Exchange.

* * * * *

(d) * * *

(9) In case of a retroactive termination in accordance with paragraph (b)(1)(iv)(A) of this section, the termination date will be no sooner than 14 days after the date that the enrollee can demonstrate he or she contacted the Exchange to terminate his or her coverage or enrollment through the Exchange, unless the issuer agrees to an earlier effective date as set forth in paragraph (d)(2)(iii) of this section.

(10) In case of a retroactive cancellation or termination in accordance with paragraph (b)(1)(iv)(B) or (C) of this section, the cancellation date or termination date will be the original coverage effective date or a later date, as determined appropriate by the Exchange, based on the circumstances of the cancellation or termination.

(11) In the case of cancellation in accordance with paragraph (b)(2)(vi) of this section, the Exchange may cancel the enrollee's enrollment upon its determination that the enrollment was performed fraudulently and following reasonable notice to the enrollee (where possible). The termination date will be the original coverage effective date.

* * * * *

39. Section 155.505 is amended by adding paragraphs (b)(1)(iii) and (b)(5) and revising paragraph (b)(4) to read as follows:

§155.505 General eligibility appeals requirements.

* * * * *

(b) * * *

(1) * * *

(iii) A determination of eligibility for an enrollment period, made in accordance with §155.305(b);

* * * * *

(4) A denial of a request to vacate dismissal made by a State Exchange appeals entity in accordance with §155.530(d)(2), made under paragraph (c)(2)(i) of this section; and

(5) An appeal decision issued by a State Exchange appeals entity in accordance with §155.545(b), consistent with §155.520(c).

* * * *

40. Section 155.510 is amended by revising paragraph (a)(1) to read as follows:

§155.510 Appeals coordination.

(a) * * *

(1) Minimize burden on appellants, including not asking the appellant to provide duplicative information or documentation that he or she already provided to an agency administering an insurance affordability program or eligibility appeals process, unless the appeals entity, Exchange, or agency does not have access to the information or documentation and cannot reasonably obtain it;

* * * *

41. Section 155.520 is amended by adding paragraph (d)(2)(i)(D) to read as follows:

§155.520 Appeal requests.

* * * *

(d) * * *

(2) * * *

(i) * * *

(D) That, in the event the appeal request is not valid due to failure to submit by the date determined under paragraph (b) or (c) of this section, as applicable, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable

timeframe determined by the appeals entity that failure to timely submit was due to exceptional circumstances and should not preclude the appeal.

* * * *

42. Section 155.530 is amended by revising paragraph (a)(4) to read as follows:

§155.530 Dismissals.

(a) * * *

(4) Dies while the appeal is pending, except if the executor, administrator, or other duly authorized representative of the estate requests to continue the appeal.

* * * *

43. Section 155.535 is amended by revising paragraphs (a) introductory text and (b) to read as follows:

§155.535 Informal resolution and hearing requirements.

(a) Informal resolution. The HHS appeals process will provide an opportunity for informal resolution and a hearing in accordance with the requirements of this section. A State Exchange appeals entity may also provide an informal resolution process prior to a hearing. Any information resolution process must meet the following requirements:

* * * *

(b) Notice of hearing. When a hearing is scheduled, the appeals entity must send written notice to the appellant of the date, time, and location or format of the hearing no later than 15 days prior to the hearing date unless—

(1) The appellant requests an earlier hearing date; or

(2) A hearing date sooner than 15 days is necessary to process an expedited appeal, as described in §155.540(a), and the appeals entity has contacted the appellant to schedule a hearing on a mutually agreed upon date, time, and location or format.

* * * *

44. Section 155.545 is amended by revising paragraphs (b)(1) and (c)(1)(i) and (ii) to read as follows:

§155.545 Appeal decisions.

* * * *

(b) * * *

(1) Must issue written notice of the appeal decision to the appellant within 90 days of the date an appeal request under §155.520(b) or (c) is received, as administratively feasible.

* * * *

(c) * * *

(1) * * *

(i) Prospectively, on the first day of the month following the date of the notice of appeal decision, or consistent with §155.330(f)(2), (3), (4), or (5), if applicable; or

(ii) Retroactively, to the coverage effective date the appellant did receive or would have received if the appellant had enrolled in coverage under the incorrect eligibility determination that is the subject of the appeal, at the option of the appellant.

* * * *

45. Section 155.555 is amended by revising paragraphs (e)(1) introductory text and (l) to read as follows:

§155.555 Employer appeals process.

* * * *

(e) * *

(1) Upon receipt of a valid appeal request under this section, or upon receipt of the notice under paragraph (d)(1)(iii) of this section, the Exchange must promptly transmit via secure electronic interface to the appeals entity—

* * * *

(l) Implementation of the appeal decision. After receipt of the notice under paragraph (k)(3) of this section, if the appeal decision affects the employee's eligibility, the Exchange must promptly:

(1) Redetermine the employee's eligibility and the eligibility of the employee's household members, if applicable, in accordance with the standards specified in §155.305; or

(2) Notify the employee of the requirement to report changes in eligibility as described in §155.330(b)(1).

* * * *

46. Section 155.605 is amended by:

a. In paragraph (b), removing the reference “paragraphs (c)(2), (f)(2), and (g) of this section” and adding in its place the reference “paragraphs (c)(2) and (d) of this section”;

b. Removing paragraphs (d), (e) and (f);

c. Redesignating paragraph (g) as paragraph (d);

d. Revising newly redesignated paragraph (d); and

c. Adding paragraph (e).

The revision and addition read as follows:

§155.605 Eligibility standards for exemptions.

* * * * *

(d) Hardship--(1) General. The Exchange must grant a hardship exemption to an applicant eligible for an exemption for at least the month before, the month or months during which, and the month after a specific event or circumstance, if the Exchange determines that the applicant has suffered a hardship in relation to his or her ability to obtain coverage because they experienced one or more of the events or circumstances listed in paragraph (d)(1)(i) through (iii) or (d)(2) of this section. Notwithstanding the length of the hardship, any hardship exemption granted pursuant to this paragraph (d) may be granted for a maximum period that is not to exceed the month before the event or circumstance and the remainder of the calendar year during which the hardship commenced, plus the next calendar year.

(i) He or she experienced financial or domestic circumstances, including an unexpected natural or human-caused event, such that he or she had a significant, unexpected increase in essential expenses that prevented him or her from obtaining coverage under a qualified health plan;

(ii) The expense of purchasing a qualified health plan would have caused him or her to experience serious deprivation of food, shelter, clothing or other necessities; or

(iii) He or she has experienced other circumstances that prevented him or her from obtaining coverage under a qualified health plan.

(2) Examples of events and circumstances for which the Exchange must grant a hardship exemption to an applicant based on paragraph (d)(1) of this section include:

(i) Individuals that the Exchange determines are homeless.

(ii) Individuals who have been evicted or facing eviction or foreclosure.

(iii) Individuals who have received a shut-off notice from a utility company.

- (iv) Individuals who have experienced domestic violence.
- (v) Individuals who have experienced the death of a family member.
- (vi) Individuals who have experienced a fire, flood or other nature or human-caused disaster that caused substantial damage to your property.
- (vii) Individuals who have filed for bankruptcy.
- (viii) Individuals who had medical bills which resulted in substantial debt
- (ix) Individuals who experienced unexpected increases in necessary expenses due to caring for an ill, disabled or aging family member.
- (x) Individuals who are seeking categorical Medicaid eligibility under section 1902(f) of the Act for “209(b)” States (codified at 42 CFR 435.121).
- (xi) Individuals who are seeking Medicaid coverage provided to medically needy individuals under section 1902(a)(10)(C) of the Social Security Act 42 U.S.C. 1396(a)(10)(C) that is not recognized as government-sponsored minimum essential coverage (MEC) under IRS regulations or HHS regulations or guidance.
- (xii) Individuals who are enrolled in Medicaid coverage provided to a pregnant women that is not recognized as government-sponsored MEC under IRS regulations or HHS regulations or guidance.
- (xiii) Individuals who are enrolled in CHIP coverage provided to an unborn child that includes comprehensive prenatal care for the pregnant mother.
- (xiv) Individuals who are eligible for enrollment in a qualified health plan (QHP) through the Exchange, lower costs on the individual’s monthly premiums or cost-sharing reductions for a time period when the individual was not enrolled in a QHP through the Exchange as a result of an eligibility appeals decision.

(3) The hardship event or circumstance described under paragraph (d)(1) or (2) of this section must have occurred within 3 years of the date the applicant submits an application to the Exchange under §155.610, except in the case of applicants who are or who were homeless or experienced domestic violence.

(i) The date of submission of an application means the date of receipt of the application by the Exchange via the channels available for the submission of an application, as described in §155.610(d) or the date the application was signed by the submitter.

(ii) [Reserved]

(4) Lack of affordable coverage based on projected income. The Exchange must determine an applicant eligible for an exemption for a month or months during which he or she, or another individual the applicant attests will be included in the applicant's family, as defined in 26 CFR 1.36B-1(d), is unable to afford coverage in accordance with the standards specified in section 5000A(e)(1) of the Code, provided that—

(i) Eligibility for this exemption is based on projected annual household income;

(ii) An eligible employer-sponsored plan is only considered under paragraphs (d)(4)(iii) and (iv) of this section if it meets the minimum value standard described in §156.145 of this subchapter.

(iii) For an individual who is eligible to purchase coverage under an eligible employer-sponsored plan, the Exchange determines the required contribution for coverage such that—

(A) An individual who uses tobacco is treated as not earning any premium incentive related to participation in a wellness program designed to prevent or reduce tobacco use that is offered by an eligible employer-sponsored plan;

(B) Wellness incentives offered by an eligible employer-sponsored plan that do not relate to tobacco use are treated as not earned;

(C) In the case of an employee who is eligible to purchase coverage under an eligible employer-sponsored plan sponsored by the employee's employer, the required contribution is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost self-only coverage.

(D) In the case of an individual who is eligible to purchase coverage under an eligible employer-sponsored plan as a member of the employee's family, as defined in 26 CFR 1.36B-1(d), the required contribution is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost family coverage that would cover the employee and all other individuals who are included in the employee's family who have not otherwise been granted an exemption through the Exchange.

(iv) For an individual who is ineligible to purchase coverage under an eligible employer-sponsored plan, the Exchange determines the required contribution for coverage in accordance with section 5000A(e)(1)(B)(ii) of the Code, inclusive of all members of the family, as defined in 26 CFR 1.36B-1(d), who have not otherwise been granted an exemption through the Exchange and who are not treated as eligible to purchase coverage under an eligible employer-sponsored plan, in accordance with paragraph (d)(4)(ii) of this section; and

(v) The applicant applies for this exemption prior to the last date on which he or she could enroll in a QHP through the Exchange for the month or months of a calendar year for which the exemption is requested.

(vi) The Exchange must make an exemption in this category available prospectively, and provide it for all remaining months in a coverage year, notwithstanding any change in an individual's circumstances.

(5) Ineligible for Medicaid based on a State's decision not to expand. The Exchange must determine an applicant eligible for an exemption for a calendar year if he or she would be determined ineligible for Medicaid for one or more months during the benefit year solely as a result of a State not implementing section 2001(a) of the Affordable Care Act.

(e) Eligibility for an exemption through the IRS. Hardship exemptions in this paragraph can be claimed on a Federal income tax return without obtaining an exemption certificate number. The IRS may allow an individual to claim the hardship exemptions described in this paragraph (e) without requiring an exemption certificate number from the Exchange.

(1) Filing threshold. The IRS may allow an applicant to claim an exemption specified in HHS Guidance published September 18, 2014, entitled, Shared Responsibility Guidance – Filing Threshold Hardship Exemption,” and in IRS Notice 2014-76, section B.

(2) Self-only coverage in an eligible employer-sponsored plan. The IRS may allow an applicant to claim an exemption specified in HHS Guidance published November 21, 2014, entitled, “Guidance on Hardship Exemptions for Persons Meeting Certain Criteria,” and in IRS Notice 2014-76, section A.

(3) Eligible for services through an Indian health care provider. The IRS may allow an applicant to claim the exemption specified in HHS Guidance published September 18, 2014, entitled, “Shared Responsibility Guidance – Exemption for Individuals Eligible for Services through an Indian Health Care Provider,” and in IRS Notice 2014-76, section E.

(4) Ineligible for Medicaid based on a State’s decision not to expand. The IRS may allow an applicant to claim the exemption specified in HHS Guidance published November 21, 2014, entitled, “Guidance on Hardship Exemptions for Persons Meeting Certain Criteria,” and in IRS Notice 2014-76, section F.

47. Section 155.610 is amended by revising paragraph (h)(1) and adding paragraph (k) to read as follows:

§155.610 Eligibility process for exemptions.

* * * * *

(h) * * *

(1) Except for the exemptions described in §155.605(c) and (d), after December 31 of a given calendar year, the Exchange may decline to accept an application for an exemption that is available retrospectively for months for such calendar year, and must provide information to individuals regarding how to claim an exemption through the tax filing process.

* * * * *

(k) Incomplete application. (1) If an applicant submits an application that does not include sufficient information for the Exchange to conduct a determination for eligibility of an exemption the Exchange must—

(i) Provide notice to the applicant indicating that information necessary to complete an eligibility determination is missing, specifying the missing information, and providing instructions on how to provide the missing information; and

(ii) Provide the applicant with a period of no less than 10 and no more than 90 days, in the reasonable discretion of the Exchange, from the date on which the notice described in

paragraph (k)(1) of this section is sent to the applicant to provide the information needed to complete the application to the Exchange; and

(iii) Not proceed with the applicant's eligibility determination during the period described in paragraph (k)(2) of this section.

(2) If the Exchange does not receive the requested information within the time allotted in paragraph (k)(1)(ii) of this section, the Exchange must notify the applicant in writing that the Exchange cannot process the application and provide appeal rights to the applicant.

48. Section 155.615 is amended by-

- a. Removing paragraphs (c), (d), and (e).
- b. Redesignating paragraphs (f), (g), (h), (i), (j), and (k) as paragraphs (c), (d), (e), (f), (g), and (h), respectively.
- c. Revising newly redesignated paragraph (c)(1).
- d. Removing newly redesignated paragraph (c)(3).
- e. Further redesignating newly redesignated paragraph (c)(2) as paragraph (c)(3).
- f. Adding paragraph (c)(2).

The revision and addition read as follows:

§155.615 Verification process related to eligibility for exemptions.

* * * * *

(c) Verification related to exemption for hardship—(1) In general. For any applicant who requests an exemption based on hardship, except for the hardship exemptions described in §155.605(d)(3), the Exchange must verify whether he or she has experienced the hardship to which he or she is attesting.

(2) Hardship. If the hardship-qualifying event or circumstance in §155.605(d)(1) began more than 3 years prior to the date the exemption application was submitted, as specified in §155.605(d)(3)(i), and the event or circumstance continued beyond the initial 3-year period, the Exchange must verify the applicant continued to experience the hardship to which he or she is attesting during a period that is within 3 years from the date of the exemption application submitted under §155.605(d)(1).

* * * *

49. Section 155.625 is amended by revising paragraphs (a)(2) and (b) to read as follows:

§155.625 Options for conducting eligibility determinations for exemptions.

(a) * * *

(2) By use of the HHS service under paragraph (b) of this section.

(b) Use of HHS service. Notwithstanding the requirements of this subpart, the Exchange may adopt an exemption eligibility determination made by HHS.

50. Section 155.705 is amended by:

- a. Adding paragraphs (b)(3)(viii), (ix), and (x).
- b. In paragraph (b)(4)(ii)(B), removing the semicolon and adding a colon in its place.
- c. Adding paragraph (b)(4)(ii)(B)(1) and adding and reserving paragraph (b)(4)(ii)(B)(2).
- d. Revising paragraphs (b)(4)(ii)(C)(2) and (b)(11)(ii)(A), (B), and (C).
- e. Removing paragraphs (b)(11)(ii)(D) and (E).

The revisions and additions read as follows:

§155.705 Functions of a SHOP.

* * * *

(b) * * *

(3) * * *

(viii) For plan years beginning on or after January 1, 2017, a Federally-facilitated SHOP will provide a qualified employer a choice of three methods to make QHPs available to qualified employees and their dependents:

(A) The employer may choose a level of coverage as described in paragraph (b)(2) of this section;

(B) The employer may choose a single QHP; or

(C) The employer may offer its qualified employees a choice of all QHPs offered through a Federally-facilitated SHOP by a single issuer across all available levels of coverage, as described in section 1302(d)(1) of the Affordable Care Act and implemented in §156.140(b) of this subchapter.

(ix) For plan years beginning on or after January 1, 2017, a Federally-facilitated SHOP will provide a qualified employer a choice of three methods to make stand-alone dental plans available to qualified employees and their dependents:

(A) The employer may choose to make available a single stand-alone dental plan;

(B) The employer may choose to make available all stand-alone dental plans offered through a Federally-facilitated SHOP at a level of coverage as described in §156.150(b)(2) of this subchapter; or

(C) The employer may offer its qualified employees a choice of all plans offered through a Federally-facilitated SHOP by a single issuer across all available levels of coverage, as described in §156.150(b)(2) of this subchapter.

(x) States operating as a State-based Exchange utilizing the Federal platform for SHOP enrollment functions will have the same employer choice models available as States with a Federally-facilitated SHOP.

(4) * * *

(ii) * * *

(B) * * *

(1) In a Federally-facilitated SHOP, payment for the group's first month of coverage must be received by the premium aggregation services vendor on or before the 20th day of the month prior to the month that coverage begins.

(2) [Reserved]

(C) * * *

(2) The number of days for which coverage is being provided in the month described in paragraph (b)(4)(ii)(C)(1) of this section.

* * * *

(11) * * *

(ii) * * *

(A) When the employer offers a single plan to qualified employees, the employer must use a fixed contribution methodology under which the employer contributes a fixed percentage of the plan's premium for each qualified employee and, if applicable, for each dependent of a qualified employee. A tobacco surcharge, if applicable, will be applied after the employer's contribution is applied to the premium.

(B) When the employer offers a choice of plans to qualified employees, the employer may use a fixed contribution methodology or a reference plan contribution methodology. Under

the fixed contribution methodology, the employer contributes a fixed percentage of the premiums for each qualified employee and, if applicable, for each dependent of a qualified employee, across all plans in which any qualified employee, and, if applicable, any dependent of a qualified employee, is enrolled. Under the reference plan contribution methodology, the employer will select a plan from within the level of coverage offered as described in paragraphs (b)(2) and (3) of this section to serve as a reference plan on which contributions will be based, and then will define a percentage contribution toward premiums under the reference plan; the resulting contribution amounts under the reference plan will be applied toward any plan in which a qualified employee or, if applicable, any dependent of a qualified employee, is enrolled, up to the lesser of the contribution amount or the total amount of any premium for the selected plan before application of a tobacco surcharge, if applicable. A tobacco surcharge, if applicable, will be applied after the employer's contribution is applied to the premium.

(C) The employer will define a percentage contribution toward premiums for employee-only coverage and, if dependent coverage is offered, a percentage contribution toward premiums for dependent coverage. To the extent permitted by other applicable law, for plan years beginning on or after January 1, 2015, a Federally-facilitated SHOP may permit an employer to define a different percentage contribution for full-time employees from the percentage contribution it defines for non-full-time employees, and it may permit an employer to define a different percentage contribution for dependent coverage for full-time employees from the percentage contribution it defines for dependent coverage for non-full-time employees.

* * * * *

51. Section 155.715 is amended by revising paragraph (g)(1) to read as follows:

§155.715 Eligibility determination process for SHOP.

* * * * *

(g) * * *

(1) Each QHP terminates the enrollment through the SHOP of the employer's enrollees enrolled in a QHP through the SHOP; and

* * * * *

52. Section 155.725 is amended by revising paragraphs (c), (e), (h)(2), (i)(1) introductory text, and (j)(2)(i) to read as follows:

§155.725 Enrollment periods under SHOP.

* * * * *

(c) Annual employer election period. The SHOP must provide qualified employers with a standard election period prior to the completion of the employer's plan year and before the annual employee open enrollment period, in which the qualified employer may change its participation in the SHOP for the next plan year, including –

(1) The method by which the qualified employer makes QHPs available to qualified employees pursuant to §155.705(b)(2) and (3);

(2) The employer contribution towards the premium cost of coverage;

(3) The level of coverage offered to qualified employees as described in §155.705(b)(2) and (3); and

(4) The QHP or QHPs offered to qualified employees in accordance with §155.705.

* * * * *

(e) Annual employee open enrollment period. (1) The SHOP must establish a standardized annual open enrollment period for qualified employees prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period.

(2) Qualified employers in a Federally-facilitated SHOP must provide qualified employees with an annual open enrollment period of at least one week.

* * * *

(h) * *

(2) For a group enrollment received by the Federally-facilitated SHOP from a qualified employer at the time of an initial group enrollment or renewal:

(i) Between the first and fifteenth day of any month, the Federally-facilitated SHOP must ensure a coverage effective date of the first day of the following month unless the employer opts for a later effective date within a quarter for which small group market rates are available.

(ii) Between the 16th and last day of any month, the Federally-facilitated SHOP must ensure a coverage effective date of the first day of the second following month unless the employer opts for a later effective date within a quarter for which small group market rates are available.

* * * *

(i) * *

(1) If a qualified employee enrolled in a QHP through the SHOP remains eligible for enrollment through the SHOP in coverage offered by the same qualified employer, the SHOP may provide for a process under which the employee will remain in the QHP selected the previous year, unless—

* * * *

(j) * *

(2) * *

(i) Experiences an event described in §155.420(d)(1) (other than paragraph (d)(1)(ii)), or experiences an event described in §155.420(d)(2), (4), (5), (7), (8), or (9);

* * * * *

53. Section 155.735 is amended by revising paragraphs (c)(2) introductory text and (d)(2) to read as follows:

§155.735 Termination of SHOP enrollment or coverage.

* * * * *

(c) * * *

(2) In an FF-SHOP, for premium payments other than payments for the first month of coverage—

* * * * *

(d) * * *

(2) In the FF-SHOP, termination is effective:

(i) In the case of a termination in accordance with paragraphs (d)(1)(i), (ii), (iii), and (v) of this section, termination is effective on the last day of the month in which the Federally-facilitated SHOP receives notice of the event described in paragraph (d)(1)(i), (ii), (iii), or (v) of this section.

(ii) In the case of a termination in accordance with paragraph (d)(1)(iv) of this section, the last day of coverage in an enrollee's prior QHP is the day before the effective date of coverage in his or her new QHP, including for any retroactive enrollments effectuated under §155.420(b)(2).

(iii) The FF-SHOP will send qualified employees a notice notifying them in advance of a child dependent's loss of eligibility for dependent child coverage under their plan because of age.

The notice will be sent 90 days in advance of the date when the dependent enrollee would lose eligibility for dependent child coverage. The enrollee will also receive a separate termination notice when coverage is terminated, under §155.735(g).

* * * * *

54. Section 155.740 is amended by revising paragraphs (c)(2), (d)(2), and (l)(3) to read as follows:

§155.740 SHOP employer and employee eligibility appeals requirements.

* * * * *

(c) * * *

(2) A failure by the SHOP to provide a timely eligibility determination or a timely notice of an eligibility determination in accordance with §155.715(e).

(d) * * *

(2) A failure by the SHOP to provide a timely eligibility determination or a timely notice of an eligibility determination in accordance with §155.715(f).

* * * * *

(l) * * *

(3) Be effective as follows:

(i) If an employer is found eligible under the decision, then at the employer's option, the effective date of coverage or enrollment through the SHOP under the decision can either be made retroactive to the effective date of coverage or enrollment through the SHOP that the employer would have had if the employer had been correctly determined eligible, or prospective to the first day of the month following the date of the notice of the appeal decision.

(ii) If an employee is found eligible under the decision, then at the employee's option, the effective date of coverage or enrollment through the SHOP under the decision can either be made effective retroactive to the effective date of coverage or enrollment through the SHOP that the employee would have had if the employee had been correctly determined eligible, or prospective to the first day of the month following the date of the notice of the appeal decision.

(iii) If the employer or employee is found ineligible under the decision, then the decision is effective on the first day of the month following the date of the notice of the appeal decision.

* * * * *

PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

55. The authority citation for part 156 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301-1304, 1311-1313, 1321-1322, 1324, 1334, 1342-1343, 1401-1402, Pub. L. 111-148, 124 Stat. 119 (42 U.S.C. 18021-18024, 18031-18032, 18041-18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701).

56. Section 156.20 is amended by adding a definition of “Standardized option” in alphabetical order to read as follows:

§156.20 Definitions.

* * * * *

Standardized option means a QHP with a standardized cost-sharing structure specified by HHS and that is offered for sale through an individual market Federally-facilitated Exchange.

57. Section 156.50 amended by revising paragraph (c) to read as follows:

§156.50 Financial support.

* * * *

(c) Requirement for Federally-facilitated Exchange user fee. (1) To support the functions of Federally-facilitated Exchanges, a participating issuer offering a plan through a Federally-facilitated Exchange must remit a user fee to HHS each month, in the time frame and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for Federally-facilitated Exchanges for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through a Federally-facilitated Exchange.

(2) To support the functions of State-based Exchanges on the Federal platform, a participating issuer offering a plan through a State-based Exchange that elects to utilize the Federal Exchange platform for certain Exchange functions described in §155.200 of this subchapter, as specified in a Federal platform agreement, must remit a user fee to HHS, in the timeframe and manner established by HHS, equal to the product of the sum of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for State-based Exchanges that use the Federal platform for the applicable benefit year plus any additional user fee rate that HHS will collect on behalf of the State-based Exchange, multiplied by the monthly premium charged by the issuer for each policy under the plan where enrollment is through the State-based Exchange on the Federal platform.

* * * *

58. Section 156.80 is amended by revising paragraph (d)(3)(ii) to read as follows:

§156.80 Single risk pool.

* * * *

(d) * * *

(3) * * *

(ii) A health insurance issuer in the small group market (not including a merged market) may establish index rates and make the marketwide adjustments under paragraph (d)(1) of this section, and make the plan-level adjustments under paragraph (d)(2) of this section, no more frequently than quarterly. Any changes to rates must have effective dates of January 1, April 1, July 1, or October 1. Such rates may only apply to coverage issued or renewed on or after the rate effective date and will apply for the entire plan year of the group health plan.

* * * * *

59. Section 156.135 is amended by revising paragraph (g) to read as follows:

§156.135 AV calculation for determining level of coverage.

* * * * *

(g) Updates to the AV Calculator. HHS will update the AV Calculator annually for material changes that may include costs, plan designs, the standard population, developments in the function and operation of the AV Calculator and other actuarially relevant factors.

60. Section 156.150 is amended by adding paragraphs (a)(1) and (2), (c), and (d) to read as follows:

§156.150 Application to stand-alone dental plans inside the Exchange.

(a) * * *

(1) For plan years beginning after 2016, for one covered child – the dollar limit applicable to a stand-alone dental plan for one covered child specified in this paragraph (a) increased by an amount equal to the product of that amount and the quotient of consumer price index for dental services for the year 2 years prior to the benefit year, divided by the consumer price index for dental services for 2016.

(2) For plan years after 2016, for two or more covered children – twice the dollar limit for one child described in paragraph (a)(1) of this section.

* * * * *

(c) Consumer price index for dental services defined. The consumer price index for dental services is a sub-component of the US Department of Labor’s Bureau of Labor Statistics Consumer Price Index specific to dental services.

(d) Increments of cost sharing increases. Any increase in the annual dollar limits described in paragraph (a)(1) of this section that does not result in a multiple of 25 dollars will be rounded down, to the next lowest multiple of 25 dollars.

61. Section 156.230 is amended by adding (d), (e), and (f) to read as follows.

§156.230 Network adequacy standards.

* * * * *

(d) Minimum threshold. A QHP in a Federally-facilitated Exchange meets the standard under paragraph (a)(2) of this section if its network is determined adequate under the following standards:

(1) In a State that implements an acceptable quantifiable network adequacy metric commonly used in the health insurance industry to measure network adequacy, under that metric;
or

(2) In any other State, under the Federal time and distance standard, based on minimum number of providers and average time and distance to those providers. QHPs that cannot meet the time and distance standard established by HHS may satisfy this requirement by reasonably justifying variances from this standard based on such factors as the availability of providers and variables reflected in local patterns of care.

(e) Provider transitions. A QHP issuer in a Federally-facilitated Exchange must—

(1) Make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal;

(2) In cases where a provider is terminated without cause, allow an enrollee in active treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.

(i) For the purposes of paragraph (e)(2) of this section, active treatment means:

(A) An ongoing course of treatment for a life-threatening condition;

(B) An ongoing course of treatment for a serious acute condition;

(C) The second or third trimester of pregnancy; or

(D) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

(ii) Any decisions made for a request for continuity of care under paragraph (e)(2) of this section must be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable State or Federal law or regulations.

(f) Out-of-network cost sharing. Notwithstanding §156.130(c), for a network to be deemed adequate, each QHP that uses a provider network must:

(1) Count the cost sharing paid by an enrollee for an essential health benefit provided by an out-of-network provider in an in-network setting towards the enrollee's annual limitation on cost sharing; or

(2) Provide a written notice to the enrollee at least ten business days before the provision of the benefit that additional costs may be incurred for an essential health benefit provided by an out-of-network provider in an in-network setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing.

62. Section 156.235, as amended on February 27, 2015 (80 FR 10873), is further amended by revising paragraphs (a)(2)(i) and (b)(2)(i) to read as follows:

§156.235 Essential community providers.

(a) * * *

(2) * * *

(i) The network includes as participating practitioners at least a minimum percentage, as specified by HHS, of available essential community providers in each plan's service area. For plan years beginning prior to January 1, 2018, multiple providers at a single location will count as a single essential community provider toward both the available essential community providers in the plan's service area and the issuer's satisfaction of the essential community provider participation standard. For plan years beginning on or after January 1, 2018, multiple contracted or employed full-time equivalent practitioners at a single location will count toward both the available essential community providers in the plan's service area and the issuer's satisfaction of the essential community provider participation standard; and

* * * * *

(b) * * *

(2) * * *

(i) The number of its providers that are located in Health Professional Shortage Areas or five-digit zip codes in which 30 percent or more of the population falls below 200 percent of the Federal Poverty Line satisfies a minimum percentage, specified by HHS, of available essential community provider in the plan's service area. For plan years beginning prior to January 1, 2018, multiple providers at a single location will count as a single essential community provider toward both the available essential community providers in the plan's service area and the issuer's satisfaction of the essential community provider participation standard. For plan years beginning on or after January 1, 2018, multiple contracted or employed full-time equivalent practitioners at a single location will count toward both the available essential community providers in the plan's service area and the satisfaction of the essential community provider participation standard; and

* * * * *

63. Section 156.265 is amended by revising paragraph (b)(2)(ii) to read as follows:

§156.265 Enrollment process for qualified individuals.

* * * * *

(b) * * *

(2) * * *

(ii) Ensure the applicant received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site or an Exchange approved web service using the FFE single streamline application.

* * * * *

64. Section 156.270 is amended by revising paragraphs (d) introductory text and (g) to read as follows:

§156.270 Termination of coverage or enrollment for qualified individuals.

* * * * *

(d) Grace period for recipients of advance payments of the premium tax credit. A QHP issuer must provide a grace period of 3 months for an enrollee, who when failing to timely pay premiums, is receiving advance payments of the premium tax credit. During the grace period, the QHP issuer must:

* * * * *

(g) Exhaustion of grace period. If an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period in paragraph (d) of this section without paying all outstanding premiums, subject to a premium payment threshold implemented under §155.400(g) of this subchapter, if applicable, the QHP issuer must terminate the enrollee's enrollment through the Exchange on the effective date described in §155.430(d)(4) of this subchapter, provided that the QHP issuer meets the notice requirement specified in paragraph (b) of this section.

* * * * *

65. Section 156.285 is amended by revising paragraph (c)(5) and removing and reserving paragraph (d)(2) to read as follows:

§156.285 Additional standards specific to SHOP

* * * * *

(c) * * *

(5) In a Federally-facilitated SHOP, must send enrollment reconciliation files on at least a monthly basis according to a process, timeline, and file format established by the Federally-facilitated SHOP;

* * * * *

(d) * * *

(2) [Reserved]

* * * * *

66. Section 156.298 is amended by--

- a. Revising paragraph (b)(4).
- b. Removing paragraph (b)(5).
- c. Redesignating paragraph (b)(6) as paragraph (b)(5).
- d. Revising newly redesignated paragraph (b)(5).

The revision reads as follows:

§156.298 Meaningful difference standard for Qualified Health Plans in the Federally-facilitated Exchanges.

* * * * *

(b) * * *

(4) Plan type; or

(5) Child-only versus non Child-only plan offerings.

* * * * *

67. The heading of subpart D is revised to read as follows:

Subpart D -- Standards for Qualified Health Plan Issuers on Federally-Facilitated Exchanges and State-Based Exchanges on the Federal Platform

68. Section 156.350 is added to subpart D to read as follows:

§156.350 Eligibility and enrollment standards for Qualified Health Plan issuers on State-based Exchanges on the Federal platform.

(a) In order to participate in a State-based Exchange on the Federal platform, a QHP issuer must comply with HHS regulations, and guidance pertaining to issuer eligibility and enrollment functions as if the issuer were an issuer of a QHP on a Federally-facilitated Exchange. These requirements include —

- (1) Section 156.285(a)(4)(ii) regarding the premiums for plans offered on the SHOP;
- (2) Section 156.285(c)(8)(iii) regarding enrollment process for SHOP; and
- (3) Section 156.715 regarding compliance reviews of QHP issuers, to the extent relating directly to applicable eligibility and enrollment functions.

(b) HHS will permit issuers of QHPs in each State-based Exchange on the Federal platform to directly enroll applicants in a manner that is considered to be through the Exchange, as if the issuers were issuers of QHPs on Federally-facilitated Exchanges under §156.1230(a), to the extent permitted by applicable State law.

(c) If the State-based Exchange on the Federal platform does not substantially enforce a requirement in paragraph (a) of this section against the issuer or plan, then HHS may do so, in accordance with the enforcement remedies in subpart I of this part, subject to the administrative review process in subpart J of this part.

69. Section 156.805 is amended by revising paragraph (d) to read as follows:

§156.805 Bases and process for imposing civil money penalties in Federally-facilitated Exchanges.

* * * * *

(d) Request for hearing. (1) An issuer may appeal the assessment of a civil money penalty under this section by filing a request for hearing under an applicable administrative hearing process.

(2) If an issuer files a request for hearing under this paragraph (d), the assessment of a civil money penalty will not occur prior to the issuance of the final administrative decision in the appeal.

* * * *

70. Section 156.810 is amended by revising paragraphs (a)(12) and (13) and (e) and adding paragraphs (a)(14) and (15) to read as follows:

§156.810 Bases and process for decertification of a QHP offered by an issuer through a Federally-facilitated Exchange.

(a) * * *

(12) The QHP issuer substantially fails to meet the requirements related to the cases forwarded to QHP issuers under subpart K of this part;

(13) The QHP issuer substantially fails to meet the requirements related to the offering of a QHP under subpart M of this part;

(14) The QHP issuer offering the QHP is the subject of a pending, ongoing, or final State regulatory or enforcement action or determination that relates to the issuer offering QHPs in the Federally-facilitated Exchanges; or

(15) HHS reasonably believes that the QHP issuer lacks the financial viability to provide coverage under its QHPs until the end of the plan year.

* * * *

(e) Request for hearing. An issuer may appeal the decertification of a QHP offered by that issuer under paragraph (c) or (d) of this section by filing a request for hearing under an applicable administrative hearing process.

(1) If an issuer files a request for hearing under this paragraph (e):

(i) If the decertification is under paragraph (b)(1) of this section, the decertification will not take effect prior to the issuance of the final administrative decision in the appeal, notwithstanding the effective date specified in paragraph (b)(1) of this section.

(ii) If the decertification is under paragraph (b)(2) of this section, the decertification will be effective on the date specified in the notice of decertification, but the certification of the QHP may be reinstated immediately upon issuance of a final administrative decision that the QHP should not be decertified.

(2) [Reserved]

71. Section §156.1110 is amended by revising paragraphs (a) and (b) and removing paragraph (d) to read as follows:

§156.1110 Establishment of patient safety standards for QHP issuers

(a) Patient safety standards. A QHP issuer that contracts with a hospital with greater than 50 beds must verify that the hospital, as defined in section 1861(e) of the Act:

(1) For plan years beginning before January 1, 2017, is Medicare-certified or has been issued a Medicaid-only CMS Certification Number (CCN) and is subject to the Medicare Hospital Conditions of Participation requirements for--

(i) A quality assessment and performance improvement program as specified in 42 CFR 482.21; and

(ii) Discharge planning as specified in 42 CFR 482.43.

(2) For plan years beginning on or after January 1, 2017--

(i)(A) Utilizes a patient safety evaluation system as defined in 42 CFR 3.20; and

(B) Implements a mechanism for comprehensive person-centered hospital discharge to improve care coordination and health care quality for each patient; or

(ii) Implements evidence-based initiatives to reduce all cause preventable harm, prevent hospital readmission, improve care coordination and improve health care quality through the collection, management and analysis of patient safety events.

(3) A QHP issuer must ensure that each of its QHPs meets the patient safety standards in accordance with this section.

(b) Documentation. A QHP issuer must collect:

(1) For plan years beginning before January 1, 2017, the CCN from each of its contracted hospitals with greater than 50 beds, to demonstrate that those hospitals meet patient safety standards required in paragraph (a)(1) of this section; and

(2) For plan years beginning on or after January 1, 2017, information, from each of its contracted hospitals with greater than 50 beds, to demonstrate that those hospitals meet patient safety standards required in paragraph (a)(2) of this section.

* * * * *

72. Section 156.1220 is amended by revising paragraphs (a)(3) and (a)(4)(ii) to read as follows:

§156.1220 Administrative appeals.

(a) * * *

(3) Time for filing a request for reconsideration. The request for reconsideration must be filed in accordance with the following timeframes:

(i) For advance payments of the premium tax credit, advance payments of cost-sharing reductions, or Federally-facilitated Exchange user fee charges, within 30 calendar days after the date of the final reconsideration notification specifying the aggregate amount of advance payments of the premium tax credit, advance payments of cost-sharing reductions, and Federally-facilitated Exchange user fees for the applicable benefit year;

(ii) For a risk adjustment payment or charge, including an assessment of risk adjustment user fees, within 30 calendar days of the date of the notification under §153.310(e) of this subchapter;

(iii) For a reinsurance payment, within 30 calendar days of the date of the notification under §153.240(b)(1)(ii) of this subchapter;

(iv) For a default risk adjustment charge, within 30 calendar days of the date of the notification of the default risk adjustment charge;

(v) For reconciliation of cost-sharing reductions, within 30 calendar days of the date of the notification of the cost-sharing reduction reconciliation payment or charge; and

(vi) For a risk corridors payment or charge, within 30 calendar days of the date of the notification under §153.510(d) of this subchapter.

(4) * * *

(ii) Notwithstanding paragraph (a)(1) of this section, a reconsideration with respect to a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error may be requested only if, to the extent the issue could have been previously identified by the issuer to HHS under §153.710(d)(2) of this subchapter, it was so identified and remains unresolved.

* * * * *

73. Section 156.1250 is revised to read as follows:

§156.1250 Acceptance of certain third party payments.

(a) Issuers offering individual market QHPs, including stand-alone dental plans, and their downstream entities, must accept premium and cost-sharing payments from the following third-party entities on behalf of plan enrollees:

(1) A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;

(2) An Indian tribe, tribal organization, or urban Indian organization; and

(3) A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf consistent with the program's statutory authority.

(b) An entity making third party payments of premiums under paragraph (a) of this section must notify HHS of its intent to do so, and the expected number of consumers for which it will do so, in a format and timeline established by HHS.

74. Section 156.1256 is added to subpart M to read as follows:

§156.1256 Other notices.

As directed by the FFE, health insurance issuer that is offering QHP coverage through an FFE must notify its enrollees of material plan or benefit display errors and the enrollees' eligibility for a special enrollment period, included in §155.420(d)(4) of this subchapter, within 30 calendar days after the error is identified.

PART 158—ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

75. The authority citation for part 158 continues to read as follows:

Authority: Section 2718 of the Public Health Service Act (42 U.S.C. 300gg-18), as amended.

76. Section 158.103 is amended by revising the definitions of “Large Employer”, “Small Employer”, and “Unpaid claim reserves” to read as follows:

§158.103 Definitions.

* * * * *

Large Employer has the meaning given the term in §144.103 of this subchapter.

* * * * *

Small Employer has the meaning given the term in §144.103 of this subchapter.

* * * * *

Unpaid claim reserves means reserves and liabilities established to account for claims that were incurred during the MLR reporting year but had not been paid within 6 months of the end of the MLR reporting year.

77. Section 158.140 is amended by revising paragraph (a) introductory text to read as follows:

§158.140 Reimbursement for clinical services provided to enrollees.

(a) General requirements. The report required in §158.110 must include direct claims paid to or received by providers, including under capitation contracts with physicians, whose services are covered by the policy for clinical services or supplies covered by the policy. In addition, the report must include claim reserves associated with claims incurred during the MLR

reporting year, the change in contract reserves, reserves for contingent benefits and the medical claim portion of lawsuits, and any incurred experience rating refunds. Reimbursement for clinical services, as defined in this section, is referred to as “incurred claims.” All components of and adjustments to incurred claims, with the exception of contract reserves, must be calculated based on claims incurred only during the MLR reporting year and paid through June 30th of the following year. Contract reserves must be calculated as of December 31st of the applicable year.

* * * * *

Dated: October 23, 2015.

Andrew M. Slavitt,
Acting Administrator,
Centers for Medicare & Medicaid Services.

Dated: November 17, 2015.

Sylvia M. Burwell,
Secretary,
Department of Health and Human Services.

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